AN EXPLORATION OF THE IMPACT OF ROLE MODELLING ON ADULT NURSING STUDENTS' PROFESSIONAL DEVELOPMENT

by

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ABSTRACT

Service users expect to be cared for by a nurse who is both competent and professional, a particularly pertinent point following the Francis and Keogh reports (DH 2013a, DH 2013b). Nursing students' experience of education in practice strongly shapes their behaviour and knowledge but the ways in which this influences development of their professionalism is not yet fully understood. This study explored nursing students' lived experience of role modelling aiming to understand the impact on their development as professional practitioners.

In June 2013 twelve student nurses (4 first years, 4 second years, 4 third years) participated in in-depth interviews which were non-structured to allow exploration of the phenomenon that were most important to the participant. Using Interpretive Phenomenological Analysis, the information gathered from participants underwent several stages of thematic analysis.

The influence of peers and service users on students' professional development expands upon previously reported research. This is directly related to how students perceive their role model status and although not generalizable participants in this study found that reflecting on experiences with peers and observing the reaction by service users to care delivery had a positive influence on their professional development. Other principal findings include the importance to students of feeling valued as part of the team within their clinical placements and the potentially deleterious impact on students working with nurses who are displaying signs of burnout.

Consequent to these findings, it would appear important for student nurse education to include acknowledgement of how clinical nurse observed behaviour may influence student development, facilitation of peer-to-peer interaction as appropriate to the clinical situation and the potential impact of fostering a 'personal yet professional' relationship with the student. A number of other issues are also identified. Given the potential influence of peers in enhancing students' education, one way of optimising the effect of this novel finding could be to include a formal peer to peer mentoring system across all three years of a pre-registration programme. The findings indicate a limited awareness of the potential influence of academic staff as professional role models. This is a possible area for development. Students should also be guided to work with a number of staff in order to ensure exposure to a variety of practice behaviours.

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To my role models who have inspired me.

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I am indebted to Dr Alison Smith. Her advice and guidance in the early stages helped get this study off the ground and put me on the right track. Her steadfast belief in my ability gave me the confidence to carry on and complete my doctoral journey.

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This thesis is dedicated to Mum, James and the rest of my family for their unending support and faith in my ability to succeed. Their constant love, patience and encouragement have been so warmly felt. Thank you doesn't seem enough.

DECLARATION

I declare that this work has been carried out in accordance with the regulations of Canterbury Christ Church University.

The work is original, except where indicated by reference within the text and no part of the thesis has been submitted for any other academic award.

Any views expressed in the thesis are those of the author.

Signed _____

Date _____

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LIST OF APPENDICES

LIST OF ABBREVIATIONS

Abbreviation	Name in full
BERA	British Educational Research Association
DH	Department of Health
ESRC	Economic Social Research Council
HEA	Higher Education Academy
HPC	Health Professions Council
IPA	Interpretive Phenomenological Analysis
NHS	National Health Service
NMC	Nursing and Midwifery Council
OPSI	Office of Public Sector Information
SLT	Social Learning Theory
UK	United Kingdom
UKCC	United Kingdom Central Council

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CHAPTER 1 – INTRODUCTION

This chapter discusses the background to the study, explaining why it is important. Issues surrounding the development of nursing as a profession and the professionalisation of nurse education are of global importance and currently a major focus of development for UK nursing. The summary of recent reports given in the thesis demonstrates that the professionalism of nursing is being called into question. Ways of learning about professionalism including the place of role modelling are discussed, acknowledging the author's personal perspective related to the phenomenon under investigation. The chapter concludes with the research aims, question and objectives.

1.1 Concept of a profession

There is a lack of consensus as to the definition of a profession (Hoyle and John 1995, Beach 2002, Cutliffe & Wieck 2008). Eraut (1994) indicated that the 'ill-defined concept' of a profession has been approached by some authors through the compilation of professional traits. There is some consensus that there should be a recognisable duration of education and/or training; the teachers should always be members of the occupation and usually be full-time; the primary training should seldom be on the job; state registration should allow entry to some and deny others; the occupation should be affiliated to a University and the teachers should undertake research to organise, refine and expand upon the occupations' body of knowledge (Rutty 1998, Friedson 2001). The three original learned professions as defined by Friedson (1971) were law, medicine and the clergy (Hilton & Southgate 2007). Common characteristics of these professions are:

- A body of specialist knowledge and skills;
- A commitment to high standards of service;
- Varying degrees of self-regulation and autonomy;
- Moral and ethical standards of behaviour

(Hilton & Southgate 2007 p267)

Accountability and responsibility are closely related to professionalism (Hoyle & John 1995, Humphreys 2000), and require a degree of autonomy and trust from clients. Professional autonomy enables self-regulation, the efficacy of which professions guarantee by stringent recruitment and training processes, the development and publication of an ethical code of practice and inception of a formal committee structure to deal with any breaches of these

codes (Eraut 1994). An established central body of knowledge that includes abstract theories or concepts is a consistent theme in the literature regarding professions (Friedson 2001, Beach 2002, Watson 2006, Cutliffe & Wieck 2008, Van Mook et al 2009). This technical or specialist knowledge must be out of reach of lay people and practical work should be grounded in 'discretionary judgement guided by basic theory' (Friedson 2001).

Whilst an agreed definition of a profession appears difficult to achieve, it seems clear that the various aspects of professionalism discussed above are directly relevant to nursing. Whilst classed many decades ago as a semi-profession (Etzioni 1969) it appears developments such as nurse registration and regulation through the Nursing and Midwifery Council (NMC) bring the occupation closer to the 'fully-fledged' profession initially desired. With regard to knowledge development this is further exemplified through the evolution of nurse education.

1.2 The professionalisation of nurse education

The professionalisation of nurse education appears to pick up pace in 1964 when the Platt report postulated that the then current system for training nurses needed completely reconstructing (Royal College of Nursing [RCN] 1964) stating that 'students should be that in fact and not just in name'. Following the United Kingdom Central Council (UKCC) inauguration in July 1983 (Humphreys 2000) students qualified as State Registered Nurses (SRN) or Registered General Nurses (RGN). There was also a second, shorter, more practical training that concluded with the qualification of Enrolled Nurse (EN). The Judge report (Commission on Nurse Education 1985) reiterated the need for nurse training to be placed in higher education and extensive recommendations from the RCN led to the publication of 'Project 2000: A New Preparation for Practice' (UKCC 1986). It was at this crucial stage fundamental changes were instigated and nurse training moved into Universities to become nurse education.

The UKCC (Peach Report 1999) evaluation found that newly qualified nurses were better equipped to implement evidence-based practice and adapt to change. However it was noted that often newly qualified nurses were unable to take responsibility, lacked practice skills and more generally there were problem areas that impacted upon the fitness to practice at the point of registration (UKCC 1999). There were also concerns regarding a potential theory-practice gap, the credibility of academic tutors within the University setting who were far removed from practice and clinical nurses who were unaware of the relevance of theory to their work. Whilst nurse education has remained in higher education there have been

significant developments in the standards and competencies expected of newly qualified nurses in order to bridge this perceived gap and ensure fitness for practice. Many such developments have been instigated by the UKCC's successor the Nursing and Midwifery Council (NMC). The most recent development in initial nurse education is the move to an all graduate entry programme across the UK from 2013 (BBC 2009). At the time the Health Minister for England Ann Keen stated:

> "Nurses are the largest single profession within the health service, and are critical to the delivery of high quality healthcare. By bringing in degree-level registration we can ensure new nurses have the best possible start to meet the challenges of tomorrow. Degree-level education will provide new nurses with the decision-making skills they need to make high-level judgements in the transformed NHS." (BBC 2009)

An all graduate profession has brought nursing into line with other Health and Social Care professions indicating a move away from the subservience to medicine suggested through its initial 'semi-profession' label (Etzioni 1969). When one considers the fact that nursing is regulated by the NMC, has an ethical code of practice and the developments in education and research mean an independent body of knowledge is being established it is conceivable that nursing has met a number of the key criteria for a profession.

1.3 Current context

The status of 'profession' is often related to knowledge and responsibility, defined as a process whereby the professional ensures the interests of the client are met (Hoyle & John 1995). A number of Government led investigations regarding concerns about professional Nursing practice and the subsequent publication of reports have outlined recommendations required to enhance nursing professionalism (Department of Health 2012, Department of Health 2013a, Department of Health 2013b), the most recent being the Francis Report.

The Mid Staffordshire NHS Foundation Trust Public Inquiry (the Francis report 2013) found failings at Trust board level though noted significant failings in the nursing care provided to patients residing at the Trusts' main hospital. An associated area of concern is the impact of being exposed to such poor standards of care on the development of nursing students placed within the Trust. As explained by Robert Francis QC (DH 2013a) *".....this led in turn to a* declining professionalism and tolerance of poor standards…".

In 2013 Professor Sir Bruce Keogh published the report of his review into the quality of care and treatment provided by 14 hospital trusts in England (DH 2013b). This review had been prompted by concerns regarding hospital trusts with persistently high mortality rates. Whilst the findings indicated that nurse staffing levels and skill mix were primary concerns the fact that high mortality rates had been associated with several failings including professionalism, leadership and governance at Mid Staffordshire presents another concern (DH 2013b).

When considering the above in light of discussions surrounding trust placed in professionals by the relevant client group (Hoyle & John 1995) it is clear to see that the maintenance of professional standards needs to remain a key concern if this trust is to be earned and maintained. The Healthcare Professions Council (HPC) conducted a series of research studies focused on professional practice. They stated that there is very little published research on professionalism in the professions they regulate and further confirmed that no research was evident that explored the perceptions of students and educators; the findings in this thesis contribute new information to support this understanding. The 2011 publication specifically concerned professionalism and intimated that

> *'The personal characteristics underlying professionalism may develop early in life as* well as through education and work experience, but role modelling is also important in developing the necessary awareness of appropriate action in *different contexts.'* (HPC 2011)

This study is focused on exploring student perceptions of their professional development in direct relation to role modelling finding that there are important influencers through student engagement with others in the context of their nursing programme. It is set in the context of nurse education post Project 2000 (UKCC 1986) with all its subsequent developments to address initial concerns regarding nurses educated in an academic setting (UKCC 1999). This includes the relatively recent move to an all graduate profession.

1.4 Teaching professionalism in nursing

Healthcare professionals often have difficulty in articulating what professionalism is despite perceiving the requirement to behave in a professional way as a central tenet of their role (NHS Scotland 2012). Professionalism is important to service users and is often taken to refer to competence, appearance, empathy, care, compassion, respect, dignity and good interpersonal skills as well as other attributes and characteristics (NHS Scotland 2012).

Applebee (2006) asserts that teaching medical professionalism within the curriculum is as important as medical knowledge and patient care. It is posited that developing an understanding of a student's experience of professionalism is important to guide the development of educational experiences (Brockopp et al 2003, Secrest, Norwood & Keatley 2003). The method by which education influences professionalism has been the subject of debate in recent years. This has often related to the place and efficacy of role modelling. Howe (2002) suggests that successful professional development should be based on explicit values that are role modelled by those involved in the educational process and demonstrated in the learning environment.

Good role modelling often aids the development of students when faced with difficulties in retaining compassion (Stephenson, Higgs & Sugarman 2001). This often relates to situations whereby students have been told to value the concept of caring but subsequently see practices based on 'other' factors, such as financial concerns (Gallagher & Tschudin 2010). Given this and the fact that the clinical area and associated roles are becoming increasingly complex, it has been suggested that the traditional method of transmitting professional values by role modelling is outdated and no longer viable (Steinart et al 2005). However, Goldie et al (2007) later suggested learning activities that promote critical reflection are very effective in enhancing professional development. Brockopp et al (2003) claimed that mentoring is an activity which enhances the development of professionalism among nursing students. They further postulate that practising nurses can mentor students by being competent role models.

Students will interact with many individuals, some of whom may become role models, while other people in the workplace may unconsciously influence their development (Gallagher & Tschudin 2010). During this interaction or experience, students who actively seek out role models may acknowledge the impact they have on their development in some way (Ettinger 1991). Other students may simply emulate those they are working with subconsciously (Roberts 2008). Gallagher and Tschudin (2010) assert in their study on leadership that an individual is both a leader and a follower at the same time. Therefore contact between friends and work colleagues has a strong influence on others.

Given the uncertainty around a definition of professionalism, the implication that role modelling may or may not be an effective teaching and learning strategy and the fact that there is the potential for all individuals the students come into contact with to have an

influence on their development it is important to explore the concept of role modelling in relation to professional development.

1.5 Personal Perspectives

The drive to complete this study comes from both a professional and personal standpoint. My role leading the pre-registration Adult Nursing programme often requires me to meet with students who have not conducted themselves in the manner expected either by the University or the NMC Code (NMC 2008a). They are bound by the NMC Code at all times, whether in practice and dealing directly with service users or outside of practice in a social context. This therefore necessitates a level and expectation of professional behaviour that is sometimes not expected of other students/subject areas in the University.

From a personal perspective I, as a member of the public, expect to be cared for by a nurse who is competent and behaves professionally. This to me is someone who is courteous, polite, trustworthy, and respectful, treats me as an individual and generally upholds the reputation of the nursing profession. This viewpoint has been informed by my everyday work, reading policy documents and the research literature and through the fact that I am a registered nurse with high standards set for my own practice. Meetings with service users during nursing programme development showed I was not alone in the desire for nursing students to demonstrate care, compassion and professionalism. Therefore whilst there is a personal element to my expectations of a nurse much of this has stemmed from a wider perspective.

The current conduct of registered practitioners has also been called into question. There are national examples of registered practitioners being struck off the register for inappropriate use of social networking sites to contact patients or post inappropriate photographs (Nursing Times 2011). The increase in mobile technology is apparent in contemporary practice for practitioners to access data relevant to their work. However the exploitative use of this technology by some registered practitioners raises concerns over the modelling of unprofessional practice and the influence this has on students.

It is for these reasons along with the fact that the standards of compassion in nursing are currently being challenged that I believe it is important to consider the impact role modelling has on nursing students development as professional practitioners. Gaining a more in depth understanding of who the role models are, how they are selected and what influence they

have on nursing students could help nurse education to capitalise on the positive influences. This can only serve to enhance the nursing profession thereby improving patient care.

Nurses with whom I worked inspired me through the dedication they displayed to their, and my, chosen career. They went above and beyond expectations and as a result were very highly regarded by both service users and colleagues. In academia some of the nurses working at the University, inspiring the next generation of practitioners became my role models. All of my role models have similar qualities – they are knowledgeable and pass on that knowledge to others; they have excellent interpersonal skills and an ability to converse easily with others; and are willing to 'go the extra mile' beyond that expected of them within their particular role. They are also selfless with a passion for their jobs and a compassion for others. This is important to me since as a child I have been raised to ensure that I do my best to help and support others. My parents were role models who have shaped how I behave in adulthood. I have always believed in the importance of individuality and as such, whilst there are naturally personal qualities that I have strived to emulate, this has not intentionally been as a 'person' per se but rather a professional in the sense of working in a particular field. That is, qualities that have enabled me to develop in a particular role.

This section has been included to acknowledge my ontological position in relation to professionalism and role modelling. I am aware of my understanding of role-modelling and feel there is coherence with the interpretations of role models and professionalism in the literature. I do though need to remain cognisant of these so that my viewpoint does not influence the rigour of this study and potentially impact on the conclusions drawn. Reflecting on this section it is particularly evident that I strive to emulate role models relative to my career as opposed to 'in life'. That is, I have professional role models working in the same occupational field and it is these qualities that I emulate. This may not be the case for the participants in this study so I must be open to all perceptions of role modelling and their potential influence.

1.6 Relation of this study to existing literature

There have been a significant number of publications related to role modelling, many outside the UK. The majority of these have been associated with student perceptions of what a role model is and the qualities that they must demonstrate to be classed as 'good' (Davies 1993, Pfeil 1997, Donaldson & Carter 2005, Illingworth 2006, Hayajneh 2011). Other publications have focused on role modelling as a teaching strategy outside nursing, particularly

midwifery, medicine and non-Health and Social Care professions such as the police (Wright, Wong & Newill 1997, Wright & Carrese 2002, Bluff 2003, Filstad et al 2007, Lunenberg, Korthagen & Swennen 2007, Armstrong 2008). Few papers have focused on an aspect of professionalism in relation to role modelling (Ettinger 1991, Kenny, Mann & MacLeod 2003, Cruess, Cruess & Steinart 2008, Curry, Cortland & Graham 2011). These are based outside the UK and primarily concerned with medicine. There were no papers found during the literature search that focused specifically on UK Adult Nursing students' perceptions of role modelling and how this aspect of their educational experience impacted on their development as professional practitioners.

Previous research on nurse education and professional socialisation tended to focus on the development of the ward learning environment and in particular the role of the ward sister (Orton 1981, Ogier 1982 & 1989, Fretwell, 1982, Melia 1987). These research reports include elements related to student nurse development and influencing factors, including the place of the role model and therefore this similarity has relevance to the current study. However there were also major differences in the nature of learning in nursing 25 years ago when nurses in training were the main labour force, delivering care to patients through an apprenticeship type process (Ogier 1982, 1989). This was at a time when the Project 2000 proposals were being put forward for genuine student and supernumerary status for those in training, whereas currently student nurses are purportedly supernumerary which creates a different learning environment. A purpose of this study is to explore these differences and the importance of role modelling in the current nurse education system.

The context for nurse education and the role of professional socialisation has changed markedly since previous relevant research. This study explores issues in the new context. The combination of a UK based study exploring the experiences and understanding of Adult Nursing students in relation to role modelling and their professional development will expand on the current literature base regarding role modelling practice.

1.7 Study aim & research question/objectives

This study aims to explore nursing students' choice of role models and their lived experience of role modelling with a particular focus on the development of Adult Nursing students as professional practitioners. The information gained may influence student nurse education in relation to professional practice. This in turn could influence care and compassion which is a

particular concern to Health and Social Care in the aftermath of the recent reviews as previously discussed.

Research question

1) How do Adult Nursing students experience role modelling and what does this mean to them?

2) In what ways do Adult Nursing students understand the impact of role modelling experiences on their development as professional practitioners?

Objectives

a) To establish the role models that students are exposed to during their educational journey and how they change over time.

b) To identify which attributes or characteristics students look for in the role models they choose and the way in which this relates to their current position in their educational journey.

c) To explore students' understanding of professionalism and the perceived influence of their role models on the development of their attributes as professional practitioners.

1.8 Outline of subsequent chapters

Chapter 2 provides the background literature regarding role modelling and links to professionalism. The chapter commences with an explanation of the literature search process.

Chapter 3 outlines the researchers' ontological and epistemological position in relation to the chosen methodology. The rationale for and discussion of phenomenology and in particular Interpretive Phenomenological Analysis is included.

Chapter 4 provides explicit detail regarding the study design, including sampling, data collection and analysis. Issues regarding validity and reliability of the study are discussed and consideration is given to the ethical aspects of the research.

Chapter 5 presents the findings of the study. This chapter proceeds with an in-depth presentation of those themes that either, a) answer the research questions, thereby explicating

the phenomenon, or b) address issues that were identified in the literature in relation to role modelling.

Chapter 6 synthesises the findings and discusses them in relation to the existing literature to place the new insights into context.

Chapter 7 acknowledges the potential limitations of the study.

Chapter 8 provides detail regarding how the findings are likely to be disseminated and gives an indication of the direction of future work as a result of this study.

Chapter 9 is the final chapter and outlines the conclusions of the study and makes recommendations for education and practice.

CHAPTER 2 – CONTEXT & BACKGROUND

This chapter outlines the strategy used to identify relevant literature related to the research topic. This then proceeds to a review of the literature to provide background theory and establish a framework in which to locate this study.

2.1 Literature Search Strategy

A comprehensive search of the literature is vital to not only provide the background to the research study but also to determine in the initial stages whether the research will provide a novel contribution to the subject area. Organising the literature associated with the proposed research topic is one of the first tasks that researchers should undertake (Cresswell 2009) and helps to determine if a topic is worth studying. The literature search for this study was undertaken in three phases.

An initial scope of the literature was undertaken to develop the background to the study and explore the relevant known information utilising the generic keywords and/or phrases of 'professionalism', 'professional development', 'education' and 'nursing' (see table 2.1 below). The abstracts of the papers found were then reviewed in order to establish the general focus of the research. Formulating this into an initial research matrix (appendix 1) identified limited to no literature specifically focused on the impact of role modelling as a learning and teaching strategy in relation to UK nursing students' education and the development of their professionalism.

Research questions and objectives were generated from this overview. This also allowed for the development of an interview schedule with generic exploratory probes. The identified literature was then put to one side and not consulted further until after data collection was completed.

Following data collection the literature found was reviewed, using the critiquing framework from Benton and Cormack (2000), adding to my research matrix. This allowed me to explore the existing theoretical knowledge and context in which to place the study findings. During this phase the literature search was repeated to enhance the theoretical framework in which to locate the study findings. A number of further papers of relevance were located.

Following data analysis and during the write up stage the literature was reviewed once more to identify existing work related to issues arising from the participants' experiences. This was again to enhance the theoretical context in which to place the findings and enhance the rigour of the study. This literature searching was much more targeted at specific concepts such as nurse burnout, belongingness and interactional justice. This then fed in to the discussion chapter.

Table 2.1 Summary of keywords and sub-keywords

Role-modelling / Role-modeling (UK and US spelling)	Nurse Education	Professional Development
Education; Practical Experience	Education	Professional Development
Mentoring	Education; Nursing	Professionalism
Education; Methods	Education; Occupational Therapy	Socialisation
Role models	Education; Midwifery (this continued to include other Health & Social Care professions)	
Teaching Methods	Education	
Education; Clinical		

2.1.1 Search of electronic databases

To clarify the definition of role-modelling and professional development for the purposes of this study, it was important to examine the literature in related fields that included leadership and management, school education and so on. A search was conducted using the key words noted above separately and combined using Boolean logic (OR/AND/NOT), truncation to identify word derivatives and wild cards to identify any alternative spelling options.

The following sources were selected for the wide subject area coverage including business and management, education, health and social care, psychology, medicine and social sciences. The number of years over which relevant publications spanned, the fact that the majority of databases included reference sources up to and including the current year, and their relevance to the proposed research area were also considered important (Bell 2005). Using Role Modelling (truncated to Role Model*) and Nurse Education individually and in combination the following results were achieved (Table 2.2).

Table 2.2 Databases used, noting reason and the number of hits in the search for role model* and nurse education

Database	Subject area coverage	Role Model*	Nurse Education	Role Model* AND Nurse Education	Since 2000, English Language
CINAHL	Comprehensive source of full text for nursing & allied health journals	1530	2334	10	-
MEDLINE	Bibliographic and abstract coverage of biomedical literature	2809	10915	33	-
PUBMED	Biomedical and life sciences – US source	590	7746	9	-
British Nursing Index	Database for support of practice, education, and research for nurses, midwives, and health providers	1092	10887	135	-
Cochrane Library	Information on the effects of interventions in health care	1822	2666	3	-
Maternity and Infant Care	Journal articles relating to the midwifery profession	107	137	3	-
PsycInfo	Professional and academic literature in psychology and related disciplines	4573	14077	9684*	20
Science Direct	Leading full-text scientific database	1330	2874	127	-
Wiley	Multidisciplinary collection of online resources covering life, health and physical sciences, social science, and the humanities	1024	888	3	-
NHS Evidence	Access to evidence-based health information	601	381	26	-
TRIP database	Clinical search engine for sources of evidence based practice	115	302	35	-
British Education Index	All aspects and fields of education from preschool to adult and higher education	829	746	13	-
ASSIA	Indexing and abstracting tool covering health, social services, and education	351	1563	280	-
ERIC	U.S. Department of Education access to education-related literature	3346	2440	30	-
IBSS	International Bibliography of the Social Sciences	702	378	15	-
Oxford	Oxford University Press	6	12	0	-

Journals	covering humanities, social sciences, law, science, and medicine				
Emerald Management	Business research tool provides information including strategy and leadership	1084	1327	34	-
Web of Knowledge	Three multi-disciplinary databases	1391	5175	38	-
Index to Theses	To review if any related doctoral work	0	185	0	-
EThOS	To review if any related doctoral work	97	91	2	-
RCN Thesis search	To review if any related doctoral work	2	53	0	-

*Psycinfo was further limited to English language and articles since 2000 to reduce the number of hits to a manageable size. Following identification of these reference sources each abstract/article was read and a decision made by the researcher whether the focus was relevant to the study. Those sources identified as relevant in relation to the research questions and objectives were then reviewed and used to inform the remainder of this chapter.

2.1.2 Other literature searching

To ensure thorough searching the researcher also used reference chaining, hand searching within the University and local NHS Trust libraries, and a search of relevant Professional body literature. A backward chaining process was also used through reviewing the reference lists of the relevant articles found through searching the electronic databases. This assisted in the identification of seminal work that has been included.

Through the conduct of the above procedures the researcher is confident that the relevant reference sources have been sought to inform and frame the context of this study.

2.2 Role Modelling

This section will outline some of the current literature related to various aspects of role modelling and professional development. Subsections identified have arisen from a deconstruction of the research questions.

2.2.1 Role model definition

Charters (2000) maintains that teaching and learning within Health and Social Care is a dual relationship, conducted between two people with the majority of learning acquired informally

via role modelling. The term 'role model' is often understood to describe a person who exemplifies behaviour or a social role for others to emulate, who sets a positive example and whose attitudes and values are assimilated by learners (Perry 2009, Price & Price 2009). These definitions raise the question of whether a role model is someone who teaches the 'how' within their own profession or whether there is more in terms of the personality traits and characteristics that make up their identity within that particular professional group. Indeed Paice, Heard and Moss (2002) describe role models as people we identify with (socialisation), who have qualities we would like to have (personal development) and are in positions we would like to reach (role definition).

When considering professional socialisation, defined as acquiring the values, attitudes, knowledge and skills of a professional group (Roberts 2008), it is conceivable that role models are expected to establish and indeed demonstrate the accepted norms of conduct and behaviour and not just how to 'do the job' (Howkins & Ewens 1999, Price 2008). Patients expect to be cared for by a nurse who is competent but also 'behaves' professionally (DH 2013a, DH 2013b). Therefore it is important that students are educated to develop the professional qualities necessary to not only enhance the quality of care provision but also meet the expectation of service users. Nursing students are exposed to many individuals during their educational programme and those forming the nursing occupational group are a diverse range of individuals (Melia 1987). Therefore the factors that influence the development of their professionalism can be varied and complex. It is important to explore, identify and capitalise on the positive influences of role modelling in relation to the development of student nurses as professional practitioners.

For the purposes of this study the term role model is defined as someone who exemplifies the practical, professional and personal traits expected for nursing.

2.2.2 Potential role models

The primary individuals with whom students collaborate during their educational programme are 1) the academic staff within the University, 2) clinical staff, 3) service users within their placement areas and 4) their peers across the theoretical and practical aspects of the programme (Felstead 2013). Any or all of these groups could be considered role models by students. Previous research indicates that students perceive clinical nursing staff and their peers to be significant contributors to their learning (Ogier 1982, Melia 1984 & 1987). This section discusses these four key groups.

Academic staff

Pfeil (1997) reported that initially academic staff are the role models for nursing students but as students' progress towards registration the focus changes to more clinically active nurses. However this does not seem compatible with the notion that students enter the programme with a very fixed idea of what nursing is and what they aspire to be (Chow & Suen 2001), a notion that anecdotally appears to hold true today. This could naturally lead students to view clinical practitioners as different from full-time academic staff in the sense that they enter the programme to become a nurse and therefore only clinically active practitioners can facilitate their development. Role theory suggests individuals perceive their identity in relation to those groups with whom they closely identify in terms of roles (Illingworth 2006). This could influence students into not thinking of academic staff as role models as they may not be seen as nurses (Felstead 2013).

With the move of pre-registration nursing away from Schools of Nursing and into higher education the responsibility for clinical supervision fell to mentors working clinically (Chow & Suen 2001). Lewis and Robinson (2003) found in their study that academic staff appeared reasonably low in the hierarchy of role models. It was suggested that the move of the educational base may however influence this position. Nursing has been based within the University setting since the inception of Project 2000 and therefore it is possible that academic staff may now be regarded as role models on a par with clinical staff, as the University is the primary educator in Health & Social Care. Also, the requirements for those wishing to enter 'nurse education' may lead them to perceive academic staff having a greater influence on their development.

Much of the literature concerning role modelling in nursing is associated with learning in the clinical environment. This potentially has a negative impact on the 50% theory, 50% practice nature of pre-registration nursing programmes as governed by the NMC. The fact that many authors focus on the idea that the ideal environment for students to learn nursing is in practice could do a disservice to the educational colleagues who, through the partnership approach, are responsible for half of the students' education/development as a professional. This is further perpetuated by authors such as Charters (2000) who maintain that much of his nursing socialisation and behaviour was not learnt within the School of Nursing but by observing others in practice. He states that role models for him were 3rd year students and staff nurses he worked with during his training. This certainly concurs with the earlier research of Ogier

(1982) and Melia (1987). Charters does however state that he 'watched and copied' them, rather diminishing the concept of building one's own professional identity and role. After all, the aim is not to create 'clones' but to stimulate a desire on the part of students to become role models in their own right (Ottewill 2001). The nature and mechanism of role model influence is discussed within the results of this study.

Students automatically placed emphasis on the clinical experience and expertise of their teachers who, if minimal, were not seen as role models (Pfeil 1997). Lown (2007) states that the ability to act as a role model to students stems from the responsibility to teach a programme with an academic and practical component. It is considered however that this depends on how much 'practical component' is taught within the University by 'academic' staff (Felstead 2013). Lecturing staff have difficulty in being seen as 'clinically credible' by students if there is no engagement in what they see as real nursing. This is particularly relevant when nursing is viewed in line with medical training where the vast majority of tutors are practicing doctors. The nurses' role is an amalgam of education and professional socialisation in the practice setting (Illingworth 2006) and therefore both clinical and academic staff should be seen as role models.

Conversely teacher education is unique in that educators not only teach their students about teaching but also, through their own teaching, model the role of the teacher (Lunenberg, Korthagen & Swennen 2007). This is an interesting perspective and the authors make a direct comparison with medical education stating that doctors who teach medicine do not serve as role models as they do not 'treat' their students. When this is aligned to nursing education it is identified that on the whole academic staff teach about nursing practice but do not role model the actual practice of nursing (Felstead 2013). This is with the obvious exception of simulated practice learning if facilitated within the University environment by academic staff. Clinically based nurses on the other hand are able to role model the practice of nursing but their teaching role in relation to the theoretical underpinnings of practice is reduced. This perhaps automatically leads to clinical staff being viewed as role models by nursing students but to the potential detriment of the theory behind the practice (Felstead 2013). The place of lecturer-practitioners and staff (both educational and clinical) that hold honorary positions in the 'opposing' camp may alter student choice of role models. It is not known how these individuals are viewed by students.

Ottewill (2001) examined undergraduate business education to establish the role of tutors within higher education intimating there is/should be a new element of 'role modelling for the career'. It was established that tutors within HE hold a position that allows strategic modelling of the attributes expected of graduates by employees. There was a specific focus on professionalism (in its widest sense) and the ability to 'fit into the work culture'. Whether this holds true for nursing education is questionable given what has already been discussed regarding academics limited engagement with clinical practice (Felstead 2013). The role of academic staff in research activity associated with practice may however have an impact. There is also the consideration that working in a clinical area exposes students to situations that cannot be replicated within a classroom setting (Pfeil 1997) thereby inhibiting some of the students' occupational experiences. It is conjectured that students becoming 'immersed in a culture' may in fact replicate all practices that they witness, whether good or bad. The need to feel as though they 'fit in' with the team and 'get on' with their mentor/supervisor potentially limits the students ability to discern what is poor practice. This is particularly relevant if the role model is the practitioner who will be assessing them. Despite the fact that academic staff may not be seen to be role models in the clinical sense they still have a place in exemplifying professional qualities. The difficulty comes when 'countervailing pressures' lead to academic staff failing to attend to their student responsibilities (Ottewill 2001). Students consequently perceive them as failing to manage their priorities given that they are usually unaware of the multitude of non-teaching commitments that academic staff may have. This results in damage to their credibility as a role model.

There are evidently conflicting views within the literature as to whether academic staff are role models for nursing students. If they are considered to be role models debate continues as to in what capacity (emulating practical nursing skills and/or professional qualities for example) and what factors may influence this.

Clinical staff

Students most likely have a 'vision' or perception of what they expect a nurse to do and how a nurse should behave on commencement of their educational journey (Chow & Suen 2001). This may influence who they choose as a role model and subsequently influence their professional development as professional expectations can be taught in a didactic way but the application to practice is how students learn to integrate these into clinical care (Ettinger 1991). It is generally agreed that clinically active staff can and do act as role models for

nursing students (Charters 2000, Lewis & Robinson 2003, Donaldson & Carter 2005, Perry 2009).

Students' perception of clinical nurses and their beliefs about the role as exemplified through the staff they work with may be influenced by a number of factors including:

- Recent pressures on the nursing workforce that have led to limited time for qualified staff to deliver bedside care (Allan & Smith 2010).
- A perception that the nurse is more concerned with technical care to the detriment of the fundamental aspects of person centred practice (Allan & Smith 2010). This is particularly evident in the research conducted by Melia where students noted the difference between their work and that of the staff nurse, crucially the perceived move away from the patient (Melia 1987).
- The intense division of labour between the registered and non-registered workforce (Allan & Smith 2010). This again is evident in earlier research where students often perceived themselves as interchangeable with auxiliaries [that is, untrained staff] (Melia 1987) and were primarily seen as 'workers' (Fretwell 1982, Melia 1984).

The place of bedside care is questioned and students focus on the 'other' aspects of the nurses' role. This is particularly notable in the students' mentor who will be assessing them and therefore the student is likely to follow what they do. It is evidently important for nurses to exemplify holistic compassionate care if the student is to learn the crucial aspects of person centred practice (Newton 2010). This does indicate the need to train the non-registered workforce in relation to student education given that they are likely to be role modelling essential care in many areas but may not perceive themselves as role models given the students are learning to be nurses. Of course this infers the perception that essential or 'basic' care is key to student learning, unlike the findings reported by Fretwell (1982) where these activities were perceived by ward staff as 'work' rather than 'learning'.

Perry (2009) states that many definitions of role modelling in the health care professions equates effective role models as senior staff. This is supported by Lewis and Robinson (2003) who found within their study of student radiographers that the top nominations for workplace role models were senior staff in chief positions. Lewis and Robinson (2003) concluded that this was related to senior staff being 'prominent demonstrators of clinical skills and professional conduct'. There is however an issue regarding whether these staff have the capacity to model behaviour for all students (Perry 2009). This is potentially not feasible

given the small number and large remit of senior staff. This creates the potential for a dissemination approach whereby senior staff role model to junior staff facilitating the students' development (Felstead 2013). That said, Ogier (1982) points out that often senior staff state that they do not have the time to teach without realising that simply by working with the learner they are teaching at the same time as completing the work.

As indicated, previous research has examined the role of the ward sister in relation to the creation of the learning environment (Orton 1981, Ogier 1982, Fretwell 1982). Perceived by students as a key learning resource it is clear they can play a significant role in professional development. Subsequent research has however indicated that junior nurses report little role modelling of holistic care by senior staff (Henderson 2002). Therefore what students are actually learning requires further examination.

It is evident that clinical staff can and indeed should be role models for nursing students. Questions remain over the focus and quality of student learning and whether seniority in practice has an impact on students' professional development.

Mentors as role models

A mentor may actively direct a students' learning according to the guidance and competencies outlined by the NMC. Mentors are a perceived expert in a field of clinical practice and spend time with the student supporting and guiding their development (Ettinger 1991, Kenny, Mann & MacLeod 2003). This is potentially in direct contrast to role modelling which is more passive and involves teaching by example, often unconsciously. This is more informal and episodic (Kenny, Mann & MacLeod 2003). Therefore mentoring as a concept is not the same as role modelling. Some authors however maintain that mentors can be role models (Kilcullen 2007, Ness et al 2010). Indeed the NMC state in their developmental framework to support learning and assessment in practice that nurses must act as a role model for safe and effective practice (NMC 2008b). Therefore if a mentor is not acting as a role model during their interactions with students they will only be fulfilling part of their role. Further to this, research has previously suggested that nurses who are trained to teach (that is mentors) tend to be more sensitive to the needs of learners, provide appropriate feedback and demonstrate a personal value system through care and concern for others (Marson 1982). Demonstration of these values is vital for student professional development and advocated by Ogier (1989) who encouraged nurses to 'let their caring enthusiasm shine through' (p41) and ensure that they are approachable in order to facilitate professional socialisation.

Service users

The information available regarding whether service users are, or can be role models for students is focused on general impact in nurse education from the service user or educationalist perspective and is usually associated with mental health nursing or social work. No literature specifically pertaining to service user influence on Adult Nursing professional development could be found. It is suggested that how service users conduct themselves in difficult circumstances may influence how students behave in similar situations. Those times of anger, frustration, anxiety, limited knowledge or understanding may indeed demonstrate to the student how to conduct themselves with professionalism and decorum in difficult circumstances. Bandura's Social Learning Theory is built on the premise that the observers' behaviour can be substantially modified as a function of witnessing other peoples' behaviour and its consequences for them' (Bandura 1977 cited in Donaldson & Carter 2005, p355). It is this that may indeed point to the potential impact of service users' behaviour and reaction to students during clinical work. That is, the development of a students' professionalism may be impacted upon by how service users react to them (or those they are working with) during every day work. This links closely to the concept of emotional intelligence. This is broadly defined as the capacity and ability to manage emotions in ourselves and in our relationships (Goleman 1997, Freshwater & Stickley 2004). Emotional intelligence includes elements of self-awareness, self-regulation, motivation, empathy, and social skills and is recommended as an integral part of nurse education programmes (Beauvais et al 2011). Beauvais et al (2011) concluded that facilitating and encouraging emotional intelligence in students and qualified practitioners significantly improved nursing performance. This included the interpersonal relations and communication dimension which involves exchanging verbal and non-verbal information and meeting a patient's emotional needs. Having an awareness of patients' emotional reaction to care provision could influence students' future care delivery. Professional capital is generated, acquired and maintained through learning in professional workplaces (Gobbi 2008). The non-economic dimension is referred to as personal professional capital (Gobbi 2008). Principally linked to values and beliefs, the individuals' self-concept and the relationships they have with others in the professional context are thought to influence its development. Personal professional capital may also include the connections, relationships of trust and mutual obligation that are characteristic of a professional community (Gobbi 2008). When these factors are considered, it is conceivable that exposure to modelled behaviour in response to service user reaction to

care delivery can be a significant learning opportunity for students through the generation and enhancement of personal professional capital.

Peers

As well as clinical skills development there was an overwhelming sense of 'learning the ropes' from fellow students (Roberts 2008). Length of time in a particular area appeared to be more important to students than seniority when related to professional socialisation - a student may be in their first year but can still aid integration of a third year student into the environment if they have been in the placement for a period of time. Professional socialisation has been defined as the process by which student and neophyte nurses learn their nursing role (Henderson 2002). This incorporates the development of social identity through immersion in a culture with expected norms and values. Roberts (2008) found that these elements of socialisation will not be 'taught' by mentors as it is expected students will just 'know' the cultural rules of the qualified staff. It is here that new students will pick up cues from fellow students to facilitate integration into the team. Original research by Melia indicated that permanent staff on the ward expected students to simply turn up and work without any sort of induction (Melia 1987). In order to function effectively students were likely to copy peers behaviour and seek their assistance indicating the potential for fellow students to influence professional development. This study seeks to answer the question of who students choose as role models and their perceived influence. This further exploration has the potential to identify the extent to which Melia's finding is true, leading to possible recommendations regarding the explicit integration and enhancement of peer support within pre-registration nurse education.

Multiple role model exposure

When considering the individuals that nursing students are exposed to during their educational journey there is much debate regarding the influence of multiple exposures. That is, do students take examples from many individuals in order to build their own professional identity or is there an element of singular association (Felstead 2013). Students will often talk about a relative who has entered the nursing profession before them and how this has influenced their career choice however it is conjectured that this may not inform them about the reality of nursing. Whilst being a student they will gain an insight into, progressing to a deeper understanding of, nursing (Felstead 2013). It is thought however that the behaviour of role models is likely to be interpreted in light of past learning experiences (Davies 1993). The nature of a pre-registration programme with the multitude of competencies that students are

required to achieve necessitates frequent moves between clinical areas thereby limiting reinforcement from one particular individual. Donaldson and Carter (2005) state that observers rarely pattern their behaviour after a single source preferring instead to adopt different aspects and characteristics from a variety of models. Students may however follow their primary mentors' example given they will be assessing their competence. Exposure to several different role models has the potential to enhance the students' development by offering them experience of differing practices. Certainly students' internal values may lead them to pick and choose traits or qualities from a variety of sources (Wright, Wong & Newill 1997, Maudsley 2001), and different locations in view of students moving between different placement areas.

In summary, there is limited information on the influence of peers as role models, and none directly relevant to Adult Nursing professional development regarding service users' influence. There is however general concurrence of the two other main areas influencing students' development; that clinical nursing staff have a full role model influence and academic tutors to a lesser extent.

2.2.3 Role model qualities

Success as a role model is founded in what and how people say and do things (Perry 2009). The ability to maintain and articulate a 'sense of connection' to the other person and how they are feeling are key qualities. This also relates to how professionals work with each other. This section identifies some of the qualities or attributes that are important for an individual to have for them to be considered a role model.

Lewis and Robinson (2003) found that less emphasis was placed on formal education when respondents were asked which attributes feature prominently when selecting a role model. This appears to question the recognised concept of a profession as one of the commonly held beliefs is that for a role to be considered a profession there should be a standard for higher and continuing education. This creates a paradox if the perception of an effective role model is that a formal standard of education is not essential when the concept of a profession requires it. Again this potentially relates to staff working within a University setting not being viewed as a role model if students perceive the role to solely be what is happening 'out there' in clinical practice.

The literature points to a variety of attributes required of a good role model. Cruess, Cruess and Steinart (2008) identifies three categories – clinical competence, teaching skills and personal qualities – into which attributes identified by other authors can be placed (Table 2.3). This has been included to acknowledge the multitude of attributes demonstrated by role models and indicate how the complex nature of positive traits may complicate an individuals' capacity to be a role model. For example, a nurse may have excellent teaching ability but not be very sociable thereby not fulfilling the expectations of the students in the study by Paice, Heard and Moss (2002).

Table 2.3 Role model attributes organised according to categories defined by Cruess, Cruess & Steinart (2008)

	Clinical Competence	**Teaching Skills**	**Personal Qualities**
Lewis & Robinson (2003)	Patient care Team worker Communication	Teaching Skills / Learning Communication	Patience Professionalism Ethics Personality Communication
Wright & Carrese (2002)	Clinical attributes (provide high quality, compassionate care, assuming responsibility in difficult situations, going the extra mile for patients, being an advocate)	Establishing rapport (treat learners as colleagues, approachable, interested in learners as people) Developing teaching philosophies & methods (interactive exchange, encourage self-awareness and responsibility) Committed to growth of learners (thoughtful advisor, increase self-esteem, be generous with time)	Interpersonal skills (supportive, caring, respectful) Positive outlook (enthusiastic, friendly, easy-going, having and showing job satisfaction) Commitment to excellence and growth (creativity, inquisitiveness, high standards) Integrity (ethical, genuine, true to one's values) Leadership (inspiring, strength, pride, influence on others, non-judgemental)
Paice, Heard & Moss (2002)	Clinical competence	Teaching ability Share professional experiences	Positive attitude Compassion Enthusiasm Integrity Sociable Open about personal life
Illingworth	Consistent high	Interest in others	Understanding of others

(2006)	standards Knowledgeable practitioner		Interest in others Responsible approach to occupational role
Miller (2006)	Caring attributes (empathetic, empowering, caring, attentive)	Wise	Compassionate Willing to listen Energetic Spirited Loving Respectful of others

Student choice

An important component of professionalization is the identification of professional role models who are the primary socialisers in learning professional roles (Kenny, Mann & MacLeod 1993, Lewis & Robinson 2003). Standards and expected norms of behaviour are enforced by these individuals who also act to protect professional ideals. The ability to define these role models is however difficult given the individual attraction to role models who appeal. This potentially has an impact on how pre-registration nursing students develop. There needs to be a consistency across the profession in relation to the maintenance of standards and professional regulation. However this conflicts with the individual nature of someone's development. If students choose their own role models then they are likely to get different experiences to their peers. In relation to competency development this has been addressed through a common set of standards demonstrated by the student however it may not be possible to regulate role modelling influence on professional development. Indeed this may not be desired given the fact that individuals will all have different development requirements. Developing an understanding of students experience will however aid further knowledge of this phenomenon and its impact.

An important aspect to take into consideration is how the individual practices of the role model will impact on the development of a student and whether they choose to emulate behaviours or not. Melia (1984) identified that certain expectations of behaviour were placed on students. The participants in her study admitted that to be accepted as part of the team they would elicit behaviours that were demonstrated by the permanent staff, especially by those in authority. This, they believed was the best way to 'get through' their training programme, even if it conflicted with their personal values. This implies that the impetus to adopt exemplified behaviours is wholly the students' need to 'survive' the placement. A further dimension to this was identified through later research that indicated the approach of the staff member has a direct impact on whether students adopt certain behaviours. Bluff (2003)

describes a ‘continuum’ of midwifery practitioners and how particular traits influence whether a student will choose to emulate their practice or feel compelled to (table 2.3).

Table 2.4 Continuum of role model traits adapted from Bluff (2003)

Prescriptive practitioners		Flexible practitioners
Pedagogical approach		Androgogical approach
Focus on learning the rules		Focus on developing necessary skills
Students viewed as complete novices	→	Students viewed as autonomous individuals who need encouraging
Learn in environment of fear of reprisal		Learn in stimulating, enabling environment
Student feels compelled to emulate role model		Student chooses to emulate role model or not

Donaldson and Carter (2005) concur that enhancing or promoting student independence is seen as a characteristic of good role modelling. It is possible to enhance the professional development of the student through promoting autonomy. The conscious selection of mentors for/by students is therefore potentially more appropriate than mere allocation when considering the fact that some students may require more direction in their learning than others.

This section has outlined some of the desired attributes expected of role models as highlighted in the literature. There was also some discussion as to the approach taken by role models and how this may influence student learning and development.

2.2.4 Role modelling strategies

Role modelling is often implicit with students’ unconsciously modelling a nurses’ practice (Felstead 2013). Cruess, Cruess and Steinart (2008) maintains that we model ourselves consciously and unconsciously on individuals we trust and respect and aspire to be like. Price and Price (2009) argued that role modelling should be explicit and is only effective when well-planned and conducted with clarity. Pang & Wong (1998) assert that emulation should be a structured clinical activity to ensure that the behaviours indicative of professional nursing are brought to the students’ attention. More recently Cruess, Cruess and Steinart (2008) stated that awareness of being a role model can improve the process and Wright and Carrese (2002) identified that physicians consciously think about being role models during interactions with their students. All of these authors appear to suggest that role modelling should be a conscious activity. However, there is a contrary interpretation as awareness and

planned activity could give the impression of something 'false' which has the potential to influence role modelling behaviour (Felstead 2013). Professionals are 'embodying' a role, not 'playing' a role (Kenny, Mann & MacLeod 2003) and 'unconscious role modelling' is important. Warhurst (2011) maintains that learning from unconscious role modelling is aided by purposeful reflection.

When considering professionalism in respect of conduct, behaviour and attitude for example this should potentially be modelled through all interactions (Felstead 2013). Role modelling is a very powerful educational tool that has the ability to enable learning about the 'real world' of nursing. The question remains however whether this is only achievable if the role modelling is explicit in nature.

2.2.5 Role model influence on ways of learning

There is a general sense within the literature that role modelling is a basic component of the educational process (Ettinger 1991, Cruess, Cruess & Steinart 2008). The intricacies of professionalism are not necessarily an element that is outwardly discussed and debated but rather exemplified through the educators' behaviours, actions and attitudes which may be 'good' or 'poor'.

It is proffered that for students to really learn what it means to be professional the most appropriate method is for them to see this 'in action' (Ettinger 1991). It is conjectured that where teaching is didactic within the University it may be difficult for students to see professionalism and expectations in a meaningful way. This is not to negate the aspects of learning that take place in the academic setting, elements such as the development of graduate skills, critical thinking and research awareness (Perry 2009). This relates to the concept of 'situated learning' whereby learners participate in and are gradually accepted into a community of practice (Kenny, Mann & Macleod 2003). On a visit to a community based clinic David Benton, Chief Executive Officer of the International Council of Nurses, saw situated learning in practice. His editorial noted that the demonstration of excellence in practice and the support offered to students to emulate the nurses' behaviour helped instil values and attitudes expected in today's nursing workforce (Benton 2010). Presenting this knowledge in the 'real' setting and the social interaction had a significant impact on the students learning. Some of this learning will be observational which is considered a powerful means of transmitting values, attitudes and behaviours. This involves not only watching others actions but also the reactions to the observed behaviour. Bandura (1977) states that

most human behaviour is learned observationally through modelling and that this is the fundamental premise on which the Social Learning Theory (SLT) is founded. The Social Learning Theory provides a useful framework for understanding how role modelling contributes to learning in the absence of theory regarding the process (Warhurst 2011).

Social Learning Theory is linked with positive reinforcement and the concept of stimulus-response. It is postulated that the consequences of a behaviour have a greater influence on whether the learner will repeat the behaviour. If a tutor or nurse communicates inappropriately but the outcome is that which was desired it may be that the learner emulates that behaviour. If however the poor communication leads to a negative outcome then modelling that behaviour is much less likely. Bandura (1977) suggests that the students' value set is influenced by the role model and the outcome of their behaviour. Therefore the imparting of professional nursing values is a component of the socialisation of students. The concern over professional socialisation is that there is a high probability students will internalise poor practice if this is the norm in their placement (Murray & Main 2005). Self-efficacy has to play a role in whether the learner adopts certain behaviour (Donaldson & Carter 2005); particularly as role modelling is more than imitation. This suggests a fundamental 'change' in the learner to a more professional attitude.

According to Melia (1987) there is a contention between the status of the learner and their ability to 'try out', or emulate, a qualified nurse role that may impact on their learning. She postulates that patients have different role expectations of a staff nurse and a student. A student may emulate a qualified nurses behaviour however the outcome may be different for the student given the patient may respond in the knowledge that they are a student and not yet qualified. This, Melia suggests, is a potential limitation of role modelling as part of the socialisation process (Melia 1987). This is an important variable when considering information derived from the current student cohort given the modern context of nurse education. Project 2000 in part attempted to enhance the supernumerary status of students and change the perception that they are 'workers', and therefore in placement to carry out the instructions of the senior staff, to 'nurses' undertaking an educational programme leading to professional registration. This may have made it easier for students to emulate a qualified nurse role, given that they should no longer be the primary workforce in the clinical area.

The retention of the observed behaviour is also seen as vital in the Social Learning Theory (Donaldson & Carter 2005). Clinical practice observations can be practiced and reproduced

in clinical skills laboratories for motor skills but it is not so easy to mimic professional situations whereby beliefs and values can be examined. Recreation of these 'skills' to teach professionalism and the various complexities of practice is much more difficult and this is where role modelling becomes even more significant as supported by Bulman, Lathlean & Gobbi (2013). Their study investigated the process of reflection in professional nurse education and found that educators experienced in reflective practice were able to model the skills of reflection, ultimately facilitating their students' progression through the programme. The power of observational learning is addressed within this study.

The relational nature of role modelling, that is, conducted most commonly between two individuals, leads to a consideration of the impact on the role model and if the process has the potential for them to learn about themselves and their practice. In the study by Etheridge (2007) participants commented that they had become more competent due to the fact they were considered as role models by learners. There was a 'mutual co-construction of knowledge' through the processes of questioning, answering, challenging and critiquing involved in facilitating learner development. Exploration of this 'co-construction of knowledge' is considered important and features within this study.

2.2.6 Role modelling and links to the curriculum

Learning within the Nursing formal curriculum appears to be heavily influenced by the enthusiasm and commitment to learning and teaching by tutors (Felstead 2013). It should be acknowledged that there had been a curriculum revalidation during 2012 meaning that the year 1 participants were studying a different curriculum to the year 2 and 3 students. The impact this may have had on the enthusiasm demonstrated by tutors within year 1 of the programme is not explored as part of this study.

The informal curriculum is highly interpersonal and very powerful (Cruess, Cruess & Steinart 2008) and includes the elements of a role that are observable but not explicitly defined, such as behaviour, attitude, values and communication, and are believed to be handed down from generation to generation (Paice, Heard & Moss 2002). As Eraut (2000) indicates, socialisation into an organisation, or in this case a profession, can occur without awareness of what is being learnt. This infers dependence on role models to deliver the informal curriculum both within practice and the University environment. Indeed, learning the art of nursing is infinitely difficult if 'the art' cannot be specified in detail (Gobbi 2011). Here,

learning occurs by 'example from master to apprentice' (Polanyi 1958 cited in Gobbi 2011) and the learner must place their trust in the master and emulate his practices.

When considering the need to explore informal learning with research participants it is vital that respondents are given a way to make it easier to discuss events that are taken for granted (Eraut 2000). Chapter 4 describes the facilitated reflective approach adopted within this study. Eraut (2000) maintains that research participants are often unaccustomed to talking about their learning and therefore tend to refer to formal or structured learning. Alheit and Dausien (2002) discuss 'biographical learning' and the fact that many learning processes occur implicitly and form patterns of experience that are not consistently reflected upon. Biographical learning can be defined as learning from one's own life experiences through a reflexive process (Tedder & Biesta 2007). However this reflexive learning is not solely confined to the learner and depends on communication and interaction with others. If professional development is heavily influenced by informal learning then encouraging biographical learning during data collection is important to elicit participants' perceptions of role modelling.

2.2.7 Role modelling and professional socialisation

There appears to be a clear link between professional socialisation and role modelling. Socialisation of students into the nursing profession will include the obvious acquisition of skills and knowledge but also the development of their professional identity and an understanding of the cultural norms and values that underpin practice (Holland 1999, Howkins & Ewens 1999, Price 2009). Several studies have identified the importance of occupationally significant individuals to the neophyte nurse (Campbell et al 1994, Melia 1987, Kilcullen 2007, Brown et al 2012). These individuals include nurses working in practice who appear responsible for supporting the development of professional values (Brown et al 2012) and fellow students where three dimensions have been identified – emotional support, facilitating learning and collaborating on physical tasks (Campbell et al 1994). Filstad (2004) particularly references the importance of role models for newcomers to an organisation. Nursing students can feel vulnerable when starting a new placement and may require social support, reassurance and acceptance from established members of the community of practice they are confronted with (Cope et al 2000, Spouse 2001). The auxiliary has been acknowledged as a key figure in student nurse occupational socialisation (Melia 1987) with students acknowledging they would seek advice from them on entering a ward.

The impact of the practice environment on student nurses and their professional socialisation has been well researched including the influence of exposure to high quality role models (Orton 1981, Ogier 1982, Fretwell 1982, Melia 1987). Throughout much of the literature the concept of 'fitting in' is prevalent (Henderson 2002, Murray & Main 2005, Kilcullen 2007). Students appear to believe that they need to fit in to the ward in order to learn. In some cases this can mean emulating poor practice, particularly if this is the norm, and compromising on their idealised concept of care delivery. Henderson (2002) found that student nurses were 'desensitised' during their professional socialisation and often faced discrepancies between the values taught within the educational environment and those witnessed within practice. This finding links closely to that in an earlier study by Melia (1987). A particularly pertinent finding in Melia's' study is the apparent 'segmentation' of nursing between the education and service sectors of the profession. She had earlier identified that the education segment promoted what she termed the 'professional' version of nursing whereas the service segment was more concerned with 'getting the work done'. This led students to learn to adapt to whichever context they were working in, in order to 'get through' their training. For the students in Melia's' study it was clear that they were learning to be student nurses, able to recognise and adapt to what was required to fit in at the appropriate time, rather than learning to be nurses. Role modelling has been identified as an accepted method to facilitate the development of professional values (despite differing opinions [Steinart et al 2005]). These values are often professed within the education segment (Savage 1998, Howe 2002) but evidence has suggested they are not demonstrated within practice. Students' allegiance to the service segment in Melia's study and other such findings only serve to emphasise the importance of good role models (Murray & Main 2005).

There is no doubt that the development of professionalism is important in many occupational settings but particularly Health and Social Care given recent events (Francis and Keogh reports 2013). Various elements can lead to this development in individuals and one such means is through positive role modelling as discussed in this chapter. The nature and influence of role modelling for Adult Nursing students in their choice of role models and their lived experience remains to be explored and is the focus of this study.

CHAPTER 3 - METHODOLOGY

This chapter provides a critical discussion of the methodological approaches used within this study.

3.1 Ontological and epistemological considerations

Research findings can provide new insight into phenomena or add to, confirm or reject what is already known (Parahoo 2006). Philosophical ideas influence the practice of research and it is important for researchers to explicitly discuss their philosophical position in order to justify their chosen approach (Cresswell 2009). The fundamental concept is that of knowledge. Social reality can be explored from two distinct perspectives – objectivist and subjectivist (Cohen, Manion & Morrison 2007). The ontological and epistemological considerations assist in further explaining these two conceptions. See section 1.5 for the researchers' personal ontological position.

Ontology relates to the nature of the social phenomena being investigated (Cohen, Manion & Morrison 2007). An objectivist view maintains that reality is fixed and imposes itself on the individual (the quantitative researchers' perspective). This can therefore be explicitly defined as the truth for all in a defined context. Conversely a subjectivist viewpoint maintains that there are multiple perspectives of reality and that truth is co-constructed as a product of individual consciousness. This is the viewpoint of qualitative purists. The primary goal of quantitative research is to test objective theories through a rigorous examination of variables (Cresswell 2009). Qualitative research on the other hand aims to uncover the perceptions of reality. Objectivists contend that objects of thought have an independent existence, whereas qualitative researchers (subjectivists) believe that the only source of reality is the subjective 'knower'. It is not possible to separate what is thought from the individual having that thought. In other words, reality or truth can only come from the participant experiencing it.

Epistemology refers to the theory of knowledge and knowing. What is there to know and how can we know it? Researchers' epistemological beliefs will determine how they go about uncovering knowledge through research, that is, the methodological approach. Subjectivists see knowledge as personal and unique (Cohen, Manion & Morrison 2007) thereby imposing the need to involve subjects in the research. The common epistemological approach within quantitative research is known as positivism and later, following revision in the latter half of the nineteenth century, postpositivism (Parahoo 2006). In qualitative research the common approach is generally referred to as social constructivism (sometimes interpretivism).

Quantitative research strives to test or confirm a hypothesis through deductive thinking. Data are collected in order to support or reject the hypothesis (Parahoo 2006, Cohen, Manion & Morrison 2007). Qualitative researchers generate explanations of the phenomena inductively from the data. Inductive thinking is open ended and exploratory. Conclusions are drawn after a large number of observations (Parahoo 2006, Cohen, Manion & Morrison 2007).
Positivism as a philosophical position contends that there is a single reality independent of human beings and that scientific methodology (or that of the natural sciences) should be equally appropriate for a research study of social phenomena (Parahoo 2006, MacKenzie 2011). Championed by Auguste Comte positivists believe in the notion of cause and effect (determinism) and that the nature of knowledge is derived from verifying hypotheses to establish them as fact (Denzin & Lincoln 2008; Cohen, Manion & Morrison 2007).

Postpositivists also subscribe to a deterministic philosophy about research whereby an effect or outcome is determined by a specific cause (Cresswell 2009). Karl Popper and later Thomas Kuhn's criticism of the positivist tradition led to recognition that it was naïve to believe reality could be independent of individual experience (Parahoo 2006). Postpositivists believe that knowledge can only result from experience (empiricism) (Cohen, Manion & Morrison 2007). The notion of absolute truth of knowledge was challenged along with the fact that researchers cannot be 'positive' about claims of knowledge when studying human behaviour (Cresswell 2009). Within this epistemological approach the 'true' findings become 'probably true' (Denzin & Lincoln 2008) and the nature of knowledge modifies to determining 'non-falsified hypotheses that are probable facts' (Denzin & Lincoln 2008 p258). Both positivism and postpositivism are deductive in nature and whilst primarily maintain an experimental methodology, in the quantitative sense, postpositivism does allow for the use of qualitative methods.

Social constructivists believe that individuals seek understanding of the world in which they live and work (Cresswell 2009). Subjective meanings of their experiences are developed and knowledge construction occurs as a result of social interaction, interpretation and understanding (Vygotsky 1962 cited in Adams 2006). The nature of knowledge is determined through individual or collective reconstructions (Denzin & Lincoln 2008). There is no 'objective truth test' as the authenticity of knowledge is judged on the consensus between individuals (Adams 2006).

> *''Truth or reality will be accorded only to those constructi*ons on which most people of a social group agree*"(*Adams 2006)

Constructivism is often combined with interpretivism and is aligned to a qualitative research approach (Cresswell 2009). Interpretivism is otherwise known as antipositivism and was championed by Max Weber. The general orientation about the nature of knowledge and research and its place in the world leads researchers to adopt either a qualitative, quantitative or mixed method approach (Cresswell 2009).

This study aims to explore the lived experience of Adult Nursing students in relation to role modelling and potential influence on their development. The researcher believes that reality or the truth of a phenomenon is constructed by individuals as they live through that experience. Their conscious awareness of the situation and surroundings lead them to construct their reality, a truth that is known only to them. A subjective ontological position is therefore taken. The nature of influence is unique to the individual and therefore subjective. In order to identify the reality or truth of this phenomenon an inductive approach must be taken to generate knowledge from the participant perspective. There is no 'absolute truth' and the aim of the study is not to determine a cause and effect. The aim is to explore, understand and interpret participant experiences of the phenomenon under investigation to ultimately determine a social consensus of the truth from the individual participants. Consequently the epistemological position underpinning this study is social constructivism.

Given the ontological and epistemological orientation of this study a qualitative approach was considered the most appropriate. Qualitative research is primarily used to explore and understand what people believe and/or experience, what their attitudes are, how they behave and how they interact with other people or processes in society. The qualitative research approach focuses on the way people make sense of their experiences (Holloway & Wheeler 2010) and provides data that is rich in the individuality of the research participants. This is in direct contrast to quantitative research that is more scientific in nature and generates data that lends itself to numerical analysis in order to establish a relationship between variables. The nature of the data required to answer the research questions is not explicitly numerical or easily converted into a format appropriate for numerical analysis. There is also no intention to identify whether there is a relationship between variables as identified by the participants, indicating that a quantitative approach is not suitable to this study.

An examination of the published research literature in relation to role modelling revealed that the majority of studies have taken a qualitative approach. This supports the assertion that this is an appropriate approach for exploration of this particular phenomenon. It was vital however that this study utilised the qualitative methodology that would enable the researcher to draw valid conclusions in relation to the research question.

3.2 Qualitative research

Qualitative research encompasses a number of methodological approaches that have become more clearly defined over the last 25 years (Parahoo 2006, Cresswell 2009). The most frequently used methodologies vary according to their focus, methods of data collection employed and sources of data.

The commonality between qualitative approaches is their focus on interpretation of participants' contextualised perspectives (Silverman 2000, Parahoo 2006) which can sometimes lead to 'method slurring'. An understanding of the focus of the approach helped the researcher to distinguish between them. Of the various qualitative methodological approaches it is evident that many have relevance to role modelling and impact within a specific context.

Case study methodology has the potential to limit the study in terms of only examining a particular case, whilst an ethnographic approach places a focus that could be construed as too 'wide' given its emphasis on the impact of culture and the explanation of social groupings in their real-life contexts (Cohen, Manion & Morrison 2007). Although there may be cultural influences on the development of professionalism and role modelling the primary focus of this study is on individual perception. Grounded theory and phenomenology are the most common qualitative approaches utilised, particularly in Health and Social Care (Gelling 2011). Whilst both allow the researcher to explore 'real-life' situations by data collected direct from the participants', grounded theory is a complex process that focuses primarily on the development of theory as opposed to the meaning placed on the phenomenon by those involved. Phenomenology, as the chosen qualitative methodology, enables exploration of role modelling and its influence on the students' professional development through interpretation of their experiences.

3.3 Phenomenology

Phenomenology is a philosophy that enables human beings to be understood from 'inside' their subjective experience and has two main approaches – Husserlian and Heideggerian (Mackey 2005, Todres & Holloway 2010). Phenomenological research seeks to understand how individuals perceive and make sense of their lived experience and focuses on describing how the individual experiences phenomena to reveal meaning (Annells 2006, Parahoo 2006, Finlay 2009, Flood 2010).

Husserlian phenomenology maintains that what people consciously believe about the world they live in is important as actions are influenced by beliefs. Conscious experience has value and is worthy of scientific study (Lopez & Willis 2004). Husserl believed in 'going back to the things themselves' (Cohen, Manion & Morrison 2007). This refers to a more reflexive approach whereby our gaze is moved away from the objects of the world and directed inwards to the perception of those objects. However to achieve this, subjects are required to 'bracket' off their experience and start to examine their perception of it. This bracketing occurs by expressing the situation or experience (Smith, Flowers & Larkin 2009) and is therefore possible through a facilitated reflective approach. Research subscribing to Husserl's phenomenological attitude is a purely descriptive approach without any attempt to interpret the experience. This study sought to elicit individual experiences that may well be similarly described and interpreted within each year, that is, similar for all year 1 students and so on. However as knowledge and understanding develops interpretation of role modelling influence may alter given the different expectations of professional development at various stages of the programme. Pure description may not suffice to answer the research questions.

Heidegger believed that we cannot have any knowledge outside an interpretive stance; that it is not possible to explore an experience without interpreting what that experience means (Smith, Flowers & Larkin 2009). Whilst the Husserlian focus is on enabling people to know about their own experience, the Heideggerian phenomenologist will focus on describing the meanings of the individuals lived experience and seek to explore how these meanings influence the choices they make (Flood 2010). Given the desire to explore the meaning students' attribute to their experiences of role modelling the Heideggerian approach is perhaps more appropriate. Heidegger's main subject in his seminal work 'Being and Time' is Dasein (Smith, Flowers & Larkin 2009). This is defined as 'being there' or the quality of 'being human' as uniquely situated in the world and is the focus of Heidegger's beliefs about the purpose of research - to establish the fundamental nature of Dasein. Heidegger is

interested in the relationships individuals are caught up in and in particular how the world appears to us (Heidegger 1962). Dasein requires reflexive awareness. In order to explore me, the individual, it has to be in relation to my place in the world and my relation to others. 'Being alone' is 'being without others'. Essentially Heidegger viewed the person as the 'person in context'. This links to the phenomenological concept of intersubjectivity – our ability to communicate with and make sense of each other. Human beings are 'thrown' into a world of experiences and phenomenological inquiry is concerned with how people make meaning from their experience of being in the lived world (Heidegger 1962, Polit & Beck 2010, Mackey 2005). In relation to this study and the philosophical views of Heidegger, professional development is therefore potentially reliant on relationships with others. Our own values and moral standpoint, 'who we are', may therefore be influenced by our relationship with others.

Phenomenological analysis requires researchers to look beyond what they already know from experiences (Finlay 2013). Husserl believed that researchers need to disregard prior knowledge (termed 'bracketing') to prevent any bias or preconceptions influencing the study (Polit & Beck 2010, Biggerstaff & Thompson 2008). Heidegger however emphasised that it is impossible to rid the mind of background understanding that has led the researcher to consider a topic worthy of research in the first place (Koch 1995). He referred to 'fore-conception' as the prior experiences, assumptions and preconceptions of the researcher on which any interpretation is based (Heidegger 1962). The difficulty with bracketing fore-conception is that it can never be total. When we discover something through our interpretation of new things we may discover further preconceptions or experiences we have had that may have been buried or forgotten. In the context of this study, facilitating reflection with participants about a phenomenon that the researcher has experienced is also a form of self-reflection. Indeed it is maintained by some authors that part of the research process has to be the close involvement of the researcher and participant (Pringle, Hendry & McLafferty 2011). It is imperative however that the researchers' fore-conceptions do not influence the interpretation of the participants' experiences (see Reflexivity, section 3.5).

It is believed pertinent and important to gain an understanding of our experience in the world and how people perceive their own experience. Rather than just take things for granted it is important to look deeper and try to understand why 'things' are happening to us and how they may be influencing us. To enable or enhance the usefulness of any phenomenological research findings in the wider context interpretation of what they mean for the individual is

key. Only then can the findings be extrapolated to develop an understanding of how experiences are potentially influenced 'in the world'. The philosophical stance within this study leans towards Heidegger as description of participants' experience without interpretation is not considered achievable. It is also thought that there is more value in finding the meaning in the participants' lived experiences as opposed to a purely descriptive approach given that this study is fundamentally about a phenomenon that is well known and not a new concept. Previous studies have described the experience of role modelling. This study seeks to deepen understanding and interpret the meaning of these experiences. The researcher supports the notion of the interconnectedness of each person in the world (Smith, Flowers & Larkin 2009). Phenomenology is therefore suitable as a research methodology for this study which is primarily concerned with how student nurses are influenced by their relationship with others through role modelling.

3.4 Interpretive Phenomenological Analysis

Interpretive Phenomenological Analysis (IPA) is an inductive qualitative research approach that explores participants' lived experiences (Finlay 2009). It is considered phenomenological due to its concern for individuals' perceptions. Researchers look in detail at what the experience is like for a particular individual and make interpretations that discuss meaning, cognition, affect, belief and action (Huberman & Miles 2002, Smith 2004). The fundamental concern of interpretive research is to understand phenomena from the perspective of the participants – that is, from an 'emic' rather than 'etic' perspective (Huberman & Miles 2002). In IPA there is a balance of the emic and etic as the researcher begins with hearing a description of the individual account and then they attempt to make sense of the participants' experiences in an attempt to answer a particular research question (Reid, Flowers & Larkin 2005).

Realising the potential of the individual case through analysis is vital before attempting to extrapolate this to look for themes across cases. The analytical process within this study will interpret the impact and influence on professional development for individual cases and then discuss the impact of role models in this regard more generally. This is not to say that generalisations will be made but rather to add to the body of knowledge. To concentrate on the particular and increase the depth of analysis the sample utilised in IPA is intentionally small therefore the findings are unlikely to be generalizable across the population. The overarching concern is on demonstrating 'existence not incidence' (Smith, Flowers & Larkin

2009) with the intention of indicating where extrapolation of the findings may occur in similar groups whilst recognising the limitations.

IPA as an approach is concerned with examining the meaning attributed to major life experiences (Reid, Flowers & Larkin 2005). In the case of this study the sample is derived from the Adult Nursing student population. For many, nursing is a career choice for life and there is a fundamental understanding of the commitment required to fulfil the role. Anecdotally it is also recognised that many students have had to work extremely hard to gain a place on the programme and for some it is the realisation of a long held dream. Commencing and completing pre-registration nurse training is, for most, a major life experience.

3.4.1 Hermeneutics

Hermeneutics is the theory of interpretation (Biggerstaff & Thompson 2008, Smith, Flowers & Larkin 2009). In IPA, researchers attempt to understand the participants experience by interpreting their accounts of it. Nursing students experience working with others throughout their initial educational programme and this collaborative working will have influenced their development. Reflection is a core concept utilised within the programme and this will have led students to reflect on their experiences and subsequent development. They may have therefore tried to make sense of the experience although much of this may have been subconsciously. This study aims to interpret their accounts. In this way this study is a 'double hermeneutic' (Finlay 2013) as the researcher is attempting to make sense of the participants, attempting to make sense of their experiences.

This link to hermeneutics aligns IPA with Heideggerian phenomenology. For Heidegger, phenomenology concerned examining a latent or buried phenomenon as it emerged through reflection. He also believed that one must include an examination of the 'manifest' that is the conscious experience, given its influence on the unconscious latent phenomenon. Through facilitated reflection this study will uncover the meaning students attribute to their experiences of role modelling in relation to their development into professional practitioners. There is an examination of the 'manifest' (the description of the experience and its relation to professionalism) and also the 'latent' (how the experience impacts on their professional development). This is however only possible through interpretation of the participants account. Within IPA this exploration and interpretation incorporates the semantic content and language at a descriptive, linguistic and conceptual level (Finlay 2013).

3.4.2 Idiography

A view of social reality that stresses the subjective experience of the individual over the universal perspective is idiographic in nature (Cohen, Manion & Morrison 2007). Idiographic research approaches explicate the unique aspects of the particular as opposed to nomothetic approaches that seek to generate conclusions that apply across many settings (Seale 1999). IPA is idiographic in nature as the experience of the individual is paramount. Within IPA the sense of detail and depth of analysis is enhanced through a small sample size and an iterative process of data analysis (Smith, Flowers & Larkin 2009). There is also a commitment to elucidating the phenomenon from the perspective of individuals within a particular context.

3.5 Reflexivity

It is essential that researchers consider their actions and role in the research given that they are the primary instrument of data collection and analysis (Watt 2007). This is known as the process of reflexivity. A methodical process, reflexivity enables the researcher to learn about themselves whilst facilitating an understanding of not only the research process but also the phenomenon under investigation (Kleinsasser 2000, Watt 2007). Reflexivity sometimes referred to as self-reflection, can demonstrate quality and rigour thereby adding credibility to qualitative research (Seale 1999, Carolan 2003).

In qualitative research this process is vital in order to acknowledge whether values and perceptions held by the researcher have influenced the various stages of the research process. It is not possible for a researcher to be neutral or detached from the knowledge and evidence they are generating. Instead they should seek to understand their role in that process (Mason 2002). Researchers bring their own biographies into the research and their presence can lead participants to behave in particular ways (Cohen, Manion & Morrison 2007). This is particularly pertinent to this study given the position of the researcher within the University and link to the students' programme. My initial concerns at the start of this study were related to doing the research 'well' given my limited experience. I was also apprehensive about interviewing and worried that I would introduce bias into the interview process and therefore the data collected. To aid the process of reflexivity I maintained a research journal/diary where thoughts, perceptions, potential biases and so on were recorded and reviewed during the course of the study and subsequent write up.

Watt (2007) maintains that researchers firstly need to be aware of the personal reasons for carrying out the study. What were my 'subjective motives' for choosing to research role modelling and professional development? On reflection my primary objective was to explore this phenomenon in the context of nurse education and in particular the experience of student nurses. My previous experience working in this field had led me to perceive that the collaborative nature of nurse education may impact on the development of students as professional practitioners. I particularly wanted to provide information to mentors (and other collaborative partners) regarding role modelling and the influence that this may have. I acknowledge that this study has arisen from occupational experience in relation to student professionalism (or lack of) and that personal experience and opinion will therefore have impacted upon the research process. This is more notable in relation to maintenance of standards of care provision linked to professional practice which I am particularly passionate about. Throughout the study I have remained transparent in the likely consequences of my preconceptions regarding the phenomenon under investigation. Through the introductory chapter there is acknowledgement of my viewpoint and personal perspective regarding role modelling and professionalism.

As a new researcher I recognised that my values and beliefs will impact on my choice of study design. I believe in the co-construction of knowledge between researcher and participant. A qualitative approach seemed the most appropriate to enable the 'truth' about the phenomenon to be revealed, from the perspective of the participants and through my interpretation. Reflexivity interpreted within Seale's (1999) concept of 'reflexive methodological accounting' is essentially the process of giving a full explanation of the methodological procedures used to generate a set of findings. This has been completed within the next chapter and should enable the study to be replicated by other researchers and allow for credibility assessment by the reader (Seale 1999).

CHAPTER 4 – STUDY METHODS

This chapter details the methods undertaken during the study.

4.1 Interpretative Phenomenological Analysis

The approach to analysing data can influence the strategies adopted at the start of any research study (Smith, Flowers & Larkin 2009). Interview transcripts in phenomenological research provide a description of the participants' lived experiences. These are then ready for the analysis of meanings (Todres & Holloway 2010) followed by formulation of these meanings into coherent stories of interrelated themes and insights. As noted the researcher will utilise IPA as defined by Smith (2004) as this approach adheres to guidelines regarding rigour and validity in qualitative research studies (Pringle, Hendry & McLafferty 2011).

4.2 Sampling Framework

Phenomenology usually seeks to identify insights, 'essences' that are applicable to the wider society and not just specific to the research participants (Todres & Holloway 2010). This however is dependent on various factors including the approach adopted and sample size. When considering human beings it is unlikely that common themes can be found across a wide spectrum of cultures and circumstances and therefore many researchers will seek to identify themes within particular subsets of society. This is particularly relevant to this study given the individual nature of role model selection and development of professionalism previously alluded to. Purposive sampling was used as it enables the researcher to choose participants for a particular purpose and where it is known that the phenomenon under investigation is most likely to occur (Denzin & Lincoln 1994, Silverman 2000). In this study the sample was chosen to enable exploration of their experience of role modelling. It is not sufficient to harness general views on role modelling in this study (or indeed in all phenomenological work (Todres & Holloway 2010)) given the need to interpret these in the context of the development of Adult Nursing students' professionalism. For this reason the selection of participants was specifically targeted to 1st, 2nd and 3rd year Adult Nursing students. This enabled exploration of the lived experience as the expected knowledge, understanding and indeed level of professionalism increased.

4.2.1 Participant group size

Todres and Holloway (2010) maintain that phenomenological studies can generate valuable data based on the in-depth analysis of one participants' lived experience. They do however

acknowledge that there is value in increasing the number of case studies. This study seeks to explore the phenomenon in order to develop an understanding of its impact on the participants' development as professional practitioners in a specific context. Given the specific, contextual nature of IPA there is no assertion that generalisations will or indeed can be made. What is offered here is an in-depth analysis of individual participants' understandings that may be extrapolated to offer wider insights but must be viewed with caution. The purpose of the study is to explore the experience of individuals and be able to provide a detailed account (Reid, Flowers & Larkin 2005) and therefore a relevant number of participants were recruited. It will be possible to explore the similarities and differences in how these experiences are understood across the sample but wide generalisations are not desired and indeed not possible. Pragmatically there was also a concern that by having too many participants the quantity of data produced may lead to a reduction in the depth of analysis conducted. Therefore 4 participants from each of the 3 student groups (years 1, 2, 3) were invited to participate, providing a total of 12 participants. This number was recruited in the hope that saturation of the data would occur. Saturation in the context of this study is defined as the point at which no new data is emerging from the interviews. Subsequent analysis would then explore convergence and divergence in themes across the programme thus addressing the research questions related to the students' educational journey. Whilst striving for a degree of saturation it is recognised that this is not generally a goal of an IPA approach (Hale, Treharne & Kitas 2007). Individual experience is such that true data saturation can never really be fully achieved. The increased number of participants also allowed for any attrition during the course of the study.

4.2.2 Inclusion / exclusion criteria

Consideration was given to whether it was important to stratify the participant group for demographic spread. However, generally researchers utilising IPA methodology aim for a homogeneous sample (Smith, Flowers & Larkin 2009) to reduce the variation that could influence any analysis of the phenomenon. To that end it was decided to recruit female students, as this demographic represents a majority of the student group.

4.2.3 Recruitment of participants

Potential participants were invited to participate via the University's virtual learning environment, to minimise potential for coercion, with the participant information sheet and consent form as attachments (see appendix 2 and 3). Students were recruited as they volunteered until there was a total of 4 female participants from each year.

4.2.4 Study participants

Only White British students on the degree programme at the same campus volunteered further reducing any influencing variables. The ethnic mix at this campus is predominantly White British. The sample was stratified according to age to ensure an equal number of young (18-25) and mature (25+) students. Table 4.1 details the participants' mean age and age range by year.

Table 4.1 *Study Participants' mean age and age range by year*

Year (n=4 per year)	Mean Age	Age Range
1	30.25	21-42
2	29.25	22-38
3	29	21-37

4.3 Methods of data collection

The aim of this study was to explore Adult Nursing students' lived experience of role modelling with a particular focus on the understanding of their development as professional practitioners. Within the phenomenological and particularly IPA stance the fundamental premise of data collection is to enable participants to offer a thorough, individualised account of their experiences (Reid, Flowers & Larkin 2005). Qualitative research data can be collected by a number of methods, most commonly interviewing, observations, documents and audio-visual materials (Silverman 2000, Mason 2002, Cohen, Manion & Morrison 2007, Cresswell 2009).

Generally qualitative researchers utilise semi-structured or unstructured interviews as their primary method of data collection (Price 2002, Holloway & Wheeler 2008). Interviews enhance the opportunity for complete answers and allow the researcher to delve deep for more complex responses. Given the desire to explore the experiences of the participants within this study, interviews also enable the researcher to facilitate participant reflection. It is also believed that respondents take more care over their answers given the direct responses made to the interviewer (Fielding 1994). In theory this has the potential to enhance the reliability of the data collected as respondents may think more carefully about their answers. This is particularly relevant to phenomenological research whereby an in-depth interview provides the opportunity to focus on the complexity of the experience and also enables the researcher to provide a clear exploratory focus (Todres & Holloway 2010). Given the

idiographic level of data required focus group interviews were not considered suitable. Focus groups are a form of group interview where data is generated through interaction amongst group members following initial provision of a topic by the researcher (Parahoo 2006, Cohen, Manion & Morrison 2007). The knowledge gained from such an interview is often an outcome of the interchange and discussion of ideas. The risk that this could 'contaminate' the individual understanding of the participants' experience was too great given the epistemological position of this study. Data collected via focus group tends to represent a situated account of the social interaction and therefore Krueger and Casey (2000) suggest that it is the group rather that the individual that is the focus of analysis.

There are advantages to the use of qualitative observations (visual, auditory) (Silverman 2000) including gaining a contemporaneous experience of the participants and the ability to observe any 'unusual' activity or response that may not be verbalised or accessible by any other means. Observational methods have been used for phenomenological studies, and IPA work in particular, but potential for researcher-effect, difficulties in observing complex social activities and the fact that data analysis is extremely difficult (Smith 2004) preclude its use. This study aimed to explore the meaning participants place on their experiences. Whilst the observation of practice would be achievable, the complexity of role modelling as a phenomenon and how this may impact on the learners' development would not be so easily observable. Also, it was perceived that much of the observed data may stem from the researchers' interpretation as opposed to the individual participants' perception of their experience. Therefore observation was not an optimal method of gathering information from participants.

Documents can be public or private (minutes of meetings or diaries for example). Whilst participant diaries would have enabled the researcher to access the language and words of the participant (Silverman 2000, Cresswell 2009) it would not have allowed for facilitated reflection. As many role modelling experiences may be subconscious it was thought that a participant diary would not elicit sufficient relevant information for this study. Audio-visual materials, such as videotapes and photographs, are an unobtrusive method of data collection and can provide precise 'transcripts' of naturally occurring events (Silverman 2000). The data required to answer the research questions does not 'fit' with this method of data collection as it is not a means to ascertain the views and perceptions of the participants in relation to the phenomenon.

Given the above it was determined that interviews were the most appropriate data collection method for this study.

4.3.1 Interviews

The following section provides discussion around the main types of interview in order to ascertain which will access relevant data to answer the research questions.

4.3.2 Types of interview

Table 4.2 details specific elements associated with the main types of research interview.

Table 4.2 Variations in research interview adapted from Parahoo 2006, Holloway & Wheeler 2008, Tod 2010

	Structured	Semi-structured	Unstructured
Questioning	Personal administration of questionnaire	Pre-set questions and verbal probes	Interview guide with opening question and list of topics (Tod 2010)
Flexibility / Sequencing	Cannot alter wording/sequence or change meaning of questions	Can change the wording of questions but not the meaning	Researcher chooses whether to focus on topics identified by participant. Sequence of topics can be different for each participant
Probing	YES – concerned with providing more detail about questions asked (Parahoo 2006)	YES – seeking clarification of participant responses	YES – exploratory comments - for elaboration of a particular point or to provide meaning for specific responses (Holloway & Wheeler 2008)
Quality of information	Usually seeks identical information from each participant	Exploration of views and perceptions of participants aligned to pre-set questions	Allows discussion of topics that are of significance to participant

Structured interviews tend to contradict the aim of qualitative research given that the research interview in the qualitative sense strives to develop knowledge and understanding of the phenomenon (Watson 2008) from the perspective of the participant. Certainly the more that is known about a particular subject or topic the more structured the interview as the aim tends to be focused on gathering data amenable to quantitative analysis and not the exploration of phenomena (Tod 2010). This study has 3 groups (1st, 2nd and 3rd year pre-registration

students) all of whom will have variable experience of role-modelling and therefore identical interviews will not be appropriate. It is crucial that participants within this study have the opportunity to express their own views in relation to the research topic. This is particularly pertinent as a key element is the recognition of individual perception of the role-modelling influence on development as a professional practitioner. The aim of this study requires the interview to be led by the participant's viewpoint and perspective and not the researchers (Tod 2010).

Semi-structured interviews potentially mean that it is difficult to achieve a truly participant perspective without the influence of bias on the part of the interviewer. The semi-structured nature could provide the researcher with the means to 'steer' the interview in a particular direction through the use of pre-set questions. It is the lived experience of the participant that is key to phenomenological research. That said, in the hermeneutic approach the experience of the researcher may aid the participants' reflection through self-sharing and exploratory probes. Certainly Holloway & Wheeler (2010) argue that the researcher is not a 'blank screen' and is an active participant in the research interview thereby taking part in co-constructing meaning with the participant. It remains however a concern that any kind of interview structure would increase the potential for bias.

Qualitative interviews are sometimes referred to as 'open', 'informal' or 'unstructured' (Parahoo 2006). These are otherwise known as 'non-directive' as the interviewer does not direct the participants to particular topics but allows them free expression. The interview guide or 'prompt sheet' simply acts as an aide memoire for the researcher who has to ensure that the aim of the research is achieved (Biggerstaff & Thompson 2008). It is in no way prescriptive and should not limit the expressed interests of the participant. More focus may be placed on certain issues at times during the interview in order to clarify in greater depth the nature of the phenomenon being studied (Todres & Holloway 2010). Given the nature of this study and its specific relation to the development of professional practice as opposed to role-modelling in general it was felt necessary to focus in on specific elements to facilitate the participants' reflection. If not, this could leave the research questions unanswered. When considering all factors it was decided that an unstructured approach to interviewing would elicit appropriate data to address the aim of this study.

4.3.3 Advantages of different methods of gathering information from participants

It is recognised that the interview and subsequent responses could be influenced by the presence of the researcher and researchers should be cognisant of this so called 'Hawthorne effect' (Gerrish & Lacey 2010). In this study there is the potential for 'muted' responses from students despite any assurances that the research is not connected with the researchers' role within the University. The potential anxiety of students who wish to 'impress' the researcher may also distort their responses (Fielding 1994). The use of a research assistant to conduct the interviews with students would go some way to relieving this issue but this brings with it the issue of inter- interviewer reliability and cost. There are however conflicting perspectives in the literature that discuss research interviews as not requiring the development of a relationship and that the interest in the participant is as far as the interview goes (Parahoo 2006). In one-off in-depth phenomenological interviews, unlike ethnographic approaches, the rapid development of a positive relationship is vital (DiCicco-Bloom & Crabtree 2006). It will be essential that the researcher builds trust in the relationship quickly – a skill that is often associated with healthcare professionals who may only meet clients briefly and at a stressful time in their lives. It is hoped that this skill will benefit the interview process particularly given the complicated power dynamic of the pre-existing power relationship between researcher (academic) and participant (students) (Watson 2008). Other measures are discussed in section 4.6.1.

4.3.4 Pilot study

The researcher within this study was not as familiar with interviewing as other methods of data collection and therefore a pilot interview was carried out so that experience of qualitative interviewing was achieved. This provided the opportunity to practice using audio recording equipment and reflect on the process prior to conducting the actual data collection. Following the pilot interview a more rigorous interview schedule was constructed with 'broad subject area' prompts that allowed the researcher to check these off as they were identified and discussed during each interview data collection.

4.3.5 Conduct of interviews

On arrival for the interview the participant was welcomed and thanked for volunteering. The purpose of the interview and overall research study was explained. It was clarified to the participant that this study was not being undertaken in the researchers' capacity as a staff member but as a fellow student. This was aided by the fact that the interviews were conducted in a 'neutral' environment (that is away from the researchers' office) and with the

researcher wearing casual clothing to reduce any potential perceived power imbalance. It was confirmed that the participant had read the information sheet and they were given the opportunity to ask questions. The participant was asked to read through the consent form and sign this prior to commencing the interview.

Once the interview had commenced participants were given time to answer fully any questions posed during the course of the conversation. Exploratory prompts and probes were used to 'guide' the interview and facilitate the participants' reflection on their experiences. Interviews were audiotaped for later transcription by the researcher with minimal notation made during the process to ensure that full attention could be paid to the participant.

4.3.6 Reflexive comment

My perception of an interview was that the interviewer asked questions and the participant answered them. A view shaped by my extensive experience in conducting clinical admission interviews (as a nurse) and recruitment/selection interviews (as a lecturer). Prior to this study I had not conducted interviews in the research context. I had a number of fears going into my data collection period. I was concerned that I would speak too much during the interviews and this would mean I was leading the interview and therefore not seeking the participants' perceptions. I also feared that without a defined structure and list of questions the interview 'conversation' would dry up.

Through personal transcription of the interviews I was able to assess how much of my voice came through and conversely how much of the participants. It was gratifying to note during this process that in the majority of interviews I said very little but managed to keep the interview going until its natural conclusion. I also noted during transcription that having reviewed my personal perspective of the phenomenon I was aware of my preconceptions prior to each interview enabling me to remain open-minded and non-directive. This along with the use of an unstructured interview with an opening question ensured that the data collected was wholly the participants' views uninfluenced by my perceptions of the phenomenon.

4.4 Method for analysis of information gained from participants

In qualitative research the process by which data analysis is undertaken is fundamental to determining the credibility of the findings (Ryan, Coughlan & Cronin 2007). See section 4.5 for information regarding credibility. It is important that there is sufficient description of the

method of analysis in order to establish that the final outcome is rooted in the data generated. This is particularly significant in a study that uses an IPA approach given its idiographic nature.

With qualitative data the analysis is almost inevitably interpretative, therefore providing a reflexive, reactive interaction between the researcher and the decontextualised data (Cohen, Manion & Morrison 2007). There is a tension between maintaining a sense of the holism of the interview and the tendency to fragment the data, 'in interviews the whole is often greater than the sum of the parts'. The hermeneutic circle infers that interpretation is not a linear process. In order to understand the whole the researcher needs to understand the parts and conversely to understand these they must be examined in the context of the whole (Smith, Flowers & Larkin 2009).

Smith, Flowers & Larkin (2009) provide a 'heuristic framework for analysis' that serves as a guide to the strategies employed by IPA researchers in the analysis of their data. Heuristic being experience-based techniques for learning and discovery. They state that there is no correct way to carry out IPA data analysis and encourage innovation in researchers' approach. Figure 4.1 details the analytical approach taken within this study (example data is provided in the appendices as indicated).

Figure 4.1 Steps in the analytical process (based on Smith, Flowers & Larkin 2009)

STEP 1

Listened to audio file and reviewed transcript to write interview summary (appendix 5)

Sent to participant to verify an accurate reflection of their views

↓

STEP 2

Listened to audio file and noted striking observations and reflections

↓

STEP 3

Read the transcript and made initial notation in 3 areas using different colours for easy identification (appendix 6):

1. DESCRIPTIVE – the content of what was being said at that particular time.

2. LINGUISTIC – any particular inflexions in the voice (pauses, repetition, 'strong' or emotive language etc.) that gave an indication of what the participant might be feeling about what they were saying.

3. CONCEPTUAL – more interrogative notation. This is where questions were asked of the data.

↓

STEP 4

Examined notation for similarities and interrelationships to identify emergent (subordinate) themes. Some themes stemmed directly from the raw data and some were interpretations. Noted on the interview transcript (appendix 6).

↓

STEP 5

Transcribed subordinate themes noting page reference and identifying comments from the participants' interview. Themes ordered alphabetically so that similar themes were sorted together and reviewed. Themes that were similar but may have had slightly different wording were made the same, that is, **holistic practice** and **caring for the whole person** both became **person centred practice**. This rewording was conducted following a review of the original transcript to ensure that the interpretation was not lost or altered (appendix 7).

↓

STEP 6

The emergent themes were once again ordered alphabetically and those that were similar (for example, mention role modelling or a derivative of role modelling) were grouped. This followed the process of abstraction (Smith, Flowers & Larkin 2009). This grouping was then given a new name – the superordinate theme (appendix 8). Not all subordinate themes were incorporated at this stage (Smith, Flowers & Larkin 2009).

↓

STEP 7

Steps 1-6 carried out for all 4 interviews in a year group and revisited each in light of themes identified to ensure comprehensive analysis

↓

STEP 8

Superordinate themes mapped across the year group to identify commonality. They were then ordered according to whether they were present in 4, 3, 2, or 1 interview. This identified the most common superordinate themes within the year group (appendix 9).

↓

STEP 9

Superordinate themes from across the year group were amalgamated. Information included the subordinate theme, interview participant identifying code, page reference and identifying comments from the original transcript (appendix 10). The subordinate theme list in each superordinate group was then reviewed as per the process in step 5. This led to some relabeling of similar themes (Smith, Flowers & Larkin 2009). Once again this rewording was conducted following a review of the original transcript.

↓

STEP 10

Steps 1-9 carried out for all interviews and then superordinate themes mapped across entire sample (appendix 11)

↓

STEP 11

Cross-checked subordinate theme placement in all years to ensure consistency i.e. that the same subordinate theme was located within the same superordinate theme. Given the fact that each interview/year was analysed independently to ensure that it was considered on its own merits and without influence or bias from the preceding analyses there was some disparity in how subordinate themes had been grouped. Where an anomaly was identified the subordinate themes were reviewed along with the original interview transcripts and either 1) moved into one of the two identified superordinate themes or 2) both moved into a new superordinate theme if considered appropriate.

↓

STEP 12

Each superordinate theme was taken independently and all three years combined (if present) as per step 9. Alterations were made as appropriate, for example, **student as role model** became **role modelling by students to nurses and peers** and ***nursing as 'giving back'/initial influence for nursing/initial reason for nursing/reason for entering nursing*** all became **stimulus for nursing career**.

4.5 Quality / Validity / Reliability

One of the primary concerns for any qualitative researcher is to demonstrate the rigour of their work.

Seale (1999) posits that qualitative researchers must demonstrate an awareness of the methodological decisions taken during a study in order to enhance the quality of the research. Lincoln and Guba (1985) translated the conventional positivist paradigm criteria that usually inquire as to truth value (internal validity), applicability (external validity), consistency (reliability) and neutrality (objectivity) into criteria for assessment of the trustworthiness of a qualitative study (Seale 1999). These criteria are credibility, transferability, dependability and confirmability (Lincoln & Guba 1985). It is important to note that whilst Lincoln and Guba (1985) provide this framework for quality assessment the constructivist epistemological position of this study and its inherent belief that there are 'multiple constructed realities' is inconsistent with attempting to establish a single reality, or truth, through application of these criteria. To address the wider context of this issue, a number of guidelines for assessing quality and validity have been produced. Smith, Flowers & Larkin (2009) advocate the use of criteria by Yardley (2000) as they are particularly applicable to an Interpretive Phenomenological Analysis (IPA) study. Yardley's (2000) four principles to assess the quality of qualitative research are sensitivity to context, commitment and rigour, transparency and coherence, and importance and impact.

Credibility concerns whether the findings of the study capture reality. Is the researcher measuring what they claim to be measuring (Mason 2002)? This includes the assertion that the chosen method of data collection and the data sources are appropriate to the overall aim of the study. This concept links closely to Yardley's broad principle of commitment and rigour. For her this includes how thorough the study is in relation to the appropriateness of the sample, the quality of the interview process including how attentive the researcher is to the participant and how complete the analysis is (Smith, Flowers & Larkin 2009).

To aid credibility of the findings the sample must be reasonably homogenous and appropriate to the study to enable collection of data relevant to the research question. Given the idiographic nature of IPA the researcher set out to explore the phenomenon in relation to a particular set of selected participants, namely female Adult Nursing students currently undertaking their initial nursing educational programme. As section 4.2.4 identifies the participants were homogenous (with the exception of age and year of programme) and appropriate to the study. The opportunity to conduct a pilot interview and reflect on this enabled the researcher to develop the skills required for a rigorous qualitative interview. Attentiveness to the participant was evidenced by the ratio of participant to researcher voice within the interviews (in favour of the participant). The findings chapter of this study

demonstrates the completeness of analysis. Smith, Flowers & Larkin (2009) outlines one element of this as 'sufficient idiographic engagement' and ensuring that all participants are drawn on proportionally in the write up. Proportional representation also aids to reduce 'anecdotalism' whereby the qualitative researcher is tempted to choose the best examples for their analysis and write-up and not demonstrate a critical interpretation of all of their data (Silverman 2000). This is also related to the concept of 'fairness' which strives to reduce bias by representation of all participant voices (Denzin & Lincoln 2008). Within this study there is representation proportional to the length of interview and depth of information gleaned from the participants.

When assessing validity, it is important to remember data itself cannot be valid or invalid, what are at issue is the inferences drawn from the data (Huberman & Miles 2002). The issue of validity in interviews is related to how 'true' the findings are (Tod 2010). One method to validate the findings is to include direct quotations from the participants' responses in the findings section of the final report. This is a common occurrence in qualitative studies and as indicated above is utilised within this study. It is stated that researchers cannot know if participants are telling the truth but in a sense the factual accuracy of the interview data is not as important as what lies behind the responses (Holloway & Wheeler 2010). It is generally maintained that participants are telling the truth from their perspective and this should encourage faith in the process and findings. Sometimes the truthfulness of responses is impacted upon by the fear of recognition in the final publication of the research. Participants were made aware that verbatim quotes were to be used within the final thesis and that they may be able to identify themselves. This issue was included in the consent form (see section 4.6.3).

Many authors advocate triangulation of different data sources as a method to add validity (Parahoo 2006, Cohen, Manion & Morrison 2007, Cresswell 2009). This was not however deemed possible for this study given the individual nature of the phenomenon being explored. The data required to explore the lived experience of role modelling for an individual can only come from the individual. Even triangulating with participant observation if this had been practical would have had a significant influence on the nature of the phenomenon and therefore the participants' experience of it.

Lincoln and Guba (1985) maintain that 'member checks' is the most crucial technique for establishing credibility. That is, seeking the agreement from research participants that the

interview transcripts, for example, are an accurate transcription of their views (Cresswell 2009). Given the likelihood that the participants would not be able to recall the entire interview and the perception that review of the entire transcript is high risk as participants may change their minds (McConnell, Chapman & Francis 2011) a scaled down approach was taken. Prior to full analysis of the transcripts for this study the researcher scribed a summary of each interview with some preliminary analytical statements. This was sent to each participant for them to check and verify that initial thoughts regarding their experiences attuned to their intentions. Eleven of the twelve participants responded to agree that the summary was an accurate representation. One participant did not respond and it was therefore assumed that the summary was an accurate representation. It must be bore in mind however that member checking is not full-proof as participants may agree with the researchers summary or interpretation as they believe them to be 'smarter' or more knowledgeable than they are (Polit & Beck 2010). Interview strategies such as probing, paraphrasing, the use of silence and open-ended questions enabled clarification during the co-construction of data as directed by McConnell, Chapman & Francis (2011). This enhanced the credibility of the data collected.

Transferability is the degree to which the conclusions in the study would hold for other persons in other places at other times and is analogous with generalizability (Polit & Beck 2010). The researcher must provide a rich or 'thick' description of these various elements of the study so that the reader can judge the applicability to other settings (Seale 1999, Huberman & Miles 2002, Cresswell 2009). Those assessing the transferability of a study could argue that the people, place and time in a study are 'unusual' and therefore the burden of proof rests with the researcher to describe these elements and provide sufficient information to enable judgements regarding contextual similarity (Polit & Beck 2010). Providing full information to account for the conclusions being drawn in a particular context should enable an accurate assessment of how transferable the findings are, as judged by the reader.

This has some resonance with Yardley's (2000) principle of sensitivity to context. This is explained as involving sustained engagement with the particular sample to ensure data is contextualised within the research study; having sensitivity to the data collected; and also an awareness of the existing literature regarding the phenomenon under investigation (Smith, Flowers & Larkin 2009). This last element helps to orient the study and findings in the broader context of the published literature. With regard to this study the attentiveness given

to the purposive sample during data collection and the fact that the findings chapter includes a considerable number of verbatim quotes demonstrates engagement and sensitivity to the data sources (that is, the participants). With regard to the wider issue of generalizability it has to be remembered that the intent of qualitative inquiry is not to generalise findings (Cresswell 2009) and an IPA study attempts to demonstrate existence not incidence (Smith, Flowers & Larkin 2009). Therefore there is no assertion that the findings are generalisable. That said Huberman and Miles (2002) discuss the concept of internal and external generalizability as applied to qualitative research. Internal generalizability relates to generalising within the community studied and external generalizability concerns generalising to 'other' communities. Internal generalizability is much more important to most qualitative researchers because they rarely make explicit claims about external generalizability. This is true of this study where the researchers' aim was to explore the phenomenon and draw conclusions related to female Adult Nursing students. There is high internal generalizability. The write-up of this study provides a rich, transparent and contextualised analysis of the account of the participants. Those engaged in reading this study should have sufficient information to evaluate the transferability of the findings to others in contexts which are more, or less, similar (Smith, Flowers & Larkin 2009).

Dependability examines the extent of consistency within the findings of a study (Lincoln & Guba 1985). How reliable are they? It is important that the researcher leave an audit trail and a detailed description of how the study was conducted and how the findings were derived from the data collected. This enables an external reviewer to scrutinise the data and procedures undertaken to determine dependability. Researchers can also be confident in the dependability of their findings by ensuring that there isn't a drift in the application of themes during the analytical process (Cresswell 2009). This was achieved in this study by constant comparison of data across the interview transcripts as the analysis progressed (as explained in section 4.4).

This approach also has a bearing on confirmability (Polit & Beck 2010). This refers to the objectivity of the data and can be established by external auditing. Provision of documentation that allows an auditor to draw conclusions regarding the data enables assessment of confirmability, a process that is enhanced by reflexivity. This provides a self-critical account of how the research was conducted and provides clarification as to any researcher bias (Seale 1999, Cresswell 2009) and is evident within this study. Transcripts

should also be open to further inspection by readers (Silverman 2000). An example transcript with subsequent analysis is provided as an appendix to this study (appendix 6).

Yardley's (2000) concept of transparency and coherence is relevant here. This is described as ensuring a clear description of the stages of the research process (see chapter 4), ensuring the argument is presented coherently (see chapter 5 and 6) and also demonstrating a close relationship to the underlying principles of the research methodology used (see chapter 3).

The final broad principle determined by Yardley (2000) is impact and importance. Does the research inform the reader about something that is useful, important and interesting (Smith, Flowers & Larkin 2009). It is hoped that with recent media interest in care and compassion, professionalism and the conduct of nursing and other professionals in Health and Social Care that this study adds to the debate around standards and how these can be achieved and maintained within the context of pre-registration Adult Nursing education.

4.6 Research Governance, ethical considerations & approvals

Research governance and ethical requirements were met, and ethical issues were considered in relation to the study.

4.6.1 Coercion to participate / Power imbalance

It is easy to abuse power in accessing participants and it is important that research benefits both parties (Cresswell 2009). To minimise potential for coercion, the recruitment strategy (section 4.2.3) allowed participants to volunteer without affecting their position as students. The nature of recruitment also enabled volunteers to independently consider whether they wished to be involved or not (BERA 2004).

Safeguards such as interviewing in a 'neutral' environment and the researcher dressing casually during data collection served to minimise any impact this may have had.

4.6.2 Informed consent

Participants were advised that their rights would be protected during data collection and subsequently at all times (Silverman 2000, Cresswell 2009). The aims, objectives and method of data collection of the study was made explicit to participants before recruitment and again prior to the start of the interview (see appendix 2). Participants were sent the consent form (see appendix 3) prior to the interview and then asked to review and sign prior to data

collection once they had been given the opportunity to ask any questions they may have had. Participants were advised that they could withdraw consent at any time and their data would be destroyed.

4.6.3 Privacy and confidentiality

The privacy and confidentiality of participants was maintained (Data Protection Act OPSI 1998). Participants were advised they may be able to identify themselves through verbatim quotes, however coding used ensured their anonymity to others and only the researcher held the code information. All audio recorded interviews and interview transcripts were coded and kept according to data protection act and would be destroyed a year following completion of the study. All data is stored on a password protected computer in a locked office.

4.6.4 Risk of disclosure

BERA (2004) refers to the issue of disclosure in terms of breaching confidentiality and anonymity. Given that participants would be discussing their experiences, both good and bad; there was the potential for poor practice to be identified. It was confirmed to participants before the interview commenced that if issues were discussed that warranted further action I would need to ascertain how they had dealt with them at the time. In all cases the issues had been brought to the attention of the relevant staff and dealt with accordingly. Had this not been the case reporting mechanisms would have been discussed with the participant along with their responsibility under the NMC Code to highlight concerns to their mentor and/or link lecturer (an academic who visits the placement area to support the student and mentor).

4.6.5 Emotional hurt/harm

Risk is often defined by reference to the potential physical or psychological harm, discomfort or stress to human participants that a research project might generate (ESRC 2006). Although educational research does not entail physical harm to contributors, there is a potential for adverse psychological outcomes (Polit & Beck, 2010). During data collection participants were asked to reflect on their experiences, thereby potentially exposing negative emotions. Through facilitated reflection any negative experiences were fully explored in the context of the study and if there were residual concerns participants were reminded of the availability of the University counselling services. It is not known if this service was accessed post interview.

4.6.6 Ethical approval

Full ethical approval was granted by the Education Faculty Research Ethics Committee (application reference number 12/EDU/047 – appendix 14) and confirmed by the Director of Research and Dean within the Health & Social Care Faculty (as the participants were nursing students) (see appendix 15 and 16). The only concern raised by the committee prior to full approval was the acknowledgement that even if students decide to take part there would still be a power issue with regard to the relationship between a student and the researcher. Further clarification was requested as to how this potential influence would be addressed or at least acknowledged. Feedback was provided (as per the mechanisms discussed within section 4.6.1) and full approval was granted.

CHAPTER 5 – FINDINGS

This study explored the lived experience of Adult Nursing students in relation to role modelling. The aim was to interpret the influence this phenomenon has on their development as professional practitioners. As explained in detail in chapter 4 data was collected via twelve in-depth interviews and analysed using an Interpretative Phenomenological Approach (Smith, Flowers & Larkin 2009). Four students in each of first, second and third year were interviewed and this chapter presents the themes that have emerged across all three years from the study during data analysis. Where relevant, commentary is given that is specific to each year. The analysis of the information gained through interview did not identify any findings of note in relation to the participant's age and therefore there is no distinction made within this chapter in regard to this demographic. It was clear by the fourth interview in each year group that no new themes were emerging providing confidence that data saturation had been achieved to the extent that this is possible within an IPA study.

Findings from this study that make an original contribution by extending current literature and knowledge in the context of student professionalism are:

a) The perceived influence of peers (section 5.2.2)
b) The perceived influence of the service user (section 5.3)
c) The perception that students' relation to qualified staff that appear to have 'burnout' can impact on their development (section 5.4.1)
d) The perception that students can be undervalued within clinical practice impacting on their development (section 5.7.1)

Through analysis of the data a number of subordinate themes emerged which were later grouped into twelve superordinate themes (see table 5.1 below). Some of the subordinate themes emerged from, and are directly related to, the raw data whilst some have resulted from interpretation of the described experiences. The distinction is identified within the example interview transcript (appendix 6) and within the following chapter where the use of parentheses should be taken to indicate that this is an interpretation drawn from the participants' comments. The full process for theme generation is described in chapter 4.

Table 5.1 Superordinate themes and their constituent subordinate themes

	Superordinate themes	Subordinate themes
1	Perceptions of role modelling	Role model influence
		Role model perception

		Role model qualities
		Role model traits
		Role modelling by senior staff
		Role modelling by students to nurses and peers
		Role of a mentor
		Secondary role modelling
2	Teaching and learning	Development of nursing education
		Expectations of education
		Learning through feedback
		Learning through observation
		Learning through reflection
		Motivation to learn
		Preparation of students
		Prior experiential learning
		Sources of learning
		Student responsibility for learning
		Teaching & learning - missed opportunities
		Teaching style
		Theory-practice continuum
3	Influences on perception and development	Age related influence
		Environmental influence
		Familial influence
		Feeling supported
		Generational influence
		Human nature & perceptions
		Lecturer influence
		Media influence
		Organisational influence
		Peer influence
		Personal experience
		Situational influence
4	Perception of nursing and nurses	Developments in society
		Nurse burn out & demotivation
		Nurse qualities
		Nursing as a choice
		Nursing as a role
		Ongoing professional development
		Perception of nurses

		Perception of nursing
		Why nursing?
5	Recognising the student as an individual	Career trajectory
		Future aspirations
		Inherent personal qualities
		Personal journey
		Stimulus for nursing career
		Student / occupational pride
		Valuing students
6	Delivery of safe and effective nursing care	Communication as a skill
		Justification for poor practice
		Person centred practice
		Poor clinical practice
7	Development of relationships	Relationship with mentor
		Relationship with service user
		Relationship with tutor
		Relationship within the team
8	Impact of service users on development	Service user experience
		Service user influence
9	Impact of workplace culture	Hierarchical structure
		Leadership / management influence
		Socialisation
		Team work & dynamics
10	Recognition of student status	Recognition of student status
		Student anxiety
11	Perception of students	Expectation of placements
		Perception of students
		Student responsibility
12	Concept of professionalism	Human infallibility & professionalism
		Professional qualities

This chapter proceeds with an in-depth presentation of those themes that either, a) answer the research questions, thereby explicating the phenomenon, or b) address issues that were identified in the literature in relation to role modelling. Some of the superordinate themes that emerged are not presented here as they do not add anything new to existing literature, there is limited data to support the theme (that is, only present in a few participants), or they are not directly related to the research aim (see table 5.2).

Table 5.2 Superordinate themes not presented within findings chapter as they confirm information already in the literature

	Superordinate themes	**Rationale for not presenting within chapter?**
1	Delivery of safe & effective nursing care	Theme does not add to the literature and is not directly related to the research aim
2	Impact of workplace culture	Limited data to support this theme
3	Perception of students	Limited data to support this theme and is not directly related to the research aim
4	Concept of professionalism	Very limited data to support this theme

Overall the analysis demonstrates that this particular sample of female Adult Nursing students have perceptions of role modelling, nursing and nurses, teaching and learning within their programme and 'other' influences on their perception and development, as described within this chapter. They appear to make sense of their experiences in a variety of ways although convergence is noted in some cases as detailed in relevant sections. The analysis of each superordinate theme and constituent subordinate themes is supported by verbatim extracts from the interview transcripts. Each extract is supported by a reference to indicate the participant. The number relates to year of programme, the letter to identify the participant, for example, 2a relates to the 1st year two student and 3d relates to the 4th year three student.

5.1 Superordinate theme 1 – Perceptions of role modelling

Within all interviews role modelling as a concept was perceived important and highlighted the influence that the participants thought other individuals had on their development. This superordinate theme is made up of eight subordinate themes. The table below indicates whether findings from the subordinate themes are presented here with associated rationale (Table 5.3).

Table 5.3 Perceptions of role modelling subordinate themes

Subordinate theme	Presented within chapter?
Role model influence	Presented in full – directly relevant to research question
Role model traits	
Role modelling by senior staff	
Role modelling by students to nurses and peers	
Role model qualities	Presented in summary as no new insights but relevant to research question
Role model perception	Not presented as no new insights
Role of a mentor	
Secondary role modelling	Not presented as limited data collected

5.1.1 Role model influence

Role model influence was a theme that emerged from descriptions of clinical practice being role modelled to participants. These were interpreted to have a potential impact on their development. When asked what role model means to her, one participant stated:

> *'...somebody whose practice and demeanour are kind of like a benchmark really.'* (3d, page 11)

This was themed under role model influence due to the participant's use of the term benchmark. For the researcher this term equates to a standard to be achieved and was therefore interpreted to relate to how the participant may alter her practice to achieve it. Later when discussing how she viewed the qualities of role models and how these are 'translated' to students the participant stated:

> *'I think if you are just seeking to kind of like mirror somebody's behaviour I think* you would fall short. I think it kind of again comes back to emotional intelligence and *understanding yourself to be able to understand other people…' (3d, page 12)*

This extract suggests that a role model has the capacity to influence a students' behaviour (interpretation) and is interpreted to potentially relate to the concept of self-awareness. Discussing what she thought had influenced her development and in particular the elements of practice that are considered to be 'good' the participant suggested a link to the 'profession'.

> *'...and I think if you then become part of that whole from all those pieces then actually you've got a good chance of representing the profession quite well.' (3d,* page 2)

It would appear that this participant may have developed the ability to combine various aspects of her experience and that this influences how she views nursing as a profession. Participant 3c expressed similar views. When discussing her concept of a role model she stated:

> *'...and nurses that I've had on the wards I think that you are a good role model, when I'm newly qualified I want to build up to your level…' (3c, page 11)*

This suggests that the participant considered her future aspirations when reflecting on role modelling experiences. She indicated thought beyond being a student. As with the previous participant she appears to refer to a standard to be achieved by her use of the term 'level'. This indicates that her practice has potentially been influenced in order to start the journey towards her role models' level.

For some the influence of a role model was more specific. Participant 1d described the experience of two mentors she had worked with where she had found herself thinking 'I like *that'* and '*I'd like to integrate that into my practice'*.

> *'...that almost gave a quiet authority, she wasn't intimidating or anything like that…My first mentor was quite the opposite, she wasn't loud but she was, she oozed* authority, so I suppose it was a different approach to their work but had the same *outcome…' (1d, page 3)*

This participant implied the ability to perceive the same outcome from different approaches. This suggests that exposure to differing practices may influence students into amalgamating elements from each approach into their own practice (interpretation).

Discussing how she is able to make the distinction between good and poor modelled practice participant 1a described an experience whereby her mentor demonstrated very good clinical skills but poor communication.

> *'She based all her training on the clinical side, she said that I can always work on my communication skills later on, that's not important…I put communication to one side and thought that it would just come to me.' (1a*, page 15)

This extract suggests that the participant may have been directly influenced in relation to the importance of various elements of nursing practice.

Some experiences may confuse students. During a discussion regarding participant 1a's role models she described a particular nurse who was a good role model because she 'explained *things to me'*. The participant went on to state:

> *'She says sometimes we do cut corners to save time if you are in a rush but most of* the time this is what you should be *doing' (1a, page 13)*

Her role model had told her that nurses sometimes cut corners despite knowing what should be done thereby potentially indicating that this is acceptable practice.

Participant 2c's experience suggests that it is possible to learn from negative experiences.

> *'…I think previous experience even though they were negative have enabled me to* be the person that I am and even those experiences as a nurse were negative they enable me to be a better nurse because I think the negative things will, you know, you *can always turn them around and say that I won't ever behave that way…' (2c, page* 13)

Participant 1d discussed standards of care in the community setting and described a situation related to poor standards of infection prevention and management.

> *'…where she was practising the aseptic technique allegedly, um…[pause] in catheter* changing and, I thought, oh this is good, she got everything prepared, OK it was on the bedside [said in a quiet voice], fine, but it was almost done how it should be. She *was putting on gloves and I thought, right, now I'm going to watch something here* and then she forgot something and promptly with her gloves went rummaging into *this chaps wardrobe and I thought, oh ok, maybe not [laughs]…' (1d, page 4)*

The description of this incident indicates importance to the participant. She expressed a negative reaction to the practice demonstrated. This suggests that students can learn how not to undertake procedures from poor role modelling (interpretation).

The above experiences appear to demonstrate that poor practice may influence a students' development in relation to how to perform skills. Other participants described circumstances which suggest an implicit impact on the patient when the principles of person centred care are not maintained.

> *'I got to see a hip replacement one day and the patients'* breast was out when it could have been covered and there were medical students, nursing students and *actually a nurse was like, she was just like oh, maybe she just didn't think, didn't see it, but I was thinking if that was me I'd go over and maybe go and put a gown down over the patient...' (2b, page 8)*

This participant appeared to recognise the lack of dignity and respect given to the patient. The extract suggests that the non-action of others within the scenario had an impact on the participant. It appears that the participant also attempts to justify the reaction of the nurse (*maybe she just didn't think…*). She continued:

> *'…so me and another student were the ones who covered up the patient….and the nurse was kind of like 'oh it doesn't really matter', but that's not a good role model to students who were in the room…' (2b, page 8)*

It would appear from this that the participant understands the notion of role modelling to others and the potential influence that this can have. What is not so clear is where the student has got the notion of 'good' from.

Participant 3d described a clinical situation whereby it had been reported by other nurses that a patient appeared to be getting gratification from being attended to by female staff. The participant and their mentor went to care for the patient.

> *'…we went in to see this gentleman, me and my mentor who was a man, and he kind* of went to touch himself right near his genitals and we actually discovered that he

was having pain in that area and for me it kind of really highlighted that you should *really be so objective and not be quick to make those kind of assumptions.' (3d, page* 3)

This suggests that the participant had learnt not to make judgements and assess each situation on its individual merits.

Participant 3a appeared to recognise the ongoing nature of role model influence during a discussion concerning what sort of things may influence nurses' behaviour or conduct.

'I think um…the role models that they have had is a big influence on it, if they don't know what standards they should set for themselves and they follow others and they have had a string of bad mentors or placements or anything and they think that is the nor*m then they will pick up on that…' (3a, page 7)*

This indicates that through role modelling both good and poor practice may be perpetuated (interpretation). Linked to this, other participants described experience of no-one taking responsibility for acknowledging and dealing with poor professionalism.

'…there was a nurse and he was just appalling. He was so rude to patients, he was rude to the students, rude to the care assistants, rude to the manager and he had such an abrupt personality and I was kind of *thinking why is he here?' (2b, page 5)*

Participant 2b described the above situation that suggests exposure to poor professional behaviour. The use of emotive terminology appears to emphasise the strength of its impact. The mention of the manager implicitly suggests the participant had been influenced by how the situation was poorly managed at the time (interpretation). Further exploration of the experience during the interview indicated that the situation had been reported through evaluation of the placement with subsequent action taken.

Some of the perceived influence arose from experiences the participants shared where they had witnessed the interrelations within a team. The following participant described a situation where the team she was working in 'd*idn't take'* to her mentor.

> *'I would say that she probably wasn't a team player. Um… [*pause] everything was *always on her terms, she just wasn't, there was no give and take at all.' (1d, page 4)*

For this participant she appears to understand how important it is to be open to negotiation and compromise if she was to be successful and respected in a team (interpretation).

A year 2 participant described her experience of a ward manager she had worked with and the fact that he interacted with patients as opposed to sitting in his office all day. When asked what that said about his professionalism she stated:

> *'…even though he was higher, so called higher up than band 5, band 6 nurses on the* ward, he even stepped down to the care assistants level, even there was respect shown for him, patients showed respect to him as well, and it was just a nice *atmosphere and it gave a great impression of the ward.' (2b, page 3)*

For her there appears to be an influence through leading by example. She seemed surprised that as a ward manager he was not in his office all the time suggesting this is the practice she had previously seen. This extract indicates the potential of role modelling by management and how this could influence nurses lower in the hierarchy (interpretation).

Participant 2b described her first experience of a cardiac arrest. She explained how her mentor had taken time to ask her how she was feeling, made her feel supported and encouraged her to take part.

> *'…she just like, stepping back and asking me if I* was OK, she made a big difference, so I think if I was a mentor I would be more supportive to students the way she was *because I have experienced bad mentors in the past who weren't so supportive and didn't really interact with students as much as they sho*uld have and doing that at *such an important event it really made a difference.' (2b, page 3)*

This indicates the potential influence on future practice if the student is treated with care and compassion (interpretation).

The phenomenon of role modelling is suggested to influence students. The participant accounts of their lived experience imply this could relate to the development of clinical skills and demonstration of professional qualities.

5.1.2 Role model traits

With the exception of one year 1 participant (as below), only interviews with year 3 students highlighted an awareness of role model traits. This is referring to traits per se as opposed to the identification of specific role model qualities. The researcher defines 'traits' as elements of a role model that participants would like to emulate or indeed not. This is as opposed to emulating an individual 'as a whole'.

> *'...not necessarily someone that you aspire to be but maybe some of those traits that* they have, that they have displayed, that you think you yeah, I want to be seen like *that, or I want to behave like that, or deliver care in that way.' (1d, page 7)*

Two of the year 3 participants discussed the good and bad traits in role models. When asked if she had role models at this time participant 3a explained that she does flexi work and therefore meets many different people in the course of her work.

> *'...you meet a variety of staff members and I will look at all of them and try and find* the good traits that they have, how they do things, how they cope with things, and *think, yes, I could use that or I shouldn't do that…' (3a, page 9)*

This participant appears to observe the individuals she works with and looks for the 'good' traits. She talks about using these traits as if they are a commodity she can pick up and integrate into her own practice. It appears that the participant considers the good and the bad traits suggesting she is able to discern those that suit her particular style of working. This participant later discussed how patient reaction to care delivery was a measure of whether she would emulate a particular trait or not.

This was further exemplified by participant 3b.

> *'...working with other nurses in practice, you sort of pick up bits from them that you* want to aspire to be like and *you take traits that you don't want to have that you take*

> forward as well so you sort of pick up bits and pieces from different people that you *work with.' (3b, page 2)*

This participant talked about traits that she aspired to be like. She also inferred an awareness of traits that she would not want to take forwards. When asked how she would discern the good traits she stated:

> *'I don't know, I guess it is your judgement as to what you feel are good qualities to take forward and ones that you don't, its ind*ividual I suppose. Maybe something *someone else would think was OK I wouldn't, but its subjective I suppose.' (3b, page* 2)

The participant appears to perceive a subjective influence on whether a trait is good and should be emulated. The above extract indicates that she is able to define the good from the bad (her perception) but not how she learnt that ability.

Sometimes role modelling traits are concerned with specific elements linked to patient care.

> *'...I don't want to disregard any one element of a* per*son's* care so because you learn different things from each mentor about what they think is important and sort of *carry those things with you and sort of take it forward into your practice…' (3b,* page 7)

This participant was describing experiences where nurses appeared to be only concerned with their focus in practice or their speciality. She potentially perceives this to be of detriment to holistic patient centred care. This extract indicates that she was able to learn about clinical aspects of care from different nurses she had worked with and strive to integrate these into her practice.

Exploring what she felt had influenced her development over the duration of her programme, participant 3d stated:

> *'...actually in my first placement my mentor said to me* that if you meet, every nurse that you meet, *you should take something good from them, from what they've done* and how they approach their role and patients and other staff. I think that is

something I've really taken away from that. W*hether it is I wouldn't* do it like that or I like the way that they do that… to be a bit like a sponge really and take from people *all the good things…' (3d, page 2)*

This participant appeared to recognise that she can 'take' traits from individuals and utilise this knowledge to build her own professional practice.

Role modelling for the year 3 participants appears to involve an examination of all aspects of a role models practice with a subjective discernment of those traits that are 'good' and those that are 'bad'. This indicates that their understanding of the influence of role modelling is potentially more developed than their younger peers (in terms of programme stage). Some responses suggest year 3 participants have the ability to judge whether to integrate traits into their own practice.

5.1.3 Role modelling by senior staff

Experiences in relation to role modelling by senior staff were mixed across the participants. For the purposes of this study, senior staff members are defined as ward or placement manager and senior nursing staff, for example, charge nurse or ward sister. 'Leading by example' was commonly thought to be poor. Participant 3a discussed the strictness of the ward managers and how she had experience of not seeing them following their own rules:

'…things like, you're not allowed to eat in the kitchen and its plastered everywhere and then they will come in and have something to eat and everyone else thinks it's alright, or having your hair tied up and off your collar, they will come in with their hair down or in a ponytail or something and again everyone thinks that it's alright, they look up to them, like role models to set a standard and sometimes it's not always *there…' (3a, page 7)*

This suggests an expectation that if there are rules then the one person who should follow them is the person in charge otherwise this role models poor standards to staff within the team (interpretation). Similarly negative examples were experienced in year 1. Participant 1b recounted experiences of the management on her current placement.

'I don't think I've ever seen her out of her office.' (1b, page 9)

'...would verbally dress them down in front of other staff...' (1b, page 9)

This participant had previous experience in management suggesting she had a particular interest in how managers were perceived. She provided several examples of where the manager would publicly complain to staff about what had not been completed despite not engaging herself. The perceived lack of engagement in the actual work in the placement was also exemplified by the manager's deputy.

> *'...her deputy is... is supposed to work on the floor but she doesn't... and this doesn't* give a good picture to the rest of the staff because quite often she is the second nurse and there is two floors and the one nurse who is on the floor has to end up doing both *floors...' (1b, page 10)*

For this participant there appeared to be a culture on the placement of poor management whereby the team do all the work without the assistance of the management. The extract suggests that the management do not work with the team and criticise team members if work is not completed to required standards. These experiences indicate that the participant perceives this as poor role modelling.

Some participants described experiences of good practice in relation to management and senior staff. At the very top level one participant discussed their experience of meeting nurse leaders within the NHS and the impact this had for her. Participant 3c explained how she had been to the NHS innovation conference and met the Chief Nursing Officer.

> *'...meeting the Chief Nursing Officer and all the people behind the care makers and* think, they were so inspiring, like the role models, even at the top level people still care about patients and they are not forgotten *about...' (3c, page 12)*

For this participant she had sought experiences 'outside' her programme and appeared gratified to find that very senior staff in the NHS still had their feet firmly on the ground. This suggests that despite climbing the promotional ladder the essence of patient care can remain the primary concern for nurses. This indicates a potential impact on nursing standards and care through positive role modelling (interpretation).

Similarly, although at a level closer to home, participant 1c described her experience of working with a ward manager who was also her mentor. Her previous experience and the influence of her father (who was a nurse) meant that she had concerns over the stress placed on senior staff as they progress into management roles. This view appeared to have been altered by her recent experience.

> *'I think I'd want to stay band 5 for a while, that's why I was so admirable about the* band 7 nurse, how she had progressed so quick and how she dealt with the stress so well because she had so many people you know, coming at her and she was just so *calm about it.' (1c, page 5)*

For this participant being promoted had not been in her long term plan until she had worked with her mentor. This extract indicates that she had seen it was possible to 'deal with the stresses' of management through the positive role modelling of her mentor.

When asked about any particular influences on her development, participant 2c described her experience with a particular ward manager.

> *'...she respected my autonomy as well in that role. Instead of just saying, 'you're just a student; you're in charge of the commodes'...' (2c, page 4)*

It would appear that part of leading by example is related to the ward manager respecting student autonomy and recognition that students are in placement to learn.

It is suggested that issues with leading by example were the key lived experience for participants when considering senior staff. The role modelling of practice, communication, management and 'acceptance' of students into the placement team all appear to be important for participants.

5.1.4 Role modelling by students to nurses and peers

Some of the participants described experiences that highlight the potential impact students can have as role models in given clinical situations. Participant 1c described visiting a client in the community with a nurse:

> *'...some of the nurses...they were really nice, but some would just go in there and not* really talk whilst doing the dressings. There was this one lady I went into her house *and said 'Hello, how are you? Blah blah blah', and the nurse goes, 'oh do you know her' and I said 'no, I was just being polite.' (1c, page 3)*

This extract suggests that the participant had witnessed poor interpersonal skills but did not let this prevent her from communicating with the patient in the way she believed to be effective. When asked if she had witnessed anything where she had thought she would not want to be like that she responded to say:

> *'Yeah, there was one nurse, she was quite nice but, she…we went to someone's house, an old lady and this lady was quite confused and she sort of said, 'where's you're dressings' and the women couldn't hear, and she was like, Oh God [huffed], and I thought I don't want to* be like that, the *lady can't hear,* so I sort of went right *up to her and 'WHERE's YOUR DRESSINGS' [loud voice] and she told me.' (1c,* page 4)

Again, this indicates that simple communication skills were lacking in the staff this participant was working with. It would appear that these extracts demonstrate observations where the participant was influenced by poor role modelling. It is also suggested that the participant was modelling good communication practice.

Participant 1d described an experience where effective interpersonal skill was exemplified.

> *'There was a gentleman we had on the ward once um…he was supposed to be* frightened but he was so rude, and very rude to people and I sort of thought, as a student you obviously have that bit more time and I sat down with him one day, first of *all he told me to F off um…look I said, 'you know you haven't got anyone who has come to visit you today, would you like me to make you a cup of tea?' 'Oh OK, yeah, I'll have a cup of tea yeah', so that was like the ice breaker and I ended up sitting* with him for about 15 minutes and it actually turned out that he is so frightened of *what it is going, he doesn't understand what is going on that we actually got to the bottom of why he was rude.' (1d, page 6)*

This extract suggests that taking the opportunity to sit with patients and show them a little kindness can facilitate a deeper understanding of their needs and hence enhance person centred care (interpretation). It would appear that this participant modelled this practice.

In year 2 the focus appears to shift to role modelling practice to peers. When questioned about previous care experience and how she felt this had impacted on her development up to this point participant 2c explained about a particular clinical situation.

> *'on placement because there* was quite a young person that was severely physically disabled and she was being PEG fed as well and there was one other student and I *respect her, she couldn't handle the situation, she was wanting to take a step back* and because I had that previous exper*ience I didn't have any problems with this whatsoever. I shared my experiences with her and she said 'OK then, I'll try' and then she was quite good with the individual.' (2c, page 6)*

This participant indicated that as she had experience and no qualms in this particular clinical scenario she supported the development of her peer indicating a potential role for students to teach their peers. It could be argued that this experience should have been themed as peer influence as opposed to role modelling by students to nurses and peers. The decision to present this here was made as the experience indicates students' can role model practice. The experiences described in section 5.2.2 (peer influence) relate explicitly to how participants' view their peers may have influenced them whilst not explicitly considering them as role models.

Participant 2c described how she kept her motivation and drive.

> *'I've been there since 7 o clock that morning and the nurse is saying stop being so positive [participant's name] and I'm like zip a dee doo da [singing], still going around making sure they are all OK before I leave the floor, and it's like how can* you do that and I said because you just have to love them, you have to actually feel *that empathy because they've* [the nursing staff] lost it and they say they would love *to be in your shoes again and have that drive back and that care back again.' (2c,* page 16)

This participant indicated that some nurses have lost the drive to care and explained how her positive attitude had been noted by those staff working with her. This potentially exemplified a more motivated approach to care.

The phenomenon under consideration within this study is role modelling and in the main this has been thought of as role modelling to students. This section indicates examples of role modelling by students. This is something that would be expected of year 3 students and certainly as students become registered nurses. Here however the examples stem from experiences of students earlier in their nursing careers.

5.1.5 Role model qualities

Qualities specifically exemplified by role models were primarily identified by year 1 participants. It is possible that this may have been influenced by the recent completion of a module examining concepts of professionalism and what it means to be a professional working within Health and Social Care. Table 5.4 represents an amalgamation of the qualities, attributes and characteristics identified by all study participants that were themed as either 'Role model qualities', 'Role model perception' or 'Perceptions of nurses'. These have been organised according to the categories identified by Cruess, Cruess and Steinart (2008) and participant year. Examination of the literature indicates that the qualities have previously been identified. This has not previously been organised by academic year of study although there may be some relation to the NMC progression points. These identify the attributes students are expected to evidence as they progress through their programme and into registration. This is presented here as it is relevant to the research question.

Table 5.4 Role model qualities as identified by participants

	Year 1	Year 2	Year 3
Clinical competence	Good interaction with patients Demonstration of safe & effective practice Effective management Challenge other professionals for the benefit of patient care	Interact & communicate well with patients Prioritise patient care over other aspects of the role Advocate for the patient Be supportive of the family and patient Respect the individuality of	Interact with patient & families Proactive in care management and delivery Advocate for the patient Competent at nursing role Ability to take charge of a clinical situation Go above and beyond

		patients Go above and beyond expectation for patients Knowledgeable practitioner	expectation for patients Knowledgeable practitioner
Teaching skills	Recognises student status Effectively explain things Encouraging Inspiring Listen to and values students	Recognises student status Willingness to share experience	Encourage independent learning rather than just give the answer Supportive to students Benchmark practice Guide to professional practice Supervise team members Receptive to graduate status
Personal qualities	Effective communication Approachable Enthusiastic about nursing Caring Can do attitude Professional presentation (uniform) Motivated	Exemplify good morals, beliefs & judgements Approachable Respect for others Confident in their abilities Good attitude towards work and others Display good emotional intelligence Team player Motivated	Appropriate communication Remain calm when under stress Professional neat & tidy presentation (uniform) Professional demeanour Caring Appropriate emotional detachment to enhance logical approach Appropriate use of humour Ability to network Source of support for team members

5.2 Superordinate theme 3 – Influences on perception and development

The analysis of the participant interviews revealed a number of 'other' potential influences on development. The key subordinate themes related to the research questions are Lecturer influence and Peer influence. These are therefore presented here given that they are directly related to the impact of another individual and hence potentially a role model.

Table 5.5 Influences on perception and development subordinate themes

Subordinate theme	Presented within chapter?
Lecturer influence	Presented in full – directly relevant to research question
Peer influence	
Age related influence	Not presented as limited data collected or not directly related to research question
Environmental influence	
Familial influence	
Feeling supported	
Generational influence	
Human nature & perceptions	
Media influence	
Organisational influence	
Personal experience	
Situational influence	

5.2.1 Lecturer influence

This theme emerged from descriptions of perceived influence by academic staff on participants' development as nurses and professionals. Some participants appeared to recognise the relevance of 'stories' shared by academic staff.

> *'...gradually he was telling us his own testimonies and what it was like to be a nurse* and then you could more easily have that visualisation again and there were a few *horror stories as well, but it was preparing us.' (2c, page 2)*

This appears to suggest an influence on the participants' perception of nursing (interpretation).

Motivation to engage and learn appears important to the participants. This was on two fronts – motivation demonstrated by the lecturers in their teaching, and strategies utilised to motivate the participants to learn.

> *'...there* have been certain tutors that I have met throughout sort of, like [tutor *name], she is a perfect example, she is so passionate about nursing and...you know* and that comes across in her tea*ching...' (2d, page 2)*

When asked how this comes across:

'Just the way she talks. She gets so excited about certain things. I had her for [module name] and she just got so excited and, about the topics she was teaching *and…' (2d, page 2)*

These extracts suggest motivated and passionate lecturers can have an influence on student learning (interpretation). The following participant appeared to support this interpretation. When asked if displayed enthusiasm is important she stated:

'I think it is and I think i*t's* an important quality for engaging with me. That *enthusiasm, it's the same with the tutors who are enthusiastic about their subject. Um…you know or, yeah, there's something about that which makes you want to be and makes you think, yeah, that's great, I'll look into that a bit more, I'll read up a bit more about that, and yeah.' (1b, page 14)*

This indicates the need for someone to be enthusiastic to engage with her and motivate her to want to learn.

One participant referred to 'great' and 'not so great' lecturers and was asked to clarify.

'Well I don't think I've ever had a terrible lecturer, there are some lecturers when you think, a couple spring to mind and they're so knowledgeable and they're so eager to teach you as well that they really just want to share the knowledge and make *sure that patient care is brilliant. The particular module I'm thinking of is [module* name] and my module lecturer was just brilliant, even when I am out on the ward I *think of him and I think no it's not like that, do this*, that sticks in your mind even now *and what I would do next and it was over a year ago but I can still remember it…'* (3c, page 14)

This indicates a long lasting influence from lecturers who have been enthusiastic and motivating. The participant continued:

'I think that the not so great lecturers are the kind of people that, yeah, they do want to be there, they do want to teach but they are not willing to kind of adapt it so we 100% benefit from it. Like some people will just talk at you whereas some lecturers *that are like OK, this obviously isn't working for you guys right now why don't we try*

> it from a different way, whereas the not so great are like this is the way I am going to *teach it and that's that and if you don't get it then you don't get it.' (*3c, page 14)

This suggests the requirement for lecturers to be mindful of student learning styles if their development is to be facilitated.

In relation to strategies or approaches to motivate students:

> *'We've got a lecturer at the moment and I really like his attitude. He's strict, he gets the job done, he doesn't take no nonsense and I really admire that and I enjoy his* classes more because of it because I find some of the lectures, if they are a little bit *more laid back ... it might not be as inviting, the other students can't really be bothered,' (2a, page 13)*

This participant appeared to favour the stricter lecturer, the one who, whilst approachable (as indicated later in the interview), doesn't let you get away with anything. She continued:

> *'...he will say it quite frankly, if you can't be bothered now what are you going to be* like in your professional life, and it really makes you think and it really makes you *want to do well.' (2a, page 13)*

This suggests that straight talking and pulling no punches with this participant is the way she is motivated and inspired to learn. This also indicates the influence of making the link to professional practice.

During a discussion about teaching at different universities or in different groups the following participant stated:

> *'It's um…something that comes up a lot*, is teaching and teaching styles and the teachers that you have at the uni. You discuss what you have been taught because you are all getting the same modules but people teach them very differently and you *can discuss that a lot.' (3a, page 12)*

This appears to suggest that the different ways that lecturers present or facilitate can have a direct influence on learning (interpretation). When asked about influence as a professional she stated:

> *'Um...they* involve you and make it interesting and bring in their own experiences which I think is a huge help because you can relate a bit better to that and then you *get other teachers who really don't want to be there, would rather be somewhere else [laughs]' (3*a, page 12)

This suggests that there are lecturers who don't want to teach and this is exemplified by the participants description of lecturers who '*skip slides'* (in relation to presentations), leaving students feeling as though they do not understand the content. She continued:

> *'Um… [long pause] I think the way they present themselves is a big thing because* obviously they have all been nurses or in the medical profession and had to deal with people before and if they present themselves to you in kind of a bored way it makes you think how their practice was, how they, like a lot of lecturers still do clinical work as well, how, if they are different kind of thing, some of them you kind of hope they are, but others you think, I would be very happy being nursed by you, you are *very interested in what you are doing and knowledgeable about it and um…it makes you want to be able to know as much as you can so you can be a really good nurse.'* (3a, page 13)

It would appear that the way the lecturers present themselves has an influence on how they are viewed as clinical practitioners.

This was a direct response to a question about how the participant understood the concept of role modelling.

> *'…like my personal tutor here is a great role model, she always tells us* to go out into *practice and just try our best, if we don't succeed in say giving an injection and don't* feel confident then *it's OK, try again and support yourself and she's a really good role model because she says your time will come.' (2b, page 6)*

This indicates that the approach by academic staff may impact on how a student develops (interpretation). The participant appeared to suggest a compassionate, nurturing approach is effective.

Motivation through support is suggested through other descriptions.

> *'I think one of the lecturers at the university. Um…this is just like when I emailed him* about anything he would always get straight back with a good answer and really *supported students in that aspect. Like if you're worried about anything so I think* t*hat pushes you as a student to do better, as I said it's like the support again.' (2b,* page 8)

For this participant support appears to be the key to identifying a good role model. This indicates that at the university there is a key role in supporting students to achieve.

5.2.2 Peer influence

The majority of participants described experiences where they perceived their peers had an influence on their development. For some, this influence appeared to be through support offered by their colleagues.

> *'…Um…the people I've met at University, so the friends I've made within my group and the support that I've had. Without their support I probably wouldn't be where I am…I don't know if I would be here.' (1a, page 16)*

This appears to suggest that the support of friends impacts on 'survival' on the programme (interpretation). This particular participant described how she had a traumatic year in her personal life and her friends supported her.

Participant 3c was particularly open about her experiences.

> *'I think what's helped me um…get to this point in my nursing is like having my* friends that you know we stay in the accommodation together, if we have a rough day at work we go home and we talk about it, cry about it and if we have a great day we go home and talk about it and laugh about it, *it's* just having that kind of release, *they know exactly what you've been through and you can celebrate your successes*

> *together and you hug each other when you've had a death and it's just things like that which is so nice.' (3*c, page 2)

This suggests a 'community of support' can develop through the programme. It would appear that this can enhance development through discussing peer experiences but also support in difficult times.

For some this support extended into influencing academic work.

> *'When it comes to writing assignments we would sit down a*nd do like little study *groups…*we would be able to share our ideas and if one of them, if one of my friends *had come up with an idea that I hadn't even thought of we would discuss i*t so then *I'd learn much more by actually working with them…' (1a, page 16)*

This participant appeared to value this supportive developmental approach to academic study. The concept of academic peer support is also suggested by the following participant:

> *'I think we all support each other, especially when we all had the [module name]* exam it was quite difficult. I think by studying together we could all support each *other and even if I didn't understand something it was OK because I could ask and* they would explain. I think, as one of my class mates once said, *it's* not a competition at the end of the day, we are all here together, we are all going to qualify together, it *doesn't matter who gets higher grades, as long as we all get there and qualify' (2b,* page 9)

This extract indicates that participant's value peer involvement but may also consider this is light of academic achievement across the peer group.

> *'Listening to their experiences as well because most of the people in my group have* been care assistants or worked in care before coming to university, actually hearing *their experiences of what they have had and what they have been through, it's just* has developed me because I can take that on board and just think about a lot more about than I would if I was thinking just about this is what I have been though in my *life and these are my ideas.' (1a, page 16)*

This suggests a link to development of knowledge for practice (interpretation). This is also intimated by participant 3c.

> *'Hearing what they have been through on the wards and if I've come across a situation on the wards I'll be like 'oh I remember when so and so said they did this and it worked out well for them' and but also just kind of having that time to reflect* on your day and sometimes I think I could have done a bit more and you know *sometimes things just didn't go how you wanted to but knowing that someone else has been through a similar thing, you're not going to just pack it all in…' (3c, page* 3)

These extracts indicate that learning from peers has the potential to influence knowledge, understanding and continuation on the programme.

The following participant described what she believed had influenced her knowledge and understanding of collaborative practice:

> *'…when in university study*ing collaborative practice, I get to talk to students who are radiographers, midwives, so we get to talk about our views and what we thought *the professions were and we've then been on placement, they can come back and say,* actually this is not what we tho*ught it was at all, this is actually what's happening, so talking to other students is really helpful.' (1a, page 4)*

This appears to suggest a link between theory and practice and learning from other pathway/professional students. The following participant was quite emotive in her views on this issue.

> *'I know you've got to be accountable for what you are saying but I just think that sometimes I think the university doesn't understand the reality of being in placement* as a student and it really depends on *the link tutor that you have um…as to how* supported you are and I think that we might lose a lot of good students particularly *in those first few placements when may be the reality of the placement isn't quite meeting the expectations.' (3d, page 13)*

This extract suggests that only students are able to express reality and that this may be important for development. This view is also represented in the following:

> *'I think um…other student nurses are massive help, in your class and others you* meet on plac*ement and you don't know, it is definitely someone to bounce off of* because they know exactly what you are going through kind of thing and its good and *it does spark a lot of discussion about what you've seen and what you think is right* and wrong and how they deal with situations, *it's* another learning resource *almost…' (3a, page 11)*

It would appear that other students are a learning resource for peers. This also indicates an affinity with 'students' as opposed to just those where friendships have formed. There is a suggestion that only peers know what students go through and how to deal with situations. The participant continued:

> *'Um…because we are all on different placements you get a good idea of what, if you haven't been somewhere you get a good idea* of what they have experienced and so *even if you haven't experienced it* first-hand you know a bit about that kind of *environment that they have been.' (3a, page 12)*

This indicates learning about placements from the student perspective. Sometimes peer influence appears more motivational.

> *'I think she has got a lot of drive, the others have but she'd be like lets go to the library, let's do this, let's study, yeah, she would really want to study with me, on the essays yeah, so…' (1c, page 7)*

This indicates that motivated students may influence their peers (interpretation). The following indicates that demotivated students may also have an influence:

> *'I think fellow students can make you work differently, I had an experience where I* had another student and *she was really lazy. She did not want to be there, she didn't want to work nights, weekends. She didn't want to work past 4 o'clock and start* before 9. The other staff members obviously took note of this and that made me want

to push myself to shine even *more, to think that not all students are like her. I'm not like her, because I don't like being tarred with the same brush…' (2a, page 11)*

It would appear that this participant was concerned with her individual status and reputation. The extract indicates this motivated her to engage more and be 'better' than her peer. This following indicates indirect peer influence where opportunity presented itself:

'I found that because she was the way she was I really wanted to shine and it gave me actually more oppo*rtunities to learn because in the end they didn't want to bother* asking her anything like do you want to do this, do you want to be sent down there *for the day, so I got opportunities…' (2a, page 12)*

Finally, the following participant described the experience of hearing a fellow student nurse speaking at conference.

'One of the things was the poem that was read by the student nurse at the RCN congress um…that I thought was fantastic and it did encompass a lot of what I probably believe as a student nurse…' (1b, page 15)

It appears this peer encapsulated what the participant believed about nursing and how this relates to media/public interest in the profession at a time when care is being questioned. This suggests a commonality between peers (interpretation).

Whilst not explicitly described as role models the participants have indicated there may be an influence through the lived experience of working alongside peers. This extends to knowledge of the 'reality', academic and personal support, sharing experiences as a learning resource, motivation and inspiration.

5.3 Superordinate theme 8 - Impact of service users on development

This theme emerged from participant descriptions that were related to experience with service users. It would appear that observing service user reaction to care delivery may influence student development. When discussing someone she considered to demonstrate poor care this participant stated:

> 'The reactions that I had off the patients themselves made me not want to be like her. The *gentleman who cried, it just made me realise that actually he's obviously really upset by the way she is with him…' (1a, page 6)*

This appeared to indicate that the participant was able to relate a negative patient reaction, one where the patient had become emotionally distressed, to qualities that she would not like to emulate. Participant 3d also alluded to this when describing how she would judge good and poor role model traits:

> *'Um…I guess from people's reactions, from patients reactions because people…'* (3d, page 2)

Occasionally participants appeared to suggest professional development may be associated to 'imagining' what it would be like to be that service user, sympathising with their plight. This is a theme that is indicated in extracts from all years, for example:

> *'… how much you need to imagine what* i*t's like for that person lying there whilst you're trying to do something that is not only undignified but it's painful and it's just rotten...' (1b, page 4)*

The following participant was describing her perception that nurses can sometimes have a negative attitude towards doing the 'little' things for service users:

> *'…even the simplest task of getting a jug of water seems like a mountain to climb …* where if they are positive, it takes 2 minutes *of their day, it's a very simple task that anybody can do … yet it makes a big impact on the patient that's lying in that bed unable to do that task for themselves...' (2a, page 8)*

This indicates that the participant has learnt the importance of person centred care in all its intricacies and also potentially the value of altruism in practice. She later described her perception of a positive attitude:

> *'Friendly, approachable, high spirited as well … the difference of 'morning' [said in dull way] to 'morning, Mrs Jones, how are you today?' [said in bright way], the* patients response is oh yes, thank you, it builds up a conversation and it finds out

> *more information I find for the nurse … come in a grumpily say 'morning' [dull] and the patient either won't sa*y anything back or have the same attitude themselves and *I've even heard the patients discussing 'oh she's a grumpy one' or 'she's a bit miserable, she's a bit moany, oh I don't really like her coming round'…' (2a, page 8)*

The above extract appears to indicate that the observed interaction between a nurse and service user may have the potential to influence a students' development. The interpersonal nature of communication appears to be important here. This is also suggested by the following:

> *'I think it'*s all seeing the interaction between the nurse and patients as well as nurse *and staff which will make me think, do I want to be that person when I'm qualified, and I think that actually if I'd be happy to be or do the way you're doing it…' (1a,* page 2)

When describing her experience of a mentor who had burnout and lacked motivation to care:

> *'.....it was just her overall professional attitude was just quite lazy, quite weak.* Sometimes some of it did impact on care with patients because she would be frustra*ted, because everyone knew that she clearly didn't want to be working…' (2a,* page 2)

It would appear that professional attitude and the impact this could have on the delivery of person centred care has an influence on the type of practitioner the participants' wish to become. Following on from the above regarding working with an associate mentor who was motivated and encouraging:

> *'...I was working with my associate mentor the attitude was a lot more friendlier, the* patients seemed more perky because everyon*e was in more of a positive mood…' (2a,* page 3)

This appears to support the above suggestion regarding the impact of attitude on service users.

It is also suggested that listening to service users in relation to their own care is important to the participants (interpretation). This was particularly notable on specialist placements (for example renal dialysis) where it is thought that participants may have limited knowledge and understanding depending on their prior experience. One participant stated:

> *'…on a renal ward and the patients … they were what you call professional patients.* They had been living with this condition for years and it was really nice to sort of get *their views on…what makes a good nurse.' (2d, page 8)*

Another participant extract appears to support this:

> *'… I was on a dialysis unit for 4 weeks and obviously the patients knew a lot more* about everything than I did and they could see that I was nervous doing things and they would watch and they would say you did that really well and that is a big *boost….' (3a, page 8)*

This indicates that feedback from service users may have a particular impact on the confidence and development of students. The following participant appears to concur:

> *'Um…feedback from patients I think is a big thing,* when a patient turns round and *says thank you, or you did that very well that always helps.' (3a, page 7)*

Relating to the phenomenon of role modelling, it is suggested that students observe how the engagement, involvement and integration of the service user into their care enhances relationships and person centred practice. The lived experience of service user encounters and taking note of patient reaction to care delivery (for example) appears to enable the participants to appreciate just how these aspects can enhance or damage care delivery.

5.4 Superordinate theme 4 – Perception of nursing and nurses

All the participants described experiences that indicate their knowledge, understanding and perception of both nursing as a profession and nurses as individual practitioners. Identified subordinate themes underpin the phenomenon under investigation. One sub-theme however stood out as worthy of further exploration due to the potential impact on students and is presented here.

Table 5.6 Perception of nursing and nurses subordinate themes

Subordinate theme	Presented within chapter?
Nurse burn out & demotivation	Presented in full – findings add to current literature regarding burnout
Developments in society	Not presented as limited data collected or not directly related to research question
Nurse qualities	
Nursing as a choice	
Nursing as a role	
Ongoing professional development	
Perception of nurses	
Perception of nursing	
Why nursing?	

5.4.1 Nurse burnout and demotivation

A third of participants described experiences where it is suggested the motivation and commitment of qualified practitioners was questionable. This was prevalent in year 1 and year 2 participants with no described experiences interpreted as relevant to this theme in year 3.

> *'...enc*ouraged us, he was just perfect for students actually, he encouraged us, he *would grab us whenever they were doing anything um…and was really enthusiastic about what he was doing and he has been a nurse for years so that's also nice to see* that he still ha*s that passion and yeah…' (1b, page 5)*

From this extract it is interpreted that if you are a nurse '*for years'* then you lose some of the initial passion that you have for nursing. It would appear that this is almost an inevitable consequence of remaining in the profession. The extract indicates that the mentor had an important impact on development because he still felt passionate. Later in the interview this theme arose again:

> 'You never know what people*'s personal circumstances are, you never know what'*s going on in their life and what might have happened to them that morning when they *got up. I think people can get stale in a role…' (1b, page 14)*

This suggests that doing the same thing day in day out means nurses lose enthusiasm and motivation (interpretation).

When discussing her experience of mentoring participant 2a stated:

> *'…a few have been, their attitudes have been I can't really be bothered, they've been doing it for years and years, they don't really want to do their job now so…' (2a,* page 2)

This again indicates the potential relationship between length of service and motivation.

Sometimes this theme was related to a specific clinical scenario. Participant 2b described wanting to tie a man's shoelaces and being told not to by her mentor as it wasn't her job:

> *'But it is my job, it is a nurse's job, if a patient wants something, but she just wasn't bothered, she just wanted to go for a tea break, but that's not fair on the patient…'* (2b, page 4)

It would appear that demotivation can have an impact on person centred care (interpretation). This extract suggests that the nurses' priorities had shifted and this potentially impacts on student perception and development. Participant 2c had been describing how she learns from negative situations and stated:

> *'…and then you are wondering, you can see it all, they are almost bored of the job, you know they don't want to be there anymore… that sparkle has gone, they don't want to be that nurse anymore, they are just coming in, it's like a clocking in thing…'* (2c, page 12)

This infers that negative care experiences stem from being '*bored of the job'*. The boredom potentially leads to a reduction in selfless or altruistic care delivery. It would appear that negative approaches to nursing could impact on the students' view of the profession (interpretation). The same participant later described how she is very perky and motivated from the start to the end of her shift and this surprised some of the staff she was working with:

> *'…you have to actually feel that empathy because they've* [the nursing staff] lost it and they say they would love to be in your shoes again and have that drive back and *that care back again. I say you can, you can still do that…' (2c, page 16)*

This suggests that nurses who lack motivation may be aware of this but something is preventing them from re-engaging. In relation to human factors nurses may be exhibiting a negative psychological reaction to the environment in which they are working, leading to a reduction in the delivery of person centred care (interpretation).

It would appear that the demonstration of negative feelings towards nursing has the potential to influence participants. Their lived experience appears to indicate that whilst there may be attributes in these individuals that signify a 'good' practitioner they would not necessarily consider them to be role models.

5.5 Superordinate theme 2 – Teaching and learning

Teaching and learning is a theme that emerged from 13 subordinate themes regarding various aspects participants perceived to have an influence on their development. The subordinate theme most closely related to the phenomenon and therefore presented here is learning through observation.

Table 5.7 Teaching and learning subordinate themes

Subordinate theme	Presented within chapter?
Learning through observation	Presented in full – directly relevant to research question
Development of nursing education	Not presented as limited data collected or not directly related to research question
Expectations of education	
Learning through feedback	
Learning through reflection	
Motivation to learn	
Preparation of students	
Prior experiential learning	
Sources of learning	
Student responsibility for learning	
Teaching & learning - missed opportunities	
Teaching style	
Theory-practice continuum	

5.5.1 Learning through observation

It would appear that nurses, and other staff, do not necessarily appreciate the power of observational learning and that everything they do may be scrutinised by the students.

> *'...as a first* year student, what we pretty much do is observe people. So I observe *how they interact and what they do all the time.' (1a, page 15)*

This suggests that observation is an important learning tool for first year students. Another year 1 participant also indicated this is an important strategy during a discussion regarding different approaches to care.

> *'You have to adapt to any situation to, you know, I didn't know what to expect when I* came into this interview today, so you have to sit back, watch, listen and then *hopefully with what information you have taken in you'll pick up what is good.' (1d,* page 4)

Some observational learning may arise from experiences of poor practice. During a discussion regarding 'cutting corners' this participant stated:

> *'...in for angioplasty's and stuff like that so they need their surgical wounds checking every 15 minutes but because it takes so much time they don't do it, they do it every* half an hour instead, and one person started bleeding and it had been bleeding for about 2*0 minutes and nobody had noticed.' (1a, page 13)*

It would appear from this extract that students' observe practice and relate what they see to the standards expected (if known).

Occasionally the participants witnessed attitudes that could have a significant impact. This participant had asked a senior staff member to help clean an area as she was with another patient and described the situation as follows:

> *'So I took this lady and I came out and this [nurses name] is still sitting in her office* and I said *'did someone clean up' and she said, 'oh well I asked one of the carers', well one of the carers was busy, ... so nobody had come to do the toilet and it was still in the state it was in... and I went and cleaned it up. ... I just thought...you're* sitting in your *office, why didn't you just go and get the stuff and do it, but no it was just that complete, someone else will go and if I don't look and I just pretend that I'm doing something else nobody else will have to do it.' (1b, page 11)*

This suggests that managers who do not engage in team work could influence students' perception of leadership (interpretation). It is believed that the participants' description indicates their values, in this case, particularly in relation to teamwork. Whilst it is not known where the student developed their values this experience has the potential to influence how they perceive senior staff should interact with others within the team.

Here the participant is talking about the fact that they are developing a sense of how to communicate with patients.

> *'I knew there was boundaries but I didn't know what you could talk about, what you couldn't talk about and um…really, but then hearing people say oh, we're going to* meet up Friday night at this pub and just observing patients faces and their reactions *to that.' (1a, page 11)*

This appears to substantiate that learning could be influenced by observing patient reaction to care delivery. This indicates that observational learning can be much more than simply witnessing the technicalities of a skill. Reflection on observed practice could enable development of the art of nursing (as opposed to the science). When asked if she felt she has developed since commencing the programme this participant stated:

> *'…there's things I've seen that I've thought, oh I definitely wouldn't be doing it in that way but there is also things that I've seen that, I don't know, where I've seen my* mentor or other staff that have done something, not necessarily clinically challenging but just sort of the way they*'ve worked in practice, maybe worked with a patient who was going through a really traumatic time and it's, it brings that humanity to the practice and that's what I like.' (1d, page 2)*

This suggests that students' may be influenced through observing how nurses conduct themselves in practice.

Often it would appear that learning is related to difficult or challenging situations that are circumstantial and not easily replicated.

> *'I think that is one of the biggest things I have learnt is, is how to deal wi*th difficult *situations and watching how they do it, and um…kind of picking up, the way they*

explain things or…um…calming the situation down and knowing when to back off and leave it…' (3a, page 3)

Describing her first experience of a cardiac arrest this participant stated:

> *'I was really impressed with how the team dealt with it but they get cardiac arrests all the time because of the kind of unit that they are on but… like it was so good to see everyone's role and see, you know everyone knows what they a*re doing without *realising they know what they are doing, they just do it, which is really impressive…'* (3c, page 6)

It appears from this extract that observation of emergency situations where the focus is not student learning but patient care can have an influence on the students' perception of nurses and how they conduct themselves in practice (interpretation). As a further example the following participant talked about a situation whereby a patient wasn't taking the advice of the medical and nursing team.

> *'I would be very quick to defend my situation because I don't think we did anything* wrong, he was refusing the care we wanted to give him, and it was good to see my mentor keeping a calm approach to that and just you know being logical about it and not *getting emotional in front of the patient…' (3a, page 4)*

This suggests that learning and perhaps professional attitude can be influenced by observation of a nurse role modelling practice.

This participant described observation of nursing intuition. For the researcher this refers to intuition shown by some nurses that there is something wrong with the patient but there is no tangible evidence to corroborate that feeling.

> *'…in handover the nurse that was looking after her on the night shift said that he j*ust *had a funny feeling that she just didn't seem right.' (3c, page 3)*

In relation to observational learning this suggests that students could be influenced in their practice despite nothing tangible to 'guide' that learning.

Further interpretation suggests that there is a difference between conscious and unconscious role modelling and the impact on development through observational learning (interpretation). The following participant described a mentor whom she felt had a positive influence on her development.

> *'I didn't know what to do, and my mentor took me aside and said if I was doing that this is what I'd do, this is how I'd be and then they can see that, and she actually* showed me so she went and sat talking to her, put her arm around her, just stroked *her back and tried to calm her down, talk to her as if she is a friend and I've tried that since and that worked for me.' (1a, page 7)*

This indicates that observational learning can be 'set-up' following discussion between the role model and student. This participant also indicated that learning through observation can take place in non-set-up situations.

> *'... just watching her communicating with all the different people has taught me a* range of ways of communication from people with learning disabilities to *um...people with dementia and people who are hard of hearing, so using hand* gestures and things like that. On the communication side she is amazing to watch, *she really is.' (1a, page 8)*

In this extract it would appear that learning can continue through observation once an initial trigger has alerted the student to the possibilities.

It would appear from the participant accounts that learning through observation is important to the development of professional attributes whether this be in relation to the art and/or the science of nursing.

5.6 Superordinate theme 7 – Development of relationships

All participants described experiences where the development of relationships was seen as important to their development as professional practitioners. Themes that emerged from the data are relationship with mentor; service user; tutor and within the team. During analysis of the data the researcher noted that when describing experiences of role modelling specifically related to clinical placement the participants consistently referred to their mentor. The researcher recognises that mentor and role model are not the same (see chapter 2). The

participant descriptions of their mentor experiences themed as relationship with mentor are presented here as they are considered directly relevant to the research question regarding both role model identity and influence on development.

Table 5.8 Development of relationships subordinate themes

Subordinate theme	Presented within chapter?
Relationship with mentor	Presented in full – directly relevant to research question
Relationship with service user	Not presented as limited data collected or not directly related to research question
Relationship with tutor	
Relationship within the team	

5.6.1 Relationship with mentor

This theme emerged from a majority of participant described experiences related to developing or maintaining a relationship with their mentor. These experiences appear to recognise the reliance and trust participants place in their mentors. Some suggest a poor relationship and others describe the importance of a personal connection as well as professional.

In a situation where this participant had been asked by a patient to give him suppositories instead of her mentor she described how the ward manager had taken this up and discussed the situation with both of them:

> *'...that's fine but if somebody's asking me to do something which is out of my comfort zone of something that I'm not actually capable of doing then that's a whole* different situation and I need to be able to rely on my mentor to be able to do it *instead and I need to feel safe that she's going to do it but also feel that my patients are going to feel happy with her instead of me.' (1a, page 6)*

The use of the term 'rely' in this context suggests that the participant sought assurance in the mentors' clinical ability.

Discussing how her mentor appeared to forget her professionalism due to being overly stressed resulting in poor communication with the participant she stated:

> *'...maybe a very alien environment, it's very scary and you rely on them…' (1d, page* 3)

Reliance on the mentor appeared important to this participant. These extracts suggest there may be reliance on the mentor for creation of a supportive relationship to aid integration into the environment (interpretation). The researcher interprets this to relate to advocacy. This is also addressed by participant 2a:

> *'…personally I thought if I was in her position she wouldn't want me to be like that,* she was a student once whether it was 2 years ago or 42 years ago they were all in my position and it made me think that I would never want to treat another person like that especially in a caring environment or a professional environment, let alone a *student that's come on a ward, that's nervous th*emselves, has no friends or no acquaintances to rely on so basically their mentor is their main advocate really for *being on that placement…' (2a, page 3)*

This suggests that students expect a mentor to be an advocate for them in times of anxiety and fear. There is also a suggestion that how a student is 'treated' may represent how the nurse may treat others. This indicates a possible consideration of the nurses' professionalism.

Sometimes it appears that mentors do not advocate for the student. Participant 2a described a situation where a group of 4 senior staff had formed a 'clique':

> *'They didn't like students and my mentor did actually mention that they didn't really* like having students as they found them a burden she said, to the point where when my *mentor, if she wasn't in and I was placed with somebody else I was put as a health care assistant…' (2a, page 9)*

This indicates that the mentor may not challenge negative staff views or take full responsibility for the students' learning in their absence. This is further exemplified by a later statement:

> *'I did mention it to my mentor and she said they have a tendency of, they think of* students as an extra pair of hands these particular staff members and I missed out on quite a lot of learning opportuniti*es because of that.' (2a, page 10)*

This appears to corroborate that the mentor did not advocate for the participant thereby impacting on the participants' development.

It would appear that reliance on a mentor can be unhealthy.

> *'...yesterday, my mentor wasn't there and I worked with a different nurse and it was a completely different shift you know... I know what I am doing with this and that* was something I had to keep reminding myself of yesterday, I know what I am doing with this because I have done it *before, it doesn't matter that my mentor is not here I know what I am doing.' (3d, page 10)*

This suggests that a dependent relationship can form between student and mentor and that learning may be affected in the absence of this secure relationship (interpretation).

Many of the poor experiences of relationship building with mentors appear to relate to first impressions and whether the nurse wanted to mentor the student or not.

> *'She, for me wouldn't spend any time with a student, she didn't see the poin*t of us *training in hospitals...so that affected our relationship.' (1a, page 5)*

It would appear that students expect a time commitment from their mentor which, if not met, can impact on their relationship.

> *'I've had one bad mentor that didn't want to be a* mentor but she was just put forward because she needed to do it they needed someone to be a mentor on that ward and that impacted on me quite a lot because that made me do a lot of self-learning*...' (2a, page 2)*

This infers that students may perceive a positive influence if their mentor is not engaging, that of taking responsibility for their own learning.

With regard to first impressions, participant 3d described her experience of her mentor on a placement she was particularly anxious to go to.

> *'...when I first met her she absolutely terrified me and um...she told me on my first* day that I will go home crying and when I met her I thought this is not going to go very well and actually speaking to her since she pretty much thought the same. She has told me tha*t she thought that I would drown there and um...I just thought you have just thrown me in at the deep end and that is not how I work...' (3d, page 9)*

This appears to suggest that sometimes mentors are not aware of the impact their communication can have on student learning (interpretation). The extract suggests the mentor did not attempt to find out what experience or knowledge the participant had that could have been useful to aid her development during the placement.

A personal connection to their mentor appears important:

> *'...she suffers from confidence issues and she's a really, really quiet person and she* reminds me of me because I suffer from confidence issues as well, especially in real work situations. She taught me ways in which to cope with certain *situations.' (1a,* page 7)

This extract infers a personal connection with the mentor. This appears to have had a direct impact on the participants' development. The participant described how she first met the mentor:

> *'Somebody asked me who my mentor was s*o I said and she told me that she was shy *and not to be in her face straight away because that would scare her a little bit.' (1a,* page 8)

It would appear that prior knowledge of her mentor and knowing she was shy reduced the participants' initial anxiety at being on a new placement. She continued:

> *'...we just walked around a little bit together and we just talked as we were doing different jobs just to get to know each other a little bit better.' (1a, page 8)*

Getting to know her mentor on a 'personal yet professional' level appears to be important. For this participant approachability also appears important.

> *'...I knew a little bit about her and her job there I felt like I could approach her if I* had a problem, or I could ask her questions. It just helped *relax me a little bit yeah.'* (1a, page 10)

This indicates that knowledge of a mentor can relax a student thereby enhancing approachability.

Discussing her experience with a manager who had a particular relationship with her staff (organising social outings and so on) participant 1c stated:

> *'...get to see people outside of work and know what they are really like.' (1c page 9)*

> *'I think with relationships, like with the friendships, professional relationships it was* better because we were more at ease with each other in the car chatting like on the *way to see patients, we had more to talk about, so it was good yeah. I'd feel more at ease going to them about something rather than before, you'd feel a bit distant.' (1c,* page 9)

These extracts appear to suggest a positive influence on the professional relationship through reducing student anxiety. Participant 3d stated:

> *'...we had worked some night shifts together... it gave us an opportunity to have a* time to get to know each other on a bit more of a personal level where she got to *know me, like my sense of humour, how I am…' (3d, page 10)*

> *'...and I just felt like the minute I relaxed our relationship took on a different turn…'* (3d, page 10)

This appears to support the notion that developing a more 'personal' relationship helps to develop a more productive working relationship (interpretation). This was further exemplified:

> *'...my mentor at the moment on placement I feel very comfortable with her to be able to say I can do this, I'm not sure about that, am I right i*n thinking this. Um...and I *think it is so important but it's difficult because we are all different people,*

personalities are different and you are best suited to working with some people than *others.' (3d, page 10)*

This appears to indicate a more open relationship facilitates collaboration between the student and mentor that may influence their learning and development.

Whether the participant considers their mentor a role model or not the development of a relationship appears to be important. The lived experiences described and interpreted here suggest that the participants believe a personal element to their professional relationship is important for their development.

5.7 Superordinate theme 5 – Recognising the student as an individual

All bar two of the participants described experiences were analysed as indicating students were not valued by individuals or as members of the team. This was surprising and particularly concerning, warranting full presentation within this chapter.

Table 5.9 Recognising the student as an individual subordinate themes

Subordinate theme	Presented within chapter?
Valuing students	Presented in full – findings add to current literature
Career trajectory	Not presented as limited data collected or not directly related to research question
Future aspirations	
Inherent personal qualities	
Personal journey	
Stimulus for nursing career	
Student / occupational role	

5.7.1 Valuing students

This theme emerged from interpretation of experiences where it was perceived that participants were not being valued by their mentors or other members of staff. This was interpreted to potentially have an influence on their development.

Expanding on an earlier extract participant 1a stated:

'She, for me wouldn't spend any time with a student, she didn't see the point of us training as, in hospitals in our first year because we can't do anything [stress on the 'do'] so that affected like our relationship.' (1a, page 5)

This suggests that from the outset the ability to collaborate in learning can be influenced by how the student is viewed by their mentor. This is perhaps in relation to their effectiveness within the clinical environment (interpretation). It would appear that this may be associated with self-preservation as suggested by participant 2d:

> *'They were very put out that they had a student for 12 weeks, that was a first year and my mentor wasn't willing to let me do anything. Basically she just wanted me to go in sit in a chair and watch what they were doing because that she wasn't* willing *to risk her registration by letting a student nurse do something.' (2d, page 7)*

This appears to indicate an influence on learning for students if they are prevented from engaging directly with care delivery.

Following a discussion about what made this participant feel more comfortable on placement when it was a new environment and a new experience she talked about her relationship with her mentor.

> *'On my last placement my mentor couldn't even remember my name half the time because she didn't want* to talk, she would send me off with anybody else that she *possibly could. So there was no relationship there, I couldn't feel that I could approach her…' (1a, page 8)*

This suggested that the participant felt she did not matter - not only did the mentor not remember her name but she also didn't want to work with her. When asked what would have made the experience better for her she responded:

> *'I just didn't feel like I fit in there at all, I felt like I shouldn't be there because I was* just in the way and *to have a sense of I'm there to learn and them appreciating that because I would have a few things explaining to me would have helped as well.' (1a,* page 10)

This suggested the participant perceived that if her mentor had facilitated her socialisation this could have influenced her learning on the placement (interpretation).

Participant 2a described her treatment whilst a student on placement.

> *'I was second year and I was with a band 5 doing a morning drug round shadowing* and reading out things for her and one of the sisters came along, stood in the middle *of the bay, clicked her fingers and said 'Oi, you student, a patient needs to go to the toilet, go and do it'. (2a, page 9)*

It would appear that this participant had been subjected to a difficult situation where she had not been treated with common courtesy.

Some described experiences suggested that students could be valued for their input to the ward and culture as an 'outsider':

> *'...but they would stand around and you could hear them laughing, it doesn't matter where you are on the ward you can hear them laughing, um...or you can hear them* talking about when they are going out, which pubs they are going to and things like *that.' (1a, page 11)*

This appears to indicate that students may view an environment with a similar perspective to patients and therefore can advise the placement how things may appear to them (interpretation). This links with a later comment:

> *'...so you look at, as a first year student, what we pretty much do is observe people.* So I ob*serve how they interact and what they do all the time.' (1a, page 15)*

Although stated in a different context this also suggests that students can be observers of the environment and culture. This indicates a potential resource for nurses if they value this insight in order to improve patient experience. Participant 3c recounted a similar experience.

> *'I felt like I was a burden and I shouldn't have been made to feel like that...other* placements have said we love students that come, they help us so much, they give us *insight into what our ward is really like as well, having an outside influence.' (3c,* page 11)

This extract would appear to corroborate the perception of other participants regarding students having an 'outside' perspective.

When discussing how to establish 'good' and 'bad' practice to develop her own professional practice participant 3d described a conversation with a patient about how important a smile is.

> *'...I don't think she would have had that conversation with anybody who was* wearing the blue and white dress. I think that sometimes we have that little bit more time to have those conversations with people and may be seek opinions a bit more about what people like or how they experience their stay or their condition. I think it does give you that viewpoint that maybe you might lose sight of as you get further on *in your career.' (3d, page 2)*

This suggests that students may be party to information not given to qualified staff that would give an insight into the ward and its workings so that services could be improved.

Participant 1b described an experience with a mentor in relation to how she managed her staff and communicated with them.

> *'I just think that putting people down isn't the best way to get the best out of people* and speaking to th*em like that isn't the way to encourage them to want to do better* for you to improve in the future so yes, it's just, I just had to get on with it, *it's* my *placement, I'm just the student, and my husband said to me at the beginning, well you've got to expect that now, you're not [participants' name] who is respected at work or [participants' name] who is respected by your friends, you're just the* student now and you will get spoken to like that, but I said but nobody should be spoken to like that, I shouldn*'t be, but unfortunately I've just got to bite my tongue and just get on with it because that's the way...you've got to play the game to get the end on this particular one.' (1b, page 10)*

This suggests that students can perceive themselves as 'just the student' thereby demeaning their own value in a placement. Similarly, participant 2c described her experience with a mentor in which she alludes to her self-perception.

> *'...with people like her encouraging you to do it, I mean she didn't have to, as I saw it I'm just another student, she's going to have 20 more next week but she did care,* because she saw us as future nurses, she saw us in the future, she said you could be caring for me in 30 *years' time* and you know she thought about the future rather than just *the present and I thought that was very noble of her.' (2c, page 4)*

It would appear that having a positive view of students enhances their feeling of being valued (interpretation). There were other examples that suggest positive value could be seen by the participants.

> *'And it's something that I've seen out in practice as well where doctors have said to me, well what do you think? Now you're in the second year, what would you do?'* (2d, page 3)

This appears to indicate that qualified practitioners are able to appreciate and value the input of students whether as teachers or as part of their own education.

Participant 3c was young and had entered the programme straight from school. She recounted her experience on her first placement:

> *'She just talked thr*ough absolutely everything with me, my confidence was the main thing that changed on that placement because before I was just like I am only a first *year, I don't know anything, I'm straight from school, people just think that I'm a* silly 18 year old but r*eally she was like, you know, it's obvious you've got the skills, you've got the knowledge, you just need the confidence now and that's when it went from like zero to about a million and it's like still things now that she has taught me* that I think about *now and you know what I'm not just the student, I'm good at what I do…' (3c, page 7)*

This extract points to the potential impact when a student is valued and encouraged (interpretation). This was corroborated thus:

> *'...she took me to consultant meetings, things like that, she was like 'you're not just a student nurse, you're the future, you need the right information, you need the right*

training, and you can go anywhere with it', and that's exactly what she did, she was just so like inspiring…' (3c, page 8)

Participant descriptions indicate that learning and development can be influenced according to whether they feel valued within the placement.

5.8 Superordinate theme 10 – Recognition of student status

Participants in year 1 and year 2 of the programme appear to place importance on whether their student status was recognised by those they were working with. This was a super- and subordinate theme and emerged as a result of descriptions relating to recognition of prior experience, the competing demands placed on students and the fact that they are in placement to learn.

Table 5.10 Recognition of student status subordinate themes

Subordinate theme	Presented within chapter?
Recognition of student status	Presented in full – directly relevant to research question
Student anxiety	Not presented as limited data collected

It appears important to students that previous experience or inexperience is recognised to aid delivery of person centred care.

'…being able to understand why we are doing the things that we do because I have a little bit of time with my mentor to understand what we actually do on the ward, *because for a whole week I knew what the jobs were but I didn't have any understanding of the patients or what they had or anything like that.' (1a, page 9*)

Participant 2a described an experience with a particular member of staff who was her mentor.

*'…I didn't want to really ask her any questions, when I did I would get snapped at or 'you should know this by now' even though I was a first year student, fir*st placement *as well which was quite daunting for me.' (2a, page 3)*

It would appear from the above extract that some mentors have expectations above and beyond what is appropriate or feasible for students, particularly in their first year (interpretation). A similar experience was described by a year 2 participant.

*'…if they get asked to go find something they might not know where it is because they haven't been shown, and it is the mentor'*s role, maybe like, other staff as well like, but the mentor shoul*d make sure the student's aware of where things are on the ward, who, the role of each person. Some mentors don't do that so I think that can set back a student a lot and maybe knock a students' confidence as well.' (2b, page* 4)

This would suggest when student experience is not acknowledged there can be a knock on effect to their confidence levels.

When asked what her expectations of a mentor were, participant 1b stated:

'Somebody who probably understands as well the pressures that we have academically a*s well … be mindful of the fact that we have that running in line with practice placement and um…perhaps give us the time and facilities to maybe encourage that whilst we're working…' (1b, page 12)*

This appears to indicate that students would like mentors to understand the theory element of their programme and not just focus on the clinical aspects. This issue is corroborated by participant 2a.

'…newly qualified I find more than the older generation of nurses I find have been better role models because they are a little bit more in touch because they know *what's going on with University*. T*hey understand that I've got essays to do. I had one mentor…only been qualified two years…she was very good with doing my shifts because she knew I had essays…' (2a, pag*e 7)

It would appear that newly qualified staff members are perceived to be more 'in touch'.
Sometimes recognition of student status appears to relate to the fact that the participants were in placement to learn. Participant 2a stated.

'…no, you can't do that today, we need you on the ward, this needs washing, this needs changing because we are down on health care assistants so in the long run I *missed out on a learning experience…' (2a, page 10)*

This appears to indicate the influence on learning if student supernumerary status is not acknowledged. A fellow year 2 participants' experience appears to concur:

> *'…when I went on to practice one day my mentor, 'oh you're here that's great, if* you could go off and do this, this, that and then if you work with the care *assistants…' (2b, page 3)*

Participants did report positive aspects of practice whereby it appears they were given full opportunities to learn and encouraged to maintain their student status.

> *'She kind of gave me a kick up the bum, to say [participant name], we don't want to* encourage you to be a HCA now, we want you to see past that role and more into a *nursing role, but in a nice way.' (2c, page 5)*

This suggests that sometimes students with prior care experience may slip back into their care assistant role and this could impact on learning if their mentor is not proactive. Capacity to learn in this extract appears to be influenced by the mentor acknowledging the presence and previous experience of the student.

Participant 2b stated

> *'…it was m*y first experience of cardiac arrest, but my mentor she was an experienced nurse and she took me aside and asked me how I was feeling and even though she had taken part in the arrest, she was more involved than me, she was still concerned how the student w*as feeling…' (2b, page 3)*

With regard to their experiences and potential influences on the development of professional attributes it is suggested that recognition and appreciation of student status is important.

This chapter has presented the findings and analysis of the data that is either in direct relation to the research questions or serves to answer some of the issues arising from the current literature. Findings that add to the existing literature include the perceived impact of role models in senior positions, how role model qualities are perceived as the student progresses through their programme of study and explicit findings regarding how students view academic staff and the impact they may have on their development as professional

practitioners. Further findings include the influence that peers and service users appear to exert on student professional development, the impact of working with nurses who have burnout and how students' perceive their development is influenced when they do not feel valued as a member of the team. The findings will be discussed in the next chapter.

5.9 Reflexive comment

It is acknowledged that through the process of thematic analysis and generation of the subordinate/superordinate themes I may have introduced bias. Whilst I ensured that each interview transcript was analysed independently there is the potential that prior knowledge of the phenomenon and themes generated from each interview may have impacted upon the objectiveness of my analysis. Subsequent amalgamation of themes to ensure consistency in relation to similar experiences may also have been influenced. However the study was designed aiming to minimise this through checking credibility and preliminary interpretation with the participants.

CHAPTER 6 – DISCUSSION

This study has revealed findings regarding role modelling and professional development that expand on previously reported research and therefore places them in a modern context. When exploring who it was Adult Nursing students found important to their professional development and learning, it appeared that student-peers were strongly influential. At least 17 participant comments could be interpreted to indicate peer-influence as role models (section 5.2.2 for examples). The finding of service users' strong influence on students as role models was also inferred through the majority (n = 8) of participants' commentaries. Themed as Peer influence and Impact of service users on development there were indications that each of these individual groups have the capacity to act as role models for students.

Peers as role models appeared as important as the student-participants' mentors in practice. These findings were apparent across all three HE levels and have important implications for learning and teaching approaches for nurse education. When exploring perceived role model attributes the impact of nurses who are suffering from burnout appeared to be important. Whilst only indicated in year 1 and 2 participants this theme (Nurse burnout and demotivation) serves to help practice educators understand the potential influence their behaviour and conduct can have on student nurses development. Valuing students incorporated experiences from all years that indicate there can be an influence on development if the student is not welcomed as part of the team and treated as a colleague. These findings demonstrate that care and compassion in the clinical environment is not just essential for service users but should also extend to students. These points are discussed further below.

Other findings, whilst in general agreement with the literature, add to existing knowledge. The findings confirm clinical nursing staff as role models but expand on the particular influence of senior staff members. Academic staff were found to have an influence on participants. The organisation of 'role model qualities' by HE level demonstrated the differing perceptions according to exposure and experience. Also important was the demonstration of the value of observation to students when in practice settings and the influence on professional development whether a nurse or another professional is observed. The students' relationship with their mentor and being 'recognised' as a student were also found to influence their learning and development.

The discussion of the findings has been organised to correspond with the study aim and objectives and is further defined by sub-headings to further link the discussion back to the theoretical framework in chapter 2.

6.1 Who are the role models and how do they influence student development?

The participants identified several individuals as role models. Primarily these were clinical nursing staff but academic staff members were also thought to have an influence. The experiences with these individuals were themed Role model influence (for nurses as the primary role models) and Lecturer influence (for academics). The participants also identified service users and their peers as having an influence on their development (themed Peer influence and Impact of Service Users on development). All these individuals had direct engagement with the participants in the context of their Adult Nurse education. This supports the view that individuals who have related roles and associate closely with nursing students influence the perception of their identity and role (Fitzpatrick, While & Roberts 1996). Individuals who affect or are affected by students' identity and performance also influence their perception.

Relating to the question of whether role models have an influence on student development, the participants all described experiences that demonstrated this was indeed the case. The literature points to influence in several areas including clinical skill development, values, conduct and socialisation (Paice, Heard & Moss 2002, Roberts 2008, Perry 2009, Price & Price 2009). Examples provided by the participants support the fact that there is an impact in all these areas of a student's development.

Peers

Three quarters of the participants in the current study perceived that their peers had an influence on their development. In the context of this study peers are defined as fellow Health & Social Care students. Findings in the current work indicated that peer support and learning is acknowledged at a personal/friendship level supporting Roberts (2008) view that friendships are important to learning and facilitate others socialisation into the clinical environment. Other findings indicated that fellow students met through academic or clinical placement work and, in the wider context, students at a National level also had an influence. This expands upon the existing body of knowledge regarding peer learning. The importance of peers is reported in Melia (1984, 1987), Roberts (2008) and Christiansen and Bell (2010). All of these research reports focus primarily on learning in the clinical environment. Areas of

impact in the present study include personal support, motivational influence and the notion of 'reality'.

Peer influence in this study was important in two distinct areas, 1) where participants were the role models and 2) where the participants described influence by their peers. Roberts (2008) focuses on student to student role modelling. It was therefore interesting to find that several of these experiences related to participants' that role modelled professional behaviours to the staff they were working with. The described experiences suggested that the qualified nurses did not expect to learn from the students. The researcher posits that this is a common observation within practice – the practitioner is perceived as the expert in the nurse-student relationship. Savage et al (2011) suggests that there is an unwritten rule that students are in placement to learn and their supervisors are there to teach. This conflicts however with the anecdotal view that practice areas are often keen to have students as it encourages them to keep up to date. Savage et al (2011) explored the outcome of students developing continuing nursing education courses in collaboration with qualified practitioners. They concluded that through this process the students became aware that qualified nurses still needed to learn and that they had the competency to develop materials that met that need. The students also developed in clinical competence and self-confidence. This is a phenomenon seen in this study.

The study participants described experiences related to the demonstration of good interpersonal skills and around the impact effective and appropriate communication can have on the assessment for and delivery of nursing care. This finding supports Dewar (2013) who maintains that a key process to enable and enhance compassionate, person centred care has to be interpersonal skills and emotional connections with the patient. Findings presented in sections 5.1.4 and 5.7.1 suggest that there should be a cultural shift whereby all individuals with experience and expertise are seen to have the potential to contribute to the development of the profession. Section 5.1.4 particularly demonstrates the potential of adapting the nurse-student dynamic to one of mutual appreciation of knowledge. This could enhance the delivery of person centred care by the qualified nurses and facilitate the students' development as professional practitioners. It should be acknowledged that the NMC standards for supporting learning in practice already indicate that mentors should develop effective working relationships with learners and support them to critically reflect on previous experiences to enhance future development (NMC 2008). Delivery of compassionate care to patients, as in the case of these participants, demonstrates ethical leadership. Ethical leadership aspires to achieve a good outcome through processes that

hopefully contribute to the development of others (Gallagher & Tschudin 2010). How someone conducts themselves on the journey to the outcome is just as important as the outcome itself. This concept relates to the as yet unclear issue of leaders and followers in healthcare (Gallagher & Tschudin 2010). A leader tends to be thought of as someone in a high position but an ethical leader could be someone relatively low-ranked in the nursing hierarchy such as the participants in this study. Enhancing ethical leadership in students would also help to meet the NMC requirement that students are leaders of practice at point of registration (NMC 2010).

Participants later in the programme described experiences where their peers had been influenced by their actions/conduct. This finding infers that sharing prior experience can impact on the development of peers in regard to clinical motor skills and not just in relation to socialisation, thereby supporting the findings of Roberts (2008). This finding also supports Christiansen and Bell (2010) who concluded in their study of peer-mentoring that support from a fellow learner appears to have a positive influence on student learning and development. Roberts (2008) confirms that 'vicarious learning', the term commonly applied to peer learning, has been seen to benefit students who have their own personal experiences from clinical practice but can also learn from sharing examples from others. The current study findings support this. One way to meet this need is through a formalised buddying system to support neophyte nursing students from the commencement of their programme and throughout. This may be beneficial to enhancing their learning in both academic and practice contexts. Indeed in a study carried out by the Royal College of Nursing following the Darzi review it was noted that a significant number of nursing students would value a buddy service to provide additional support (RCN 2008).

For one participant her influence was more aspirational. That is, she recognised a quality in herself that she hoped would also be seen in others. This participant demonstrated an insightful level of self-awareness that had enabled her to reflect on previous experience to inform her current situation. As Jack and Smith (2007) state the more knowledge we have about ourselves, the easier it becomes to relate to others thereby enhancing our ability to lead others in an occupational context. McCormack, Manley and Titchen (2013) maintain that self-awareness is an important foundation for life-long learning but practitioners need to be supported through self-reflection in order to learn. This suggests that facilitating reflection to enhance self-awareness whilst developing strategies to encourage vicarious or peer learning could have a significant impact on the development of nursing students.

Some participants described the importance of peers in supporting them through difficult situations both personal and clinical. This supports Roberts (2008) in relation to social relationships and caring being important for development. Melia (1987) also found that students recognised the importance of support from other students during difficult situations such as caring for a dying patient. Fellow students are considered to be vital in helping get each other through the programme. Students in the RCN study acknowledged that the support received from their peers helped them decide to stay in nursing at a time when they were considering leaving (RCN 2008). There appeared to be a participant perception that students have explicit knowledge of what other students 'go through' and can therefore empathise accordingly. Christiansen and Bell (2010) report that their participants recognise other students are on the same educational journey and therefore believe their peers to be a powerful role model. For one participant in the current study this was especially important as she was living away from home in student accommodation. She described a community of support that had developed and provided an opportunity for reflection on various elements of the programme that enhanced her development. Whilst this is pleasing to note it raises concerns regarding the peer support available to the many students who live at home. It is suggested that this is an area that would benefit from further exploration.

Peer learning can be aided by sharing of experience. Care experience and discussion of those experiences allowed participants to expand their knowledge base to facilitate a deeper appreciation of the intricacies of practice and patient care. In relation to students 'teaching' their peers Roberts (2008) noted students pass on clinical skills to their peers according to their exposure. Current study participants valued the experiences that were passed from student to student and understood these to be a reliable influence. This was despite the fact that they were all learning. This is an area of concern given the potential implications of shared skills and knowledge between students that may not be supported by underpinning theory and a sound evidence base (Roberts 2008). Christiansen and Bell (2010) found that their participants reported learning with other students enhanced their learning due to the non-threatening nature of the encounter. Certainly Campbell et al (1994) and Eraut (1994) maintain that students (in this context) find it easier to ask questions of peers if unsure than they would asking senior colleagues due to the fear of being labelled as 'weak'. This researcher suggests that if appropriately facilitated by a mentor peer-to-peer teaching could be a vital addition to the traditional student-mentor relationship.

Some of the participants perceived that students aid an understanding of 'reality', more so than academic staff. One participant in particular appeared to believe that only students have the knowledge of what it is like for students.

The findings do not indicate recognition that lecturers and qualified nurses have also experienced student life leading to questions over what impact academic staff are perceived to have. When considering the sharing of student experiences of contemporary practice it is clear to see that peers are able to provide information that others can't. It is the contemporary nature of practice that is the key element. Whilst academic staff and qualified clinical staff have experienced placements as nursing students this is historical. They can share their experiences but some participants believe that only learning from other current students about practice provides a contemporary 'real world' view. Christiansen and Bell (2010) advocate a peer mentoring system for clinical placement learning that is facilitated by a practice mentor. It is suggested that this could be adapted for more widespread use within the academic environment to facilitate students' transition into higher education.

Described experiences in regard to support for positive academic development between peers is related to the work undertaken by Miller and Parlett (1974). Their research regarding assessment practices identified that students who were a cohesive group and worked together in preparation for their final examinations achieved good results. The key element was that some of the group were 'cue-conscious', that is, perceptive to cues given out by staff regarding exam topics and so forth. Miller and Parlett (1974) hypothesised that these students may influence the less 'bright' students within the group by sharing their knowledge of cue-consciousness. Whilst the authors did not categorically state that this led to good degree results they do stress the evident importance of friendship and communication between peers. Provision of these opportunities appears important.

Service Users

Approximately half of the participants in this study described experiences whereby the involvement of service users had influenced their development. This was primarily in relation to observing reaction to care delivery and engaging in empathetic practice although there were examples of learning from 'expert' patients. Service user involvement in nurse education has been previously explored. The originality of the findings of this study lie in the fact that they are presented both within a modern context of learners with true student status and also the context of potential impact on professional development.

Several participants described experiences whereby service user observed behaviour and reaction to care delivery had an impact on their understanding of nursing and professionalism. This corresponds to the findings of a study exploring how professionals learn in practice (Cheetham & Chivers 2001). This study explored the views of 20 professional groups including nursing. They found that several interviewees identified patients or clients as rich sources of learning. In the current study service user reactions were related to the attitude of the nurses. Participants described how service users appeared more relaxed and 'happy' when cared for by a motivated nurse. One participant described how she had experienced service users asking to be seen by someone other than her mentor as they did not like her approach to care delivery. This had a significant impact on the participant as she witnessed first-hand the upset and distress this caused. For her and other participants negative reactions from service users influenced their professional development by demonstrating how not to practice.

Some participants described positive experiences where they had seen practice which placed service users at the heart of care delivery. Other experiences detailed the concept of 'professional' patients. For the participants this meant patients with expert knowledge of their condition and care requirements. One of the examples from Cheetham and Chivers (2001) indicates that a nurse had stated how a patient is the best person to explain how it feels to have a particular condition or experience nursing care. This was in direct relation to the management of their condition. The participants in the present study described experiences that demonstrated this can extend to elements of professionalism. One participant had asked a service user their views on what makes a 'good' nurse, the result of which had influenced how she interacts with patients.

Another important issue identified by the participants was the concept of feedback. Several had received positive feedback from service users. This is a concept already integrated into pre-registration nurse education. The NMC stipulate that service users and carers must be involved in the education of students through informal feedback and student assessment (NMC 2010). The importance of feedback is also supported by interviewees in Cheetham and Chivers (2001) who looked to clients to provide them with feedback on their performance. Whilst the potential impact of feedback is already known this study has further evidenced the power of the service user voice in enhancing the development of Adult Nursing students as professional practitioners.

Clinical staff

All participants referred to experiences in clinical placement working with qualified nurses. This supports the literature that states clinically active staff can and do act as role models for nursing students (Ogier 1982 & 1989, Fretwell 1982, Melia 1984 & 1987, Charters 2000, Lewis & Robinson 2003, Donaldson & Carter 2005, Perry 2009). It also supports the finding of Finn et al (2010) in their study of medical students that whilst professional development is influenced by both academic and practice staff, students place more emphasis on the clinical perspective. It was noted during analysis that commonly, but not exclusively, the participants referred to their mentors as '*role models'*. This again supports the view that students model their practice on those individuals with whom they most closely relate (Illingworth 2006). General experiences with nurses were themed Role model influence. The main findings indicated that experiences are associated with standard setting, witnessed delivery of good and poor nursing care, demonstration of professional behaviour and how incidences of poor professionalism are managed. It was gratifying to see that there were no described experiences of staff focusing primarily on technical care to the detriment of person centred practice, thereby conflicting with Allan and Smiths' (2010) view regarding the influence of contemporary nursing practice on student perception. It was also gratifying to note that participants did not report any perceived issues with being unable to learn on placement due to being considered as a 'worker' as in the earlier research into the clinical environment (Fretwell 1982, Ogier 1989, Melia 1982 & 1987). It would appear that whilst not always supernumerary in status there is finally recognition that students need a balance of 'learning about' (theory) and doing (practice) as originally indicated in Ogier (1989).

Several participants perceived that a clinical role model should benchmark practice. There were descriptions of a 'level' of practice to achieve. It is suggested that this gives the impression of ongoing development but also a finite point. That is, participants perceive the need to continue to develop until they reach the level of practice demonstrated by their mentor. This was in the context of clinical skills and in terms of conduct and behaviour. Ettinger (1991) suggests however that a clinical role model should demonstrate competence, confidence and commitment but also the qualities of being a life-long learner thereby indicating that professional development does not have an end point. The description of standards corroborates Bandura's assertion that people generally adopt the standards exhibited by models and then evaluate their own performance according to that standard (Bandura 1965 cited in Donaldson & Carter 2005). Kilcullen (2007) also identified that an ideal mentor/role model for her participants was a 'standard prodder'. It was similarly

important to the current study participants that role modelling in practice concerned benchmarking the intricacies of the role with a view to developing as a professional to meet that standard as opposed to simply copying what they did thereby opposing the concept of simple practice emulation described by Melia (1987). One participant implied an understanding that there was a need to continue developing herself in order to reach the standards set by her role models; that it was not as simple as to 'do what they do'. This participant realised the need to internalise various aspects of practice (in its widest sense) in order to integrate them into her development as a professional.

The demonstration of nursing care delivery was very important to the participants. Some had experiences of noting deficiencies in their mentors that had influenced their understanding of a nurses' role. For one participant this involved the excellent delivery of clinical skills but with very poor communication with the patient. Her development was influenced such that her knowledge and understanding of person centred care was enhanced. She witnessed that a nurse cannot focus on technical skill without consideration of the interpersonal nature of the encounter. Another participant described how she had been told that it was acceptable to 'cut corners' in certain circumstances. This appears to indicate that the concerns highlighted within the Briggs report (as reported in Ogier 1982), such as the tendency to demonstrate the quickest rather than the correct way of doing things, may still be prevalent in some areas of contemporary practice. At such an early stage of her training (first year) the researcher speculates that the 'do as I say, don't do as I do' attitude can be particularly influential. Both situations highlight the power of a role modelling situation. Each participant was hopeful of observing something good and was scrutinising their mentor's practice. Then the reality of their practice demonstrated a particular clinical skill without consideration for the wider implications for both the patient and the professional. That said it is acknowledged that poor role modelling experiences are frequently not lost and can also serve to positively influence a learners' development by demonstrating how not to do something (Illingworth 2006). The current researcher postulates that these situations concern practitioner self-awareness in terms of their own professionalism and how they demonstrate and role model safe and effective person centred care. It also identifies the issue of professional deficits within the registered workforce and how these can be managed.

There were experiences of good practice witnessed by the participants. One participant was particularly influenced by a newly qualified nurse she was working with. The participant described her as 'not appearing newly qualified' and explained how she admired her drive and motivation. This participant also believed the nurse demonstrated safe and effective

practice as she had seen practice where you have to do everything quickly and this nurse took her time. This experience unfortunately concurs with the students in Melia's' study who spoke about the speed they were expected to work on the ward and the incongruence with what they had been taught in college (Melia 1987). This experience influenced the participant to understand practice is more about quality than speed. Kilcullen (2007) found that the most effective mentors tended to be junior staff nurses, selected by her participants due to their recent familiarity with the expectations of student learning requirements.

In relation to professional behaviour one participants' experience highlighted the destructive nature of gossip as role modelled by other members of the placement team. The participant description demonstrates that being a student in the final year of her programme enabled this participant to approach the patient with objectivity and make her assessment. She recognised the impact listening to others opinions would have had and how making assumptions about patients limits the nurses' ability to carry out person centred care. The researcher posits that this may not have been the case for a student earlier in their development. This emphasises the need for clinical educators to exemplify appropriate professional behaviour as everything they say and do could be interpreted by learners as how they ought to behave (Ettinger 1991).

It was important to some participants that incidences of poor professionalism were appropriately managed. One participant was influenced not only directly through the actions and conduct of the particular nurse but also by the way that the situation appeared to have not been managed effectively. She strongly felt that the manager should have taken the situation in hand, particularly as she had been subjected to the nurses' rudeness. Referring to McGowan (2006) and the earlier studies of the role of the ward sister in developing an effective learning environment (Orton 1981, Ogier 1982, Fretwell 1982), the impact of leadership is crucial to a students' development. Not taking this staff member to task over their unprofessional conduct could lead the student to perceive that this behaviour is acceptable.

Senior staff

It is clear in the literature that many students rate senior clinical staff as their role models (Orton 1981, Ogier 1982, Fretwell 1982, Melia 1987, Lewis & Robinson 2003, Perry 2009, Gallagher & Tschudin 2010). Indeed, the aforementioned studies conducted in the early 1980's evidence the importance of the ward sister in developing the clinical environment such that it is conducive to effective learning. The participants in this study described experiences that were themed Role modelling by senior staff. The positive experiences

described by participants support Lewis and Robinsons' (2003) view that senior members of staff are considered role models due to their ability to demonstrate and exemplify excellent clinical skills and professional conduct. The participants also felt that leading by example was a key consideration. For one particular participant this included staff at the very top of the nursing profession; the Chief Nursing Officer and other national nurse leaders. For others this related to how their placement manager carried out their leadership role. Some of the participants described managers who could be considered as transformational leaders. This type of leadership is well placed in professional practice and is very much a facilitative style whereby the team is encouraged to challenge, support, create and innovate within the environment (Manley, McCormack & Wilson 2008). This concurs with the other studies that established the role of senior staff in leadership positions is integral in enhancing the learning environment (Orton 1981, Ogier 1982, Fretwell 1982, Melia 1987, McGowan 2006, Thomas & Burk 2009, Henderson et al 2010). The experience of one participant echoed the findings of McGowan (2006) and Henderson et al (2010) in relation to leadership style, supernumerary status and how students are perceived.

Having her autonomy as a student recognised and respected meant that she was able to negotiate her learning opportunities and as McGowan (2006) indicated where the sister led the rest of the staff were sure to follow. This emphasises how critical strong, effective leadership is to students' learning and development. It also highlights that the advice for ward staff provided in Ogier (1989) in relation to asking students their views and regarding them as intelligent adults is now integrated into contemporary practice in some areas.

Some of the participant experiences contradict the literature regarding positive modelling by senior staff. There were descriptions that detailed poor examples of leadership. Ward managers setting rules that they did not abide by and not working as a team player were general themes. Manley, McCormack & Wilson (2008) discuss the impact that poor leadership can have on clinical environments stating how this will potentially lead to fragmented communication, lack of teamwork, low morale and ultimately a minimised focus on the needs of the client group. This is a view shared by Cummings et al (2010) who conducted a review of leadership styles and the impact these can have on the nursing workforce and environment. They concluded that focusing on task completion through a commanding style rather than engaging with staff, tuning into their emotional needs and supporting them effectively can result in the non-completion of the team 'common goal' and provision of poor patient care (Cummings et al 2010). McCormack, Manley & Titchen (2013) maintain that an effective transformational leader should work with the team to

achieve a shared vision and role model shared values. The findings from the current study support this view. Participant descriptions evidence the negative impact on team dynamics and morale when team members feel that they have to complete all 'tasks' without support from their managers. It is disappointing to find that the concerns expressed by Fretwell (1982) regarding the need for a leader to be democratic as opposed to autocratic to aid the development of an effective learning environment may not have been heeded.

It is suggested that in situations such as those above described by the participants there is the potential for nursing students to learn that being a leader means telling others what to do or how to behave without demonstrating the willingness to do these things themselves. This could therefore contribute to the development of future ineffective leaders if nursing students do not have awareness of how this impacts on the learning environment.

The *students'* mentor

Three quarters of the participants perceived the relationship with their mentor to be an important influential factor (themed Relationship with mentor). In general a good working and learning environment is inextricably bound to positive working relationships (Fretwell 1982, Allan, Smith & Lorentzon 2008). Clinical learning is enhanced if there is an effective interpersonal relationship between the staff nurse and student (Andrews & Roberts 2003, Arries 2009). This is fundamental to the quality of the learning experience and is evidenced by the current study.

Participants in year 1 described how they 'rely' on their mentor particularly when put in a difficult situation. For one participant this directly impacted on person centred care. The experience changed the dynamic she had with her mentor as she essentially became the expert, monitoring what the mentor was doing.

Beskine (2009) suggests that it is the mentor's responsibility to establish an effective working relationship with the student re-emphasising the advice of Fretwell (1982) and Ogier (1989). It is posited that for this to be successful there needs to be trust between the parties. This corresponds to the NMC requirement for mutual trust and respect within the student-mentor relationship (NMC 2008b). This is also supported by Eller, Lev and Feurer (2013) who explored the key components of an effective mentoring relationship. The authors identified the importance of respect, trust and appreciation of each other. In an earlier study by Webb and Shakespeare (2008) exploring how mentors make judgements about the clinical competence of pre-registration nursing students it was concluded that the mentoring

relationship was integral to appropriate decision making. The authors discussed the relevance of 'toxic mentors'. These are defined as those mentors suffering from burnout and therefore not able to form constructive relationships with their students (Darling 1985 cited in Webb & Shakespeare 2008). The authors considered this concept important at the time of their study in relation to student development. The findings of the current study provide further evidence.

Nurse burnout

Several experiences themed Nurse burnout & demotivation add to the literature when considered in the context of student professional development. Some of the participants described experiences with 'bored' clinical nursing staff highlighting motivation as an essential quality. On analysis it appeared they had attributed this to the fact that the nurses had been in the role for a long time. Literature related to this area discusses the concepts of 'burnout' and 'compassion fatigue' (Joinson 1992, Sabo 2006, Yoder 2010, Rudman & Gustavsson 2012, Michalec, Diefenbeck & Mahoney 2013).

Compassion fatigue relates to nurses 'switching off' empathy for the patient when encountering stress whilst caring for someone suffering from trauma (Joinson 1992). Conversely burnout is a gradual wearing down of the individual leading to negative changes in their attitude and behaviour such as becoming angry, ineffective, apathetic, depressed and displaying diminished morale (Joinson 1992, Sabo 2006, Yoder 2010). This is often triggered by frustration and the feeling of powerlessness. The participant experiences in the current study appear to be evidence of burnout.

Rudman and Gustavsson (2011) concluded that as many as one in five nurses will suffer from very high levels of burnout during the first 3 years of their career (Rudman & Gustavsson 2011). The authors define burnout as a syndrome encompassing both sheer exhaustion and a cynical attitude towards practice. This is sometimes displayed as disengagement (Rudman & Gustavsson 2011). Whilst the current study suggests a higher incidence of burnout (a third of participants witnessed symptoms indicating one in three) it does support this view. Disengagement was displayed to participants as nurses not being bothered, bored with the job and prioritising going on a break over delivery of patient care. The impact of this on nursing students' development cannot be over-emphasised when considering how easy it is for individuals to be swept along with colleagues who are impatient, indifferent and cynical with the result that they too can lose energy and enthusiasm (Joinson 1992).

The aforementioned studies indicate that burnout has a significant impact on the delivery of person centred care and should be dealt with accordingly. In terms of student development the researcher posits this could have a positive impact. Rudman and Gustavsson (2011) commented that transition from student to qualified nurse can be extremely stressful. Newly qualified staff will often suffer from a crisis of confidence in their own ability and a reality of practice which conflicts with their values leading to a feeling of inadequate preparation for the realities of the role (Rudman & Gustavsson 2011). If students are exposed to nurses suffering from burnout during their placements they will experience the potential impact this can have on patient care. The negative connotations of this could influence them to have a more realistic perception of care delivery within the clinical environment thereby easing transition to qualified status (that is, they will have an enhanced awareness of what to expect when qualified). Certainly the participants' described experiences reinforced the primacy of person centred care and the importance of effective working relationships.

Rudman and Gustavsson (2011) hypothesise that the incentive for entering nursing as a profession can influence student engagement with their studies, subsequent outcomes and potentially the future onset of burnout. The issue of study burnout amongst nursing students has been explored with some emphasis on the impact this has on student attrition (Rudman & Gustavsson 2011, Rudman & Gustavsson 2012, Michalec, Diefenbeck & Mahoney 2013). This issue is important to discuss due to the need to enhance professional development and facilitate the progression of nursing students. Michalec, Diefenbeck & Mahoney (2013) explored the risk of burnout in students given their exposure to clinical areas and the associated connection to burnout and compassion fatigue. It was noted that clinical experiences appeared to reconfirm the students' enjoyment and enthusiasm for nursing, rather than lead to emotional exhaustion and signs of burnout or compassion fatigue (Michalec, Diefenbeck & Mahoney 2013). However the current study indicates a higher incidence of burnout than previously thought and a potential impact on student development through the relationship with their mentor if they are displaying signs of burnout. Michalec, Diefenbeck & Mahoney (2013) indicate that clinical exposure may not be the prime mechanism for the onset of study burnout in students. Whilst this may be true it is posited that nurse educationalists need to facilitate the development of professional coping strategies in students to withstand the negative implications of working in an environment where burnout is a reality.

Frustration leading to burnout can be compounded by lack of capacity to provide care to patients (Sabo 2006, Yoder 2010). The participants in the current study specifically referred

to the limited contact some nurses had with patients and the increase in paperwork associated with the role. This is perceived to be a positive finding in relation to the expectations and focus of students given that Melia found senior students appeared to move away from patient care as their training progressed (Melia 1987). This is what the students witnessed the staff nurses doing and hence interpreted this as more important and within the remit of nurses whereas the concept of basic nursing care was not seen as 'nursing' (Melia 1987). Yoder (2010) postulated that compassion satisfaction, or the pleasure derived from being able to care effectively for patients, helps to reduce the likelihood of burnout and subsequently compassion fatigue. It was suggested that feeling unsupported in an environment where the workload was high and in some instances unachievable led to burnout. Whilst in relation to qualified nurses the current researcher suggests a real risk for students as this could severely hamper their professional development. Recent developments in nursing whereby nurses are more concerned with the technical aspects of the role, leaving the bedside caring to non-regulated staff impact on the students' view of the profession (Allan & Smith 2010), although the experiences expressed by the participants seem to indicate these role developments may not be the reality in some areas. When combined however with the fact that students may work with mentors who display signs of burnout there is a risk of increased attrition through dissatisfaction with nursing before students even reach registration. The researcher believes this is an important issue worthy of further research given the increasing technicality of nursing, current dissatisfaction with care and compassion and levels of attrition both within education and clinical practice.

Relating back to the issue of reliance within the mentor-student relationship there can be negative consequences. One participant appeared to be over-reliant on their mentor, fearing their ability and competence was not sufficient without their mentors' influencing presence. It is suggested that this dependence on her mentor could negatively impact on her development, as working without her mentor appeared to increase her anxiety levels to such a point that all she could do was maintain her current level of work and not further her knowledge or skills. This indicates an advantage to working with multiple individuals. This could help to increase autonomy and confidence in the student.

A 'personal' connection

Several participants described the importance of having a 'personal connection' with their mentor and how this made them feel more comfortable in the learning environment. For one participant her mentor displayed the same lack of confidence as her, thereby enabling her to

develop as an individual through witnessing how her mentor dealt with various situations. Another participant described how she valued the social times and getting to know the mentor to 'see what they were really like'. The participant recognised that the 'personal' had an impact on her development and also her learning. She related this to being able to talk to her mentor on more of a 'friend basis' and 'normally' rather than being reserved in her conversation. So for this participant there was an expectation that students were to be reserved in the professional context but when a personal element is added her experience became more comfortable. The issue of personal connection is identified in the study by Eller, Lev & Feurer (2013) thereby supporting the findings of this study. Their student participants described the importance of mutual friendship, a supportive relationship and how mentors should take a personal interest in the student outside the academic. Whilst this study was conducted in an academic context it is possible to extrapolate the findings to the clinical environment and therefore to the context of the descriptions within the current study, particularly given that Fretwell (1982) also indicated the need for trained nurses to take an interest in the learner when they start. The development of students as influenced by clinical role models could be enhanced through development of a personal connection between mentor and student. Through this connection a mutual understanding of values could ensure targeted support. It does have to be considered however whether a personal element to the student-mentor relationship is desirable. Wilkes (2006) emphasises that the student-mentor relationship should remain on a professional level as any transgression of professional boundaries could influence the integrity of assessment, a key function of the mentors' role.

Academic staff

Whilst 8 of the 12 participants described their perceptions and experiences of lecturers at the University the descriptions are quite limited and overshadowed by descriptions of their lived experiences with qualified staff in the practice environment. This seems to support Lewis and Robinson's (2003) comment that academic staff members appear low on the hierarchy of role models. Nursing is primarily a practice oriented profession formed mainly from the practical aspects (Heshmati-Nabavi & Vanaki 2010). Therefore this finding is not surprising given the focus students have on learning to be a nurse and perhaps perceiving a disparity between being within an educational institution and the 'real world' of nursing. Acknowledging this it was however evident from the data analysis that some participants from all years did identify academic staff as role models supporting the conclusions presented by Pfeil (1997) and Lown (2007).

Whilst there may be common perceptions, there is limited literature that focuses on student perception of nurse academic influence on professional development (see section 2.2.2). Research is generally centred on learning in the clinical environment and the role of the academic in practice. The findings from this study therefore extend what is known about academic influence in nurse education. Participants' perceived influence on their development by academic staff to be focused on teaching style with particular reference to motivation. Some participants described lecturers as passionate about their subject and eager to teach. For one participant this led to an 'infectious excitement' that motivated her to want to learn more. Another participant described how the lecturers' enthusiasm encouraged her to want to explore more about the topic to ensure her knowledge for practice was comprehensive enough to be an effective practitioner. The researcher suggests that these findings indicate a positive attitude to teaching and academic staff members who demonstrate a passion to encourage learning have an important influence by motivating students to learn. This is supported by Baid and Lambert (2010) who postulate that meaningful, effective learning can be achieved through education that captures the attention of students.

Other participants described negative experiences; situations where it was clear that academic staff did not appear motivated to teach. For the participants this gave an indication of how the lecturer might be as a clinical practitioner. This adds a further dimension to the statements made by Lunenberg, Korthagen and Swennen (2007) regarding the fact that teacher educators teach subject content but also role model the practice of teaching. It was suggested in chapter 2 that this may not hold true for nurse education as academics do not nurse their students. However this finding appears to indicate that students may still be able to relate professional qualities witnessed in the University to those required in clinical practice. This emphasises the importance of academic staff acknowledging the potential influence they have on student professional development.

Some of the participants perceived that the support offered by University staff was vital for their development. This was not concerned with knowledge exchange but with general aspects of personal and professional development. One participant described her personal tutor as nurturing and motivating. This was related to advice regarding general conduct and behaviour, for example turning up on time, being motivated to learn (through completing self-directed study) and trying your best. This participant recognised the influence that her tutor had on the development of her professional qualities that would ultimately benefit her in practice. This finding supports the conclusions offered by Braine and Parnell (2011). They

found that students believed the personal tutor role and support offered was crucial to their completion of the programme.

Given the long-standing debate regarding nurse academic credibility it was interesting to find that there were no comments from participants explicitly in this regard. The researcher suggests that this is possibly due to the explicit focus on the participants' professional development as opposed to clinical knowledge for practice. There were descriptions however that indicate potential influence by the gap between theory and practice thereby adding to what is currently known. Stew (1996) argues that the move of nurse training into Higher Education led to an increased theory-practice gap in the way nurse teachers were viewed by practitioners. This also impacted upon academic staff credibility as perceived by students and subsequently on student learning. Participants in each year of the programme described experiences that allude to a disparity between theory and practice. Melia reported the gap between nursing as taught in the college and that experienced on the wards as one of her most notable findings (Melia 1987). It would appear therefore that the findings of this study support Stew's view given that Melia's study was carried out prior to the move into HE. This is particularly concerning when considered in the context of the 'improvements' to nurse education the project 2000 proposals promised.

For one participant this 'gap' related to being told the exact opposite by her mentor from information given at University. She claimed to have learnt at the University to 'detach herself' emotionally from the patient in order to deal with a potentially upsetting situation. Her mentor however had advised her that she should not detach as this would hinder the relationship with the patient and reduce the person centred nature of care delivery. Whether this comment is factually accurate as perceived by the participant or she had misinterpreted the situation, it is still clear that for her there was a direct conflict between what she had been told 'theoretically' and what she had seen to be effective 'practically'. In their study of the efficacy of clinical educators Heshmati-Nabavi & Vanaki (2010) found that there can be a number of negative consequences if there is a gap between the theory taught and the practice experienced. They claim that practice that is not based on well-founded theories could result in deprofessionalisation. Relating this view to students' it could be suggested that role modelling non-evidence based practice could hamper professional development if emulated by the student. This is not however evident from the participant descriptions in the current study. Participants have described experiences of poor practice but stated they have learnt what not to do rather than emulate these.

Some of the participants highlight the importance of theory learning to support practice. They indicate that reading around a topic and then applying this to their practice had a positive impact on their development. This may not always be the case however when considered in light of the findings of Spouse (2001). Spouse (2001) concluded that although students received extensive tutelage in interpersonal skills they had forgotten the rehearsed skills once faced with the reality of practice. In this situation they reverted to observing behaviours in practice and enacting those which met with their initial perception of what constituted good practice. This indicates that even with the exploration of supporting theory and 'safe' practice in the University students' may not be able to apply what they have learned to practice. This therefore emphasises the importance of congruence between what is taught within an academic setting and what is practised in the clinical environment. This is further supported by the findings of Curry, Courtland and Graham (2011). They reported that appropriate professional behaviours are exemplified through a workshop approach in order to support learning in the clinical environment. The findings from their study however indicate students' report observed behaviours that contradict those emphasised in the University. The authors suggest that this could lead students to feel inappropriate professional behaviour is unimportant and emulate the behaviour of the role models in practice. This view is not supported by the findings of the current study where participants were dismayed with perceived unprofessional behaviour and chose not to emulate this.

The findings of the current study indicate that participants are aware of the importance of theory application to practice. Existing research however indicates that there are inherent difficulties in students applying this learned behaviour when it is not exemplified in practice. The perceived reduction in academic staff credibility and students' natural alignment to clinical nursing staff (as evidenced by the current study) also has the potential to lead to development of professionalism that is not supported by theory and therefore possibly not appropriate to contemporary practice. It is evident that further work needs to be undertaken to 'close' the theory-practice gap.

Role model qualities and the 'adoption' of traits

This study sought to explore the attributes that students look for in their role models. The general findings related to role model qualities support those already presented in the literature (Wright & Carrese 2002, Paice, Heard & Moss 2002, Lewis & Robinson 2003, Illingworth 2006, Miller 2006). The participants did however additionally identify 'recognition of student status' and 'respect for graduate status'. Recognition of student status

primarily concerns the supernumerary status of students in order to facilitate their learning. The perceived impact of this recognition is discussed later. Respect for graduate status stems from the initial outcry from many practitioners when it was announced that nurse education was to become an all graduate entry profession (Lister 2009 cited in Royal 2012). This perception is not helped by media reports claiming deficiency in today's qualifying nursing students with headlines such as '*Graduate nurses no longer have the art of bedside care'* (Finlay 2012). For one participant her position of being a degree programme student meant she perceived a need to work harder to prove her abilities thereby adding to her stress and anxiety.

This she felt impacted on her ability to learn and subsequently her development. Wider knowledge and acceptance of the current status and future developments in nurse education is a quality participants would like to see in the colleagues they work with. This is an issue for consideration by both nurse academics who facilitate mentorship training and senior clinical staff who should exemplify behaviours to junior staff.

Two issues arose from the extant literature concerning the influence of multiple role models and the judicious adoption of role model 'traits' by students. The nature of pre-registration nursing education generally means students are exposed to many different individuals. In the case of clinical staff they often rarely work with the same individual in more than one placement during the programme. The researcher recognises that this is dependent on the particular programme placement pattern. If this is the case it limits the potential for reinforcement of particular traits unless exemplified by other clinical staff. Reinforcement is considered important to encourage adoption of the behaviour (Bandura 1977). Also, it is usual practice for a students' mentor to assess their competency (NMC 2010). There is an issue regarding whether this influences a student to emulate the mentors' behaviour even if this contradicts their values or what they know to be effective practice in order to increase the likelihood of a 'pass'. This also links to the socialisation literature as discussed in section 2.2.7 in regard to undertaking whatever practice appears to suit at the time in order to 'fit in' and be accepted into the working environment (Melia 1984).

The findings of the current study indicated that participants had the ability to discern role model traits in order to 'build' their own professional practice. This was principally confined to year 3 participants. The participants described how they look at all individuals they work with and emulated traits they considered to be good. They also implied an influence from observing traits that are bad and that they would not wish to take forward in their practice.

The participants described the ability to discern good and bad traits stemmed from their own subjective judgement of what constitutes effective person centred care. This is often related to service user reaction to care delivery. This supports Bandura (1977) and the findings of the study conducted by Donaldson and Carter (2005) which highlights the fact that observers tend to pattern their behaviour on a combination of role model attributes. This also relates to the concept of 'partial role modelling' (Bucher & Stelling 1977 cited in Donaldson & Carter 2005). The authors suggest this is the most common type of modelling where role models are selected due to the fact that the observer witnesses a skill or attribute they have recognised as deficient in themselves. The current study provides evidence to support this view. For one participant selectivity of traits appeared to relate to an aspiration to deliver holistic practice. She was aware of her lack of knowledge in relation to cardiac care and sought to emulate behaviour and care witnessed whilst on a cardiac placement. This resolution to amalgamate aspects of others practice into her own for the benefit of her patients also stemmed from her observation that some practitioners focus on their own area of expertise to the possible detriment of other vital aspects of care.

It is suggested that the frequency of exposure to an experience will influence whether the student emulates the behaviour (Savage 1998 and Bandura 1986 cited in Donaldson & Carter 2005). The NMC stipulate that students must spend at least 40% of their time with their allocated mentor (NMC 2010). This affords ample opportunity for students to work with others thereby enabling them to identify traits that may not be evident in their mentor. Given the evidence for exposure to multiple role models, there is an advantage to students working with several different staff. This is particularly important if there are concerns over the exemplified conduct and/or behaviour of certain practice staff that may or may not be mentors. The research discussed above, supported by the current study, asserts that when combined with the ability to discern and 'take' traits from individuals, students should be able to amalgamate the 'best bits' from all those staff who role model their practice. Only working with one person will lead to the learner almost becoming a 'copy' of that person as opposed to developing as a professional in their own right. The current researcher speculates that there should be an element of individuality in professional development in order to progress effectively and develop those professional attributes that are specifically lacking in the individual. This should also serve to advance the profession with the emergence of 'new' professionals who are able to adapt to the changing context of contemporary practice.

The current study did not identify how the participants perceived their mentor's influence in relation to the fact that they would be assessing them. This requires further exploration.

Role modelling strategies

Review of the literature related to role modelling strategies revealed a contentious issue. Whether role modelling should be a conscious activity or left unplanned has scope for debate. A further related consideration is the need to ensure a learner understands what they have witnessed. It is argued that structured role modelling offers an opportunity to check for appropriate learning (Charters 2000). Left to their own devices learners may misinterpret the situation or witness poor practice and emulate this without exploration of its appropriateness (Kenny, Mann & Macleod 2003). The current study focuses on the development of professionalism. The researcher challenges the appropriateness of a role model consciously planning to 'act' professionally during interaction with a learner. Professional qualities should potentially be inherent in all they do particularly given the expectation of service users that professionals will be respectful, communicate well and demonstrate scrupulous behaviour (HPC 2011).

The participants in the current study described experiences that highlight role modelling of practice is occurring both consciously and unconsciously. Perry (2009) maintains that role models contribute to the development of future practitioners and therefore the profession. She suggests that they are responsible for ensuring the provision of quality care through facilitating the integration of theory into practice as well as teaching professional behaviours and attitudes. In order to demonstrate the potential impact of role modelling the researcher of the current study proposes the following model that has arisen from the findings of the study. Table 6.1 explains the impact of a conscious-unconscious role modelling situation on learned professional behaviour. This could, for example, be a nurse demonstrating to a student how to take a patients' blood pressure.

Table 6.1 The impact on learned professional behaviour through role modelling

	Role model (nurse)	**Learner (student)**	**Impact of role modelling situation**
Conscious-Conscious	The nurse is aware they need to demonstrate appropriate professional behaviour whilst demonstrating the skill **Explicit demonstration**	The student is aware that they are observing the nurses' professional behaviour as well as the skill **Explicit observation**	The student learns appropriate professional behaviour **Explicit learning**
Unconscious-	The nurse is unaware	The student is aware	The student may learn

Conscious	that the student is observing her interaction with the patient as well as the skill and may not demonstrate appropriate professional behaviour **Implicit demonstration**	that they are observing the nurses' professional behaviour as well as the skill **Explicit observation**	inappropriate professional behaviour **Explicit learning**
Conscious-Unconscious	The nurse is aware they need to demonstrate appropriate professional behaviour whilst demonstrating the skill **Explicit demonstration**	The student is unaware that they are observing the nurses' professional behaviour whilst observing the skill **Implicit observation**	The student learns appropriate professional behaviour but is not aware **Implicit learning**
Unconscious-Unconscious	The nurse is unaware that the student is observing her interaction with the patient as well as the skill and may not demonstrate appropriate professional behaviour **Implicit demonstration**	The student is unaware that they are observing the nurses' professional behaviour whilst observing the skill **Implicit observation**	The student learns inappropriate professional behaviour but is not aware **Implicit learning**

In relation to learned professional behaviour conscious-conscious appears to be the ideal scenario. The role model plans the demonstration and both parties are aware that the learner is to observe the practicalities of the skill and the professional behaviour of the role model. One particular participant described how she had been positively influenced through the approach taken by her mentor. They had established a gap in the participants' knowledge and had discussed how to manage the situation. This was then followed by a real-life demonstration of how to approach the patient to exemplify their discussion with subsequent reflection to ensure understanding. This is a clear example of conscious role modelling and is supported by social learning theory. Bandura (1974) suggested that informing observers of expectations prior to role modelling ensured that they watched more closely (Donaldson & Carter 2005). According to the study conducted by Wright and Carrese (2002) the majority of

their informants were cognisant of the fact that learners watch all that they do and they therefore deliberately attempt to perform in an exemplary manner. The current researcher suggests that if this is the case in other role modelling situations then it will ensure the demonstration and perpetuation of appropriate professional behaviours. It is postulated however that professionals should not need to 'deliberately perform' in an exemplary manner. If the role model is unaware that they are also exemplifying how to 'act' in practice (unconscious-conscious) there is the potential that the learner could witness inappropriate behaviours and emulate these in the future believing them to be correct. The same participant later described her observation of the role models' interpersonal skills during interaction with various service users. Following her experience of conscious role modelling the participant was aware of the calibre of her mentors' communication skills. This led her to believe she could learn and develop her own skills whilst observing her mentor. Through this described experience it was inferred that whilst her mentor was teaching the participant about the particular client group (the conscious) she was also demonstrating effective interpersonal skills (the unconscious). These behaviours will not be corrected by the role model as they are unaware that the learner has observed and absorbed them. In the third scenario (conscious-unconscious) the learner is not aware they are observing the role model's professional behaviour at the same time as the skill. This may still have an influence on their professional development but without the opportunity to reflect on the scenario with the role model this learning may be lost or misinterpreted. One of the participants described a placement where she had learned 'nothing'. She had not had the opportunity to reflect on the situation and had this been the case she may well have seen that the poor experience influenced her in terms of how not to behave. This is supported by Warhurst (2011) who found in his study that participants only developed an awareness of the influence of particular individuals through facilitated reflection. It is suggested that effective role modelling depends on the opportunity to reflect on that which has been demonstrated (Kenny, Mann & Macleod 2003, Cruess, Cruess & Steinart 2008). The potential of the unconscious-unconscious scenario is the perpetuation of unprofessional behaviour in practice. Whilst the learner may only implicitly learn inappropriate behaviour the fact that the role model is unaware this has been witnessed means reflection on this aspect of the scenario is unlikely. Implicit learning is defined as gaining knowledge independent of the conscious attempt to learn (Eraut 2000). The crucial aspect appears to be the conscious awareness of the role model to ensure that appropriate professional behaviour is demonstrated and that the learner is aware. Certainly this is supported by Cruess, Cruess & Steinart (2008) who maintain that conscious recognition of how role modelling influences future performance is fundamental. This awareness could be

through ensuring the learner is cognisant of the need to observe professional behaviour pre-demonstration or via facilitated reflection post-event to establish what they have witnessed and how this has been interpreted. A key point highlighted in the study by Cruess, Cruess & Steinart (2008) is the need to protect time to facilitate reflection and explore the effect of an encounter on the patient, student and associated others. From the description of the participants in the current study this does not appear to be happening in all cases thereby limiting the potential of role modelling as a teaching and learning strategy.

Observational learning

Bandura places particular emphasis on the power of observational learning (Bahn 2001). This has been defined as a powerful means of transmitting values, attitudes and patterns of behaviour (Kenny, Mann & Macleod 2003). Themed Learning through observation experiences were noted primarily in year 1 participants. For one participant this was related to the limited knowledge and experience that she felt she had at this stage of her programme. This led her to be hyper-observant, attempting to assimilate all that she witnessed. Whilst recognised as an effective teaching and learning strategy the researcher suggests that observational learning should be viewed with caution. Those participants with limited knowledge and experience could copy role models without consideration of the evidence-base or appropriateness of their actions. Taylor (1997) suggests that novices will frequently model themselves on nurses who have varying standards of practice as they do not have the ability to discern appropriate conduct.

The participants in the current study described experiences related to various aspects of observational learning. These were not just associated with the observation of nursing care. Some participants described experiences that demonstrated the importance for role models to recognise students' observe everything. One participant described how she observes what is going on around her and then integrates some of the features into her practice. Another participant explained that she had worked with nurses who were very focused on their own specialism and how this had been to the detriment of holistic person centred care. She had therefore learned to ensure her development did not concentrate on specific areas of practice. These findings reinforce the importance of role models and awareness that their actions, behaviour, language and conduct are always being observed, particularly by students (Donaldson & Carter 2005, Girard 2006, Perry 2009, Price & Price 2009, Curry, Cortland & Graham 2011).

For another participant her experiences demonstrated both the art and science of nursing. The art of nursing is recognised to relate to the 'humanness' of the nurse and the patient whilst the science relates to professional knowledge, often technical in nature (Idczak 2007, Norman & Ryrie 2013). The participant described how her mentor had brought 'humanity' to the interaction with the patient. The researcher suggests use of this terminology infers a consideration of how care is delivered with potential reference to professional qualities. The participant had observed much more than the practicalities of changing a dressing or administering an injection. It has been suggested that an alignment between the art of nursing and the scientific elements could aid the bridging of the theory-practice gap (Conway 1994). This participant experience evidenced that this is indeed feasible if this is role modelled appropriately. Clinical experiences are ideal for students to learn the art and science of nursing provided that teachers are skilled at encouraging connections in learners (Idczak 2007). Williams (2003) suggested in her paper about learning in teacher education that important elements of informal learning can be undervalued in a system which privileges technical competence. This includes elements of implicit learning and is relevant to this discussion given the potential for nurses to concentrate on the correct technical delivery of care to the possible detriment of the art of nursing. Williams (2003) suggests that given the importance placed on informal discussion by the newly qualified teachers who undertook her induction pilot it is reasonable to question whether this is recognised and promoted. The current researcher postulates that role models may not realise the influence they have during 'informal' interactions with students, that is, those not associated with care delivery. An example of this is the participant who was told it was acceptable for her to use her mobile phone in the clinical room. What the nurses did not recognise however was that by leaving the door open (as was common practice) it was obvious to patients and visitors that this was what was happening. For the participant this presented an unprofessional image of the placement staff.

In regard to the direct observation of practice, participants describe experiences that relate to both good and poor examples. This concurs with the findings of Keeling and Templeman (2013). They found that observation in clinical practice provided their participants with an opportunity to learn from others mistakes but also identify positive role modelling. Examples of poor practice in the current study included a participant witnessing nurses not following protocol with regard to wound checks. This resulted in a negative outcome for the patient. This participant had observed negligent practice in relation to the standards expected. Her prior experience had however meant she was aware of how often wounds should be checked.

Without this prior knowledge she could have learned that deviation from the required standard is acceptable practice. Another experience related to the inappropriate use of delegation by a manager. The participants' view of management and leading by example was influenced by this situation as she had been ignored by the manager. The researcher postulates that had the manager refused to assist a clinical support worker the influence may have been very different. The participant could have learnt through observation that this was acceptable and therefore emulated this behaviour in the future having an impact on team dynamics, hierarchical structures and workplace culture.

The described experience of participants in regard to poor practice indicates a strong influence. This is supported by Warhurst (2011) who found that his participants provided powerful narratives of negative role modelling and the intensity of learning engendered from this was significant. It has been suggested that repeated exposure to role models who demonstrate poor practice increases the likelihood that the student will adopt that behaviour (Armstrong 2008). The perpetuation of poor practice is particularly pertinent for 'novice' students who do not have the knowledge or experience to challenge what they observe. The current study indicates that poor practice was not emulated but information concerning repeated exposure is not available.

Some participants described positive experiences. Often these descriptions related to challenging situations and are therefore difficult to replicate for the purpose of learning. One participant described how it was important for her to be able to deal with these situations in a calm way but she was unsure of how to go about this. She had observed her mentors' conduct and approach. She believed in the importance of being involved (albeit in an observational capacity) in these situations rather than being shielded from them. The researcher suggests that this infers students are sometimes omitted from challenging situations, possibly to 'protect' them. This is not however beneficial to the students' development. For this participant she had to see this to learn it confirming the power of observational learning. For another participant seeing practice in action enabled her to explore several aspects from 'keeping calm' to 'not getting emotional' in front of the patient. So in one experience there can be several layers of learning.

What is encouraging from the experiences described by the participants is that they are evidently getting the opportunity to observe the nurses' role, whether good or bad. Melia (1984 & 1987) described the difficulty in students learning to apply their knowledge in order to make professional judgements. Whilst it was acknowledged that students did have some

notion of how to function as nurses they did not have the opportunity to see how the education segments notion of professional judgement was translated into 'the bureaucratic organisation of care on the ward' (Melia 1984, p147). This was due to the expectation that students will simply do the work as opposed to be involved in how that work is determined or allocated for example. It appears clear that practice and the facilitation of learning have moved on in at least this regard.

Feeling valued

The majority of participants in this study described experiences which they took to mean they were undervalued (themed Valuing students). For many this related to how they had been spoken to or treated in the context of their clinical placement work. Bradbury-Jones, Sambrook & Irvine (2011) found that the multi-layered influences on student empowerment included being valued as a learner, a team member and a person. Whilst issues regarding integration are known, valuing students and the impact this can have on their development has not been fully researched since the research into the clinical learning environment conducted in the early 1980's (Orton 1981, Ogier 1982, Fretwell 1982, Melia 1984).

The descriptions offered by current participants indicated that first encounters are important. For one participant the experience was to set the tone for the remainder of the placement and subsequent experiences. Being told from the outset by her mentor that there was little point in first year students undertaking placements in hospital as they cannot 'do' anything impacted on their relationship and ability to work collaboratively. This limited her capacity to learn. This is supported by the findings of Levett-Jones et al (2009) in their study regarding student nurses' 'belongingness'. They found that students are particularly vulnerable at the start of a placement as they haven't had the opportunity to establish connected relationships. The authors concluded that belongingness was a prerequisite for learning but that time was needed for the student to become familiar with the environment. The findings of the current study indicate that time is not a consideration for some mentors who expect students to be able to 'hit the ground running'. It is frustrating to note that this is similar to the findings of Melia whereby trained staff expected students to simply 'pick up the job' and fill the vacant slot on the ward (Melia 1984). The need to 'belong' is further supported by Del Prato (2012) who concluded in her study that students felt valued and this facilitated confidence and professionalism.

Some of the participants described experiences where they were identified and referred to as 'the student'. The participants' perceived this influenced their development as they were

undervalued when they believed they could be constructive, helpful members of the team. This concurs with the findings of Christiansen and Bell (2010) and Melia (1984) who reported that trained staff did not make distinctions between students, instead stereotyping them as first, second or third years. Christiansen and Bell (2010) concluded that students are often referred to as 'the student' and this alludes to a transient role, thereby limiting their integration into the team. The perception of the participants in this study is that their mentors did not care about them or value their contribution. This was particularly important to those who were in a position to offer a perception of the culture and behaviour of staff on the placement. If valued it is suggested that this could enhance the delivery of services in that particular area.

The researcher suggests that caring in the clinical environment tends to focus on the needs of the patient. It is posited by Dewar (2013) that there needs to also be a caring focus on the health care professional. This is supported by Smith (2008) who identified that in order to care effectively for patients nurses also need to be cared for. The Boorman Review (2009) specifically highlights that the quality of care delivery is directly linked to staff well-being (Boorman 2009). Dewar (2013) suggests that the processes used to enhance compassionate care delivery to patients could well facilitate compassion between colleagues. Dewar (2011) identified several examples of behaviours and actions that illustrate how teams can demonstrate caring for each other. These included remembering the names of new staff members, including students. She concludes that the illustrated behaviours focus on effective, compassionate communication (Dewar 2011). The findings of the current study indicated that often the participants are subjected to inappropriate communication and behaviour.

Vertical violence is described as abusive behaviour between individuals with unequal power, such as a registered nurse and a student (Thomas & Burk 2009). This is as opposed to horizontal violence that describes peer to peer negative behaviour (Curtis, Bowen & Reid 2007). Thomas and Burk (2009) proposed a four level continuum of vertical violence:

- Level 1 – being ignored or patronised
- Level 2 – having assessments disbelieved
- Level 3 – being unfairly blamed
- Level 4 – being publicly humiliated

(pg 228)

The findings of the current study provide examples to support this framework. Participants experienced level 1 vertical violence in relation to the initial greeting from a nurse regarding the fact that the participant cannot do anything. At its most severe level 4 vertical violence was exemplified by a participant being addressed as 'oi, you student, go and do this' in the middle of a bay of patients. Whilst Thomas & Burk (2009) stipulate that there is no suggestion incidences of vertical violence occur in settings outside their study area, the findings of the current study appear to suggest that this is in fact the case. The implications of this phenomenon for student development can be significant. Participants in the study by Del Prato (2012) perceived that incivility was a major source of stress that negatively influenced their professional formation. This was due to the hindering effect on students' learning, self-esteem, self-efficacy, confidence and developing identity as a nurse. Thomas & Burk (2009) indicate that this kind of abusive behaviour must be eradicated as placements are stressful enough for students, there are potential physiological consequences causing ill-health if abuse leads to suppressed anger in students and the fact that patient care is compromised in hostile working environments. Decker and Schellenbarger (2012) propose several strategies to combat hostile working environments including enhanced communication between team members, effective student preparation and orientation to the clinical placement and promoting a collaborative environment. Participants in the current study wanted staff to appreciate that they were there to learn. These and other measures are highlighted as positively influencing retention of nursing students as well as their development. This is important when considered in the light of the study by Arries (2009). In this study the author explored the perceptions of nursing students' in relation to interactional justice. For the students interactional justice was determined through an evaluation of the fairness and quality of interpersonal treatment they received from the nurses compared to that witnessed with another person. Arries (2009) found that students perceive their encounters as interactionally unjust and this had a profound impact on their identity. Feeling belittled or dismissed by colleagues led students to burnout, disillusionment and a consideration to leave the programme. In the study by Del Prato (2012) the participants expressed disillusionment that some staff did not model the caring and respect for human dignity values of the nursing profession. This appears evident in other areas, as exemplified by the findings of the current study. When considered in light of earlier discussion regarding burnout it appears even more important to adequately prepare students to cope with the rigours of a clinical environment where the culture may be hostile.

A final issue that appeared important to student development is the experiences themed Recognition of student status. Two main issues were evident. It was important to the participants that clinical staff they were working with had realistic expectations of their knowledge and prior experience. The participants also believed it is important that clinical staff demonstrate an understanding and appreciation of the varying responsibilities of being a student. These findings support those previously reported by Melia (1984).

Expectations of knowledge and prior experience were related to the participants' year of study and prior clinical placement type. One participant strongly felt that nurses needed to recognise students were new to the area and did not know the policies and processes specific to that environment. In order to care for patients safely and effectively the participant stressed that the staff cannot assume that the student knows these important aspects. Whilst this was a first year participant the researcher suggests that this is relevant to a student at any stage of their programme that is exposed to a new area. Students in the study by Del Prato (2012) identified that some clinical staff had expectations about what they should know, striving for 'clinical perfection' as opposed to a recognition that they were learning to care and not yet a nurse. Del Prato (2012) concluded that this appeared to suggest the needs of the service or organisation were centred as opposed to student learning. Rather disappointingly this appears to suggest practice has not moved on from the findings of Fretwell where senior staff appeared more interested in a students' previous experience in order to determine the skills of the workforce as opposed to being interested in the progression of the students' development (Fretwell 1982). Another participant in the current study felt that her mentor had either not been prepared appropriately for mentoring students or had just not taken the time to establish the participants' prior experience and knowledge. This was specifically in relation to the first placement in the first year and further corroborates the findings of Del Prato (2012). The exclamation that the participant should '*know this by now'* infers that the mentor was possibly reluctant to demonstrate an aspect of practice for them to observe and learn. The assertion that they should be competent to complete whatever the task was indicated that this situation was more about fulfilling the needs of the service and not facilitating the development of the participant.

Some participants indicated that they would like their mentor to understand the pressures of being a student. Recognition that clinical placement learning was only 50% of their programme and that they also had academic work to undertake was seen as important. Communication and collaboration with the University was perceived to be vital to the appreciation of the multiple obligations participants were faced with. This corresponds to

findings in Levett-Jones and Lathlean's (2008) study into student 'belongingness'. They identified that there appeared to be limited development in the clinical learning environment when compared with theory-based nurse education. They concluded that the quality of the placement environment needs to be enhanced but that this faces several challenges. The challenges included the need for more collaboration between the University and practice organisations and the development of effective interpersonal relationships between all stakeholders. Each of these factors was identified by the participants as having the potential to enhance their professional development. It is concerning that 5 years on the current study has also identified issues with regard to communication and collaboration between academia and practice.

The issues discussed in this chapter indicate that concerns over compassionate care in practice and poor standards of supervision may influence the development of future practitioners. The conclusions and recommendations arising from this study are presented in chapter 9. It is clear that if nursing practice is to be enhanced addressing issues related to role modelling for students is vital.

6.2 Relation to position on programme

One of the objectives of this study was to explore whether choice of role model and associated factors change in relation to time spent on the programme. When considering the choice of role models there does appear to be some findings of note. Participants across all years identified clinical nursing staff as role models further supporting earlier assertions regarding emulation of individuals that closely align to nursing students' intended role (Illingworth 2006).

There are examples of academic tutors being considered as role models in all years but this was more prevalent in year 2 participants. The researcher suggests that this could be attributed to increasing expectations of knowledge regarding nursing practice in year 2 with the subsequent anxiety this instils in students. This is supported by Del Prato (2012) who found that caring experience increased year 2 students' awareness of the negative outcomes that can result from inadequate knowledge. Day et al (2005) conducted a study exploring changing student perceptions across an undergraduate programme, the findings of which provide evidence to support this. Within their study they found that during year 2 students began to integrate theory with practice in a more robust way. There was an increased awareness of required care and the knowledge that was needed to deliver this care. Also year 2 students started to develop an awareness of the life-long learning requirements for nursing

and an increased responsibility for their own learning (Day et al 2005). It would appear that the 'development dip' in year 2 reported by Ogier (1989, p12) may no longer be a concern. The current researcher suggests that these factors could explain the increased perception of academic staff as role models during the year 2 participants within the study.

Participants in all years felt that their peers had an influence on their development although there were more references to this in year 1. The researcher puts forward that this could be due to the additional support that students often require during the first year of University. This is certainly supported by various sources. In a review of the literature for the Higher Education Academy (HEA) regarding the first year experience Harvey, Drew & Smith (2006) identified that a key factor in ensuring progression for first year students was peer support. This was later reinforced by a research study conducted on behalf of the HEA by Yorke and Longden (2007). Their study into the first year experience revealed that meeting new people and making friends was an important consideration for new students that also aided their integration into the University. Subsequent research has also identified that peer support is a key component of first year students' integration and is a critical coping resource (Gibbons 2010, Fergy et al 2011).

The experiences regarding students' role modelling good practice to staff they were working with were confined to year 1 participants. This is congruent with the findings of Day et al (2005) and O'Brien, Mooney and Glacken (2008). These studies found that first year students perceived nursing to involve caring first and foremost despite this not necessarily being demonstrated by all practitioners. The study by Day et al (2005) also found that students became less idealistic and more realistic in their perceptions of nursing as they progressed through their programme. Exposure to various clinical areas increased their understanding of how organisational complexities can influence the delivery of person centred care. This did not however lead them to compromise their professional values although students in their final year were seen to 'bend' their beliefs to gain acceptance (Day et al 2005). This could however provide an explanation for the senior students in Melia's' study who displayed a tendency to move away from patients to more technical aspects of work (Melia 1987). These issues appear to support the findings of the current study in regard to first year students exemplifying care that is more person centred than their contemporaries later in the programme and that of their qualified colleagues.

In relation to service users there were again references in all years but the findings related to service user impact appear to be less prevalent in year 3 participants. This could potentially

be due to these students being more socialised into the clinical environment and therefore less acknowledging of the service user in their development. This is supported by the studies from Murphy et al (2009) and Ward et al (2012) who found a statistically significant decline in empathy for service users by nursing students who had more experience with practice compared to those who had less. Murphy et al (2009) specifically found a decline in caring values between first and third year students. These studies demonstrate that as students' progress and undertake more placements their relation to the service user becomes less empathically involved. Ward et al (2012) attribute this to expanded responsibility for planning patient care with increased technical competencies. The current researcher proposes this could result in a reduced perception of influence on their development.

The experiences in relation to discernment of role model traits were confined to year 3 participants. This is with the anomalous exception of one year 1 participant. This suggests that the ability to distinguish between good and bad traits, only emulating the former, increases with experience. It is thought that experience and understanding of the role of a nurse leads students to recognise aspects of their practice that require special attention. This then leads them to seek out corresponding traits in the individuals they collaborate with. Indeed this is supported by Donaldson and Carter (2005) who found that as students' progress they want more autonomy and responsibility for their practice leading to recognition of attributes that require enhancement.

The consideration of role model qualities by HE level expands what is already known. Within the 'clinical competence' category only year 2 and 3 participants describe role models 'going above and beyond' or 'the extra mile'. This is also true of describing an essential quality as being a 'knowledgeable practitioner'. The researcher posits that this could be due to first year students not having a sufficient understanding of what is expected of nurses in both care delivery and knowledge acquisition. Essentially they do not know what they do not know. They would therefore not be able to recognise when nurses had 'breached' (in a positive way) the requirements of care. The person centred care aspects appear consistent across all years which is particularly encouraging given the earlier reference to research that demonstrated a perceived decline in caring with more exposure to practice (Day et al 2005). With regard to 'teaching skills' the year 1 and 2 participants focused on role models sharing their experience and explaining the nature and purpose of certain interventions – a pedagogical approach to teaching and learning. By year 3 the desired approach is more androgogical, described as 'helping' adults to learn (Levett-Jones 2005). The participants referred to the need to feel supported in their development indicating a shift in status to becoming more autonomous

practitioners, responsible for their own learning. It is only in year 3 that the quality of 'encouraging independent learning' is highlighted. The findings of this study therefore indicate the need to alter learning and teaching approaches as students' progress through the programme. 'Personal qualities' are essentially consistent across all years although the year 3 participants appear to be much more explicative with qualities such as 'remaining calm under stress', 'appropriate emotional detachment', and 'ability to network'.

Overall the findings in relation to position on the programme indicate that there are distinct difference perceived between year 1, 2 and 3 participants. Recommendations in relation to these differences are presented in chapter 9.

CHAPTER 7 – STUDY LIMITATIONS / METHODOLOGICAL CONSIDERATIONS

Some of the methodological strengths of this study include the consideration of qualitative research evaluation criteria as outlined in section 4.5 (Lincoln and Guba 1985, Yardley 2000). Further rigour is added through the use of reflexivity to acknowledge how the researcher's preconceptions may have influenced the research. There are however some aspects that may have introduced limitations.

The idiographic nature of interpretive phenomenological analysis requires a small number of participants to enable in-depth analysis and exploration of each case (Smith, Flowers & Larkin 2009) limiting the generalisability of the findings (Cresswell 2009). The findings have been analysed and discussed to identify issues that could be transferable to other contexts (Smith, Flowers & Larkin 2009). The experiences of nursing students in other programmes, BME groups and from different geographic locations are not represented in this work, nor were male students' perceptions studied.

Whilst the findings did not indicate a difference in views and perceptions between young (18-25) and mature (25+) participants this may have been evident with a larger sample.

Data was collected from students at a time when they were in placement. This must be acknowledged as their views and perceptions could have been focused differently at a different time during their studies. Whilst this is highlighted as a potential limitation it is also acknowledged that participants were given ample opportunity to explore all issues from any aspect of their programme during the interviews in an attempt to ensure full investigation of the phenomenon.

Finally the nature of this study and the timeline imposed meant that it was not possible to explore the impact of role modelling and associated factors across the whole programme for one or more individuals. It may, for example, have been of particular interest to interview an individual at repeated intervals to explore the impact of repeat exposure to poor practice (if this was a feature of their experience). This is a potential limitation of this study and leads to a recommendation for future research.

CHAPTER 8 – DISSEMINATION / DIRECTION OF FUTURE WORK

This section outlines how the findings and conclusions from this study are to be disseminated to maximise impact. There are also recommendations for further research that have arisen from this study.

The degree of influence exerted by research is highly dependent on how well it is disseminated (Cohen, Manion & Morrison 2007). Preliminary findings from this study have already been published (Appendix 12). Additionally initial findings were presented at an international conference in July 2013 (appendix 13).

The findings and conclusions of this study will be disseminated at both a local and national level, with general and targeted audience of nurse educators. One of the primary aims of this study was to inform practice educator and mentor development in regard to the phenomenon under investigation.

Organisations responsible for the delivery of care to service users and education of the future workforce are currently developing plans to implement recommendations from recent reviews. The Local Education and Training Board have recently published their skills development strategy. One of their top five strategic priorities is compassionate care with a work stream related to education of current practice educators incorporating aspects of role modelling. Contact has been made with the lead for this work stream as the findings of this study are of particular relevance to this aspect of work.

Several areas for future work have been identified:

1. There were findings within this study that appeared to indicate the need for further study around peer support and whether students' different living arrangements may impact on the support available.

2. To explore the influence for students of working with nurses with burnout. Most research has examined study burnout in students as opposed to how exposure to nurses with burnout impacts on their professional development.

3. Further work needs to be undertaken to explore whether the views and perceptions of nursing students in relation to role modelling and their development are influenced by the nature of the mentor-student relationship. That is, the mentor role modelling practice whilst also assessing the students' competence.

4. As indicated in chapter 7 there is a potential to repeat this research but as a longitudinal study to provide information on how student development is influenced at various stages of their professional journey.

CHAPTER 9 – CONCLUSION AND RECOMMENDATIONS

The study explored nursing students' lived experience of role modelling aiming to gain information that would be useful in support of student learning in practice. Explicit objectives were:

a) To establish the role models that students are exposed to during their educational journey and how they change over time.
b) To identify which attributes or characteristics students look for in the role models they choose and the way in which this relates to their current position in their educational journey.
c) To explore students' understanding of professionalism and the perceived influence of their role models on the development of their attributes as professional practitioners.

Participants identified several individuals as role models:

- Peers were influential in areas such as personal support and sharing of prior experience.
- Participant experiences also demonstrated that students can potentially influence the behaviour of qualified staff.
- Service user reaction to care delivery by student and/or nurse has the potential to influence professional development.
- 'Balanced' exposure to poor and good practice experience was shown to be fruitful. Ensuring students have the opportunity to learn from their peers and other sources regarding the impact of poor care is important for development.
- Clinical nurses were found to influence participant development consistently across the programme. Therefore, it is important to identify and educate mentors who are ready, willing and able to role model these professional attributes.
- Senior staff within practice should lead by example.
- Participants felt managers must not be seen to tolerate poor standards of practice given that this is perceived to indicate acceptance.

Data analysis indicated that awareness of the influence of academic staff on student professional development needs to be enhanced. This is particularly relevant to students in year 1 and year 3 of the programme where the influence was not found to be as prevalent. It

appeared that participants were not aware of what they could learn from their tutors regarding professional qualities. University staff should endeavour to ensure students are cognisant of all learning opportunities and not just the explicit material that is covered within particular classes. It is also suggested that students should be educated in regard to a continuum of learning in relation to professional development. That is, that professional development does not stop at a predefined point but continues as society changes and expectations develop. Students must learn to be adaptable given the contextual nature of professionalism.

Findings from the study highlight that care and compassion in practice is equally important for colleagues and students as it is for service users. A compassionate work environment facilitates delivery of person centred care (Dewar 2013). The findings of the current study indicate that this also enhances student professional development. With particular reference to students this study evidenced the need to 'belong'. Feeling welcomed from the start of any new placement was important, as was integration into the workplace facilitated by fellow students and mentors. The participants indicated that a personal connection between mentor and student is influential in their development. Student anxiety is reduced if they feel the mentor 'gets to know them'. This includes aspects of self-sharing on the part of the mentor. As well as personal knowledge, taking the time to understand students' prior experience in order to plan their time in placement facilitates a positive experience. The assumption that students will 'know' just because they are in year 3 of the programme can be particularly disruptive to their development. An appreciation that the student has learning needs to be fulfilled is important. Effective collaboration between the University and practice is vital in ensuring an accurate understanding of the expectations of students at key times during their programme of study. Students feeling valued can be further enhanced by practitioners recognising their worth as 'outsiders' who can provide an honest appraisal of the placement environment. This can influence the environment to become more person centred thereby enhancing the service user experience.

It would appear that there is benefit to working with multiple staff when considering the role modelling of professional traits. The findings demonstrated that with facilitated reflection students can discern positive traits to emulate. The researcher postulates that a progressive step would be to expand upon the NMC stipulation that students work with their mentor for at least 40% of their placement time (NMC 2010). There should be a further stipulation that students must work with a variety of staff (perhaps coordinated by their mentor) to ensure they are exposed to different skills and behaviours.

The power of observational learning has been evidenced through this study. Participant experiences indicated that whilst mentors are demonstrating a particular skill they are also observing the implicit aspects of the interaction. It is vitally important therefore that nurses are confident in their abilities to exemplify holistic person centred practice. The findings also implied that there needs to be congruence between discussed professional behaviours and those demonstrated in practice. There may be a requirement for education and training in compassionate care for qualified nurses in order to manage any professional 'deficits'.

Recognition of burnout in staff is vital given the potential impact this can have on student development and perception of the profession. In order to tackle this, work needs to be undertaken at the clinical level to recognise the signs of burnout and implement preventative measures. In particular managers who recognise burnout in their staff should ensure they are not responsible for mentoring students. It is also important for those responsible for the education of students to discuss this phenomenon and facilitate the development of coping mechanisms.

As a result of this study the researcher has developed a model of role model influence on learned professional behaviour (table 6.1) with the intention of aiding clarity. The key element of this model is the conscious awareness of the role model regarding the behaviours they exhibit and the need for facilitated reflection with the student to ensure they have learnt.

Some of the findings of the study are similar to those previously reported and therefore serve to demonstrate that prior recommendations may not have been appropriately considered and integrated into contemporary practice. These findings are presented as unique within a modern context and indicate the need for serious consideration of how the learning environment and in particular the influence of key individuals involved in the education of student nurses can develop to enhance professional development in the future.

The standards of professionalism in nursing are currently being challenged following the publication of recent reviews (Francis report DH 2013a, Keogh review DH 2013b). There is a need to ensure the appropriate education of the future workforce and enhance care and compassion within the delivery of nursing care. This study was undertaken at a particularly important time in nursing when the conduct and behaviour of nurses is under close scrutiny.

Based on the findings of the study and related to the objectives, the following key recommendations are made:

- Clinical nurse mentors appear to be the primary role model for nursing students and should therefore exemplify safe and effective person centred practice as well as professional behaviours at all times.
- Work should be undertaken to increase awareness of the influence of academic staff as role models, with particular reference to professional attributes.
- Clinical nurse mentors could enhance peer influence by facilitating peer-to-peer interaction in practice.
- Development of a formal peer mentoring system in both academic and practice environments across all three years of a pre-registration programme could enhance development.
- Students should work with a number of clinical staff in order to ensure exposure to a variety of practice behaviours. This must however be accompanied by reflective activities to ensure appropriate learning.
- Clinical nurse mentors should consider the development of a 'personal' connection with the student as this appears to aid the mentor-student relationship and enhance learning and development.
- Students' previous knowledge and experience should be established so that their experience on placement can be tailored to meet their needs.
- Students should be valued as 'outsiders' to the placement and as such can offer a unique insight into the culture of the environment.
- All role models should understand the power of observational learning. This includes scheduled interactions with service users (in the context of placement) and any informal interactions with or without direct involvement of the student.

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APPENDIX 1

Research matrix

Author	Publication date	Type of publication	Research approach	Sample	Data Collection method	Specifically about Role modelling	English language	UK?	General Nursing	< 10 yrs	Development of Professionalism?	Concerns students?	Educational strategy?	General focus
Ettinger	1991	Lit review	n/a	n/a	n/a	Y	Y	N (USA)	Y	N	Y	Y	Y	Raising awareness of role modelling for clinical educators
Davies	1993	Research	Qualitative - grounded theory	First year nursing students	Interviews	Y	Y	N (Australia)	Y	N	N	Y	Y	The influence of role models on discovering embedded knowledge
Davies, White, Riley & Twinn	1996	Research	Qualitative	Nursing students (adult & MH)	Semi-structured interviews & case study	N	Y	Y	Y (& MH)	N	N	Y	Y	How nurse teachers can increase effectiveness in teaching
Fitzpatrick, While & Roberts	1996	Research	Qualitative	Nursing students	Semi-structure interviews	N	Y	Y	Y	N	N	Y	N	Key influences on professional socialisation
Pfeil	1997	Research	Qualitative - grounded theory	Child nursing students	Questionnaires	Y	Y	Y	N (child)	N	N	Y	N	Students perceptions of role models
Wright, Wong & Newill	1997	Research	Quantitative cross-sectional study	Medical students	Questionnaires	Y	Y	N (USA)	N (doctors)	N	N	Y	N	Relationship between role model exposure and choice of clinical field for residency training
Pang & Wong	1998	Research	Qualitative - phenomenology	Nursing students	Interviews	Y	Y	N (Hong Kong)	Y	N	Y	Y	Y	Students developing understanding of caring as influenced by model emulation
Charters	2000	Lit review	n/a	n/a	n/a	Y	Y	Y	Y	N	N	Y	Y	Role modelling as a teaching method
Atack et al	2000	Research	Qualitative - phenomenology	Nursing students & nurses	Focused interviews	N	Y	N (Canada)	Y	N	N	Y	N	impact on staff-student relationships on learning
Chow & Suen	2001	Research	Qualitative	Nursing students	Semi-structured interviews	Y	Y	N (Hong Kong)	Y	N	N	Y	Y	Views of students on role and responsibility of mentor
Ottewill	2001	Lit review	n/a	n/a	n/a	Y	Y	Y	N (business)	N	Y	Y	Y	Nature of the tutor's role in undergraduate business education
Maudsley	2001	Commentary	n/a	n/a	n/a	Y	Y	N (USA)	N (doctors)	N	N	Y	Y	Role models & the learning environment
Wright & Carrese	2002	Research	Qualitative	Physician role models	in-depth interviews	Y	Y	N (Canada)	N (doctors)	N	N	Y	Y	Insights from physician role models
Paice, Heard & Moss	2002	Lit review	n/a	n/a	n/a	Y	Y	Y	N (doctors)	N	Y	Y	Y	Role model influence on professional behaviour development
Henderson	2002	Research	Qualitative - grounded theory	Qualified nurses	In-depth interviews & observations	N	Y	N (Australia)	Y	N	N	Y	N	Factors impacting on how students transfer theory to practice
Bluff	2003	Research	Qualitative - grounded theory	Midwifery students & midwives	Semi-structured interviews	Y	Y	Y	N (midwifery)	Y	N	Y	Y	How student midwives learn about the role from their role models

Author	Publication date	Type of publication	Research approach	Sample	Data Collection method	Specifically about Role modelling	English language	UK?	General Nursing	< 10 yrs	Development of Professionalism?	Concerns students?	Educational strategy?	General focus
Kenny, Mann & MacLeod	2003	Lit review	n/a	n/a	n/a	Y	Y	N (Canada)	N (doctors)	Y	Y	Y	Y	Role modelling as an educational strategy for professionalism
Lewis & Robinson	2003	Research	Quantitative	Qualified radiographers	Structured interviews	Y	Y	N (Australia)	N (radiography)	Y	N	Y	Y	Increase information regarding role models in radiography
Rungapadiachy, Madill & Gough	2004	Research	Qualitative - grounded theory	Mental health nursing students	Semi-structured interviews	N	Y	Y	N (mental health)	Y	N	Y	N	Mental health students perception of the role of a MHN during transition to registered status
Pearcey & Elliott	2004	Research	Qualitative - phenomenology	Nursing students	Focus groups	N	Y	Y	Y	Y	N	Y	N	Student perceptions of clinical nursing & intent to follow nursing career
Donaldson & Carter	2005	Research	Qualitative - grounded theory	Nursing students	Focus groups & individual interviews	Y	Y	Y	Y	Y	N	Y	Y	Value of role modelling from perceptions of students
Murray & Main	2005	Lit review	n/a	n/a	n/a	Y	Y	Y	Y	Y	N	Y	Y	Role modelling as a teaching method
Illingworth	2006	Research	Qualitative - phenomenology	Mental health nursing students	Focus groups	Y	Y	Y	N (mental health)	Y	N	Y	N	Students perceptions of role models
Andrews et al	2006	Research	Qualitative	Nursing students & ex-students	Focus groups & telephone interviews	N	Y	Y	Y	Y	N	Y	N	Perceptions of students on clinical placements
Miller	2006	Research	Qualitative - phenomenology	Qualified nurses	Semi-structured interviews	N	Y	N (USA)	Y	Y	N	N	N	Strategies to sustain 'good work' in clinical nursing practice
Lunenberg, Korthagen & Swennen	2007	Research	Qualitative - case study	Teacher educators	Case study	Y	Y	N (Netherlands)	N (teachers)	Y	N	Y	Y	Role model impact on views of future teachers
Ranse & Grealish	2007	Research	Qualitative	Nursing students	Focus groups	N	Y	N (Australia)	Y	Y	N	Y	N	Students experience of learning in a dedicated education unit
Jowett & McMullan	2007	Research	Mixed - qual & quan	Practice educators, mentors & students	Focus groups & questionnaires	N	Y	Y	Y	Y	N	Y	N	Evaluate effectiveness of practice educator role
Filstad et al	2007	Lit review	n/a	n/a	n/a	Y	Y	N (Norway)	N (Police)	Y	N	N	N	Newcomers choice of role models & their influence
Kilcullen	2007	Research	Qualitative - descriptive	Nursing students	Focus groups	N	Y	Y	Y	Y	N	Y	N	Impact of mentorship on clinical learning
Armstrong	2008	Lit review	n/a	n/a	n/a	Y	Y	Y	N (midwifery)	Y	N	Y	Y	Advising midwives about mentoring role
Cruess, Cruess & Steinart	2008	Lit review	n/a	n/a	n/a	Y	Y	N (Canada)	N (doctors)	Y	Y	Y	Y	Raising awareness of impact of role models in the medical profession

Author	Publication date	Type of publication	Research approach	Sample	Data Collection method	Specifically about Role modelling	English language	UK?	General Nursing	< 10 yrs	Development of Professionalism?	Concerns students?	Educational strategy?	General focus
Perry	2008	Research	Qualitative - interpretive phenomenology	Qualified nurses	Interviews & observations	Y	Y	N (Canada)	Y	Y	N	Y	Y	How exemplary nurses can role model in practice
Roberts	2008	Research	Qualitative - interpretive ethnography	Nursing students	Direct participant observation	Y	Y	Y	Y	Y	N	Y	N	Whether nursing students learn from each other
Price & Price	2009	Lit review	n/a	n/a	n/a	Y	Y	Y	Y	Y	N	Y	Y	Techniques to make role modelling more effective
Heshmati-Nabavi & Vanaki	2010	Research	Qualitative - grounded theory	Nursing students & clinical educators	Semi-structured interviews	N	Y	N (Iran)	Y	Y	N	Y	N	Perceptions of clinical educator characteristics
O'Driscoll, Allan & Smith	2010	Research	Qualitative - ethnography	Qualified nurses	Interviews & focus groups	N	Y	Y	Y	Y	N	Y	N	Link between nurse leadership & student learning
Hayajneh	2011	Research	Qualitative - critical incident technique	Senior nursing students	Critical incident technique	Y	Y	N (Jordan)	Y	Y	N	Y	N	Role model behaviours that enhance student learning
Klunklin et al	2011	Research	Qualitative - descriptive	Nursing faculty members	Questionnaires	Y	Y	N (Thailand)	Y	Y	N	Y	Y	Role model behaviours that enhance student learning
Curry, Cortland & Graham	2011	Research	Qualitative - modified grounded theory	Medical students	Documented observations from students	Y	Y	N (USA)	N (doctors)	Y	Y	Y	Y	Impact of observed expemplary behaviours
Warhurst	2011	Research	Qualitative - grounded theory	MBA students	Semi-structured interviews	Y	Y	Y	N (business)	Y	N	Y	N	Role modelling influence in manager development
Del Prato	2012	Research	Qualitative - phenomenology	Nursing students	In-depth interviews	N	Y	N (USA)	Y	Y	Y	Y	N	How social interactions impcat on students professional development

Author	Publication date	Type of publication	Research approach	Sample	Data Collection method	Specifically about Role modelling	English language	UK?	General Nursing	< 10 yrs	Development of Professionalism?	Concerns students?	Educational strategy?	General focus
Orton	1981	Research	Qualitative	Ward sisters (and nursing students)	Interviews	N	Y	Y	Y	N	Not directly	Y	N	Role of the ward sister in relation to student nurse learning
Ogier	1981	Book	n/a	n/a	n/a	N	Y	Y	Y	N	N	Y	N	Working & learning: the learning environment in clinical nursing
Fretwell	1982	Research	Qualitative	Ward sisters (and nursing students)	Interviews	N	Y	Y	Y	N	Not directly	Y	N	Ward teaching & learning and the impact of the ward sister
Ogier	1982	Research	Qualitative	Ward sisters	Interviews	N	Y	Y	Y	N	N	Y	N	Leadership style of the ward sister and interaction with nurse learners in hospitals
Melia	1984	Research	Qualitative	Nursing students	Interviews	N	Y	Y	Y	N	Not directly	Y	N	Student nurses construction of occupational socialisation
Melia	1987	Book	n/a	n/a	n/a	N	Y	Y	Y	N	N	Y	N	Learning and working: the occupational socialisation of nurses

APPENDIX 2

Participant Information Sheet

An exploration of the lived experience of role modelling and its impact on the development of adult nursing students as professional practitioners.

You are being invited to take part in a research study. Before you decide to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please take time to decide whether or not you wish to take part. Thank you for reading this.

The purpose of this study is to explore the lived experience of role modelling and its impact on the development of adult nursing students as professional practitioners.

You have been chosen to take part because you are an adult nursing student, either pre or post registration.

It is up to you to decide whether or not to take part. If you do agree you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. You may decide not to take part in the study or to withdraw at any time.

If you decide to take part you will be invited to attend an interview on the University campus. The interview will last for approximately 1 hour. You will be asked about your experiences in relation to role modelling and also views on your development as a professional practitioner.

The interview will be audio tape recorded (and later transcribed verbatim) and additional notes taken to enable me to later analyse our discussion. At all times your identity will remain confidential. This reflects the standards of confidentiality that you are familiar with from the Nursing and Midwifery Council.

To verify the interview data I will send you a copy of the interview transcript. You will be able to comment on this and send it back to me indicating if you believe this to be an accurate representation of your experiences.

All information collected during the study will be kept strictly confidential. The tape recording of the interview will be locked in a drawer in a locked office and the transcripts (written versions of what was said) will be kept on a password protected computer. You will not be identified, other than as a letter and number (e.g. A1, B5) on the transcript and you will not be identified in any educational material, publications or conference papers that may be written following the study.

The study has been approved by the Faculty of Education's Research Ethics Committee.

Should you require any further information before deciding whether to take part, or not please feel free to contact Ian Felstead either by email on: ian.felstead@canterbury.ac.uk or by telephone on: 01227 782776.
Thank you for taking the time to read this information sheet.

APPENDIX 3

CONSENT FORM

Title of Project: An exploration of the lived experience of role modelling and its impact on the development of adult nursing students as professional practitioners.

Name of Researcher: Ian Felstead

1. I confirm that I have read and understand the participant information sheet for the above study and have had the opportunity to ask questions.

   YES ☐ **NO** ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.

   YES ☐ **NO** ☐

3. I understand that any data I have provided for this study may be published in an anonymised form and that my identity will remain confidential.

   YES ☐ **NO** ☐

4. I agree to my interview being audio recorded and transcribed.

   YES ☐ **NO** ☐

5. I agree to take part in the above study.

   YES ☐ **NO** ☐

Name of participant _____

Signature _____

Date _____

Copy for Researcher & Participant

APPENDIX 4
Interview Schedule

Welcome and thank you for agreeing to participate in this interview. There are no right or wrong answers and this interview is to gain your views and perceptions on the topic under review. I want to hear about your experiences.

You have the right to withdraw or stop the interview at any time. All information shared during this interview is confidential and your anonymity will be maintained at all times during and after the research.

The interview should take no longer than an hour and with your permission I would like to audio record the interview for later transcription.

Could I ask you to read and sign this consent form please?

Start tape recording

I am interested in nursing students and what they use to develop as professional practitioners through their training and into registration.

So I would like to ask you to tell me about what encouraged you into the profession? Tell me about your experiences. How have you become the person/nurse you are today?

Exploratory probes:

Probe	**Discussed**
Profession – understanding in context of nursing	
Professional practice – understanding in context of nursing	
Professional practice – potential influencers	
Role modelling – understanding of concept	
Role models – who?	
Role model characteristics – positive/negative	
Role modelling experience – examples?	

Would it be possible to contact you if I require clarification of any points during transcription of this interview? I will also send you a copy of the interview transcript for you to verify.

Thank you for your time.

APPENDIX 5

Participant 1a interview summary

You have always wanted to be a nurse since childhood and this stems from the fact that your father is disabled and you have been exposed to hospital and medical care through him and also personal health issues (familial and personal influence).

You believe that a 'good' nurse is one who is caring and takes their time to communicate well with the patient, ensuring they know who they are and giving them time to talk. Someone who looks after the individual needs of that particular patient and is conscious of their emotional as well as physical needs (person centred practice). For you, communication is a key element of good practice and caring for the patient not the documentation is vital (prioritisation within role).

You have experienced poor practice where you have learnt the importance of acknowledging a patient straight away and providing information as soon as possible (person centred care).

You feel that studying collaborative practice and then seeing collaborative care in placement has significantly impacted on your knowledge of the profession (theory-practice link).

You have had negative exposure through a nurse who was very opinionated in her view of nurse training (not in hospital in year 1 as cannot do anything) and also patients should listen to her as she knows best (expert professional, non-collaborative working). This has been evidenced to you by patient reaction to this nurse and not wanting her to care for them (service user influence through reaction to action). Also being involved in a discussion with the ward manager you have learnt that skills development (i.e. communication) is ongoing and there is an expectation that professional development is a dynamic entity that continues following qualification (ongoing professional development). You also believe that you should be able to rely on your mentor to undertake safe and effective practice (expectations of support).

You recognise that you have confidence issues (self-awareness) and having a mentor who was of a similar personality helped you to deal with some of your communication issues (e.g. how to talk with various client groups) (mentoring support aided by well-matched mentor/student). You feel that having a relationship on a more 'personal' level (in terms of knowing a little about each other) has aided your development, reduced your anxiety in new environments and influenced how you have been able to learn (relationship building between mentor/student). This helped with the approachability that you feel is vital.

You recognise that differing environments (acute/community for example) can impact on how it is possible for you to build a relationship with your mentor (organisational/environmental influences). You perceive that time to build that relationship and learn more about your patients is vital for your development. Without this you have felt a burden and 'in the way' (need to be valued as a student and part of the team).

You understand that to be professional you need to maintain a distinction between your professional and social life/persona. Not using your mobile phone or discussing your personal life in earshot of patients is an important aspect of this. This is particularly relevant in relation to the client group – how long they have been in hospital, what they would like to be doing etc. (differing levels of professionalism dependent on

circumstances). Some of this you have learnt from the reactions of patients to comments you have heard (service user influence – reaction to action).

Role modelling for you is being able to look up to someone and see them as where you want to be and how to get there (future development – leading to qualification). You also believe that a role model should recognise that they need to communicate in ways that a student understands and be mindful of the fact that they are going to be watched/copied – do the job correctly and not cut corners (conscious role modelling). Someone who explains things to you, particularly how they got to where they are, are a role model for you. Seeing the interaction between the nurse and patients helps you decide if they are a role model or not (service user influence of role model identification). You also believe that in your first year you have been observing people you have worked with and are able to distinguish traits that you like and want to emulate but can identify those that you wouldn't (selective role modelling).

Your peers have influenced you through support with academic work and discussion of various experiences.

For you, your experience has very much been around knowing that you are on a journey but not being sure of the direction of travel. Your development has been influenced by those who have guided you in the right direction.

APPENDIX 6

Participant 1a interview transcript
(Please cross-reference to Figure 4.1 Steps in the analytical process for information on the notation of exploratory comments and development of emergent themes)

Interview: 1a
Sample group: Year 1
Gender: Female
Age: 21

I = Interviewer, R = Respondent, BLUE = Descriptive notes, GREEN = Linguistic notes, RED = Conceptual notes

Emergent themes		Transcript	Exploratory comments
	I	I am interested in nursing students and what they use to help them develop as professional practitioners as they progress through their training and into registration. So, just as an opening question could you tell me a little bit about what brought you into the nursing profession in the first place.	
Perception of nurses (raw data) Perception of nursing (interpretation)	R	Ever since I was 4 years old um I've always wanted to be a nurse, when I was 4 I always used to ask if I could have a little nurses outfit and stethoscope for my birthday um…that's all because my dad's been disabled since I can remember really and all the way through my life he's got gradually worse um…and…so I've been in and out of hospital with him and seen just the impact that the nurses have on him and his wellbeing, because without them he wouldn't be here today. So that's mainly the reason why, but then I've had some experiences of being in hospital myself and talking to nurses and hearing the passion of the good nurse and how they want to try and shape health care and I've been in some places with poor nurses as well and it's made me want to be a good nurse and be like the good nurses and not like the other nurses.	First image of a nurse Idealised image of nurse from young age – stereotypical? Family ill-health & nursing Impact signifies strong association Personal ill-health & nursing What makes a 'good' nurse? Passion - emotive Is a nurse's role wider than individual patient care?
	I	OK, so you've used those words good nurse and poor nurse, if we can just drill down a little bit more into that. What makes you say that they are a good nurse? What is it about that you have seen?	
Perception of nurses (raw data)	R	A good nurse from my perspective is somebody who like…she is caring or he's caring as well, somebody who actually gives a little bit of time to be considerate to their patients instead of just going up and filling out a form or you know,	Description of a good nurse Why make the distinction between he / she – gender stereotyping?

Communication as a skill (raw data) Person centred practice (raw data) Perception of nursing (raw data)		asking them questions and just leaving them. They'll have a little bit of a conversation with them, even introducing themselves so they know their name instead of just thinking nurse, somebody who if you need something they are there to ask instead of just saying I'm too busy, you'll have to ask me in an hours time. Um…just somebody who is therefore the patients and not just the paperwork.	Influenced by me? Communication with patients What are the wider implications of why patients have to wait? What is the importance of paperwork – keeps being mentioned
	I	Right, OK	
	R	That's what I think is a good nurse, I know the paperwork is important as well but at the end of the day it is the patients who are in hospital not the paperwork.	
	I	So, can you think of a specific example, is there anything that sticks out in your mind about those experiences that you've had where there's somebody you've thought was a good nurse?	
Familial influence (raw data) Role conflict – personal vs. professional (interpretation) Familial influence (raw data) Person centred practice (raw data)	R	Um…for my dad, quite recently actually, my dad went into hospital last April for an angioplasty and on his admission he was left waiting for 3 hours, he had not seen anybody, he hadn't seen a nurse, he'd not been introduced to anybody, he didn't have a clue what was going on and was really really nervous. So I went up to the nurses station and said actually we've been here for quite a long period of time now, nobody has even said hello, welcome to the ward or anything, my dad's getting really really nervous about the whole procedure and the nurse was like 'oh we are too busy, we'll get around to seeing him eventually'. Um…we'd waited for another hour and still nobody had been so I went to make a complaint about it. Well after his operation he got moved to a different ward and as soon as he was on to the ward, he was given a cup of tea, they were really welcoming, making sure he was comfortable, a nurse was with him every 10-15 minutes to make sure he wasn't in any pain and that his procedure area wasn't bleeding or anything like that and she would have a conversation with him, make sure that the care he was receiving was the best for him and not the patient halfway down the ward.	Poor experience with father Emphasise importance – 'really, really' If she had been working here would her reaction have been different? Repeat again Good experience with father Individuality in care provision?
	I	OK, so there was a distinct difference there between the pre and post care. What do you feel you learnt from that experience? What did you take away from that?	
Person centred practice (raw data) Service user influence (interpretation) Communication as a skill	R	Um…initially um… like, his...before his op I learnt that when you leave somebody without them actually knowing what's going on the more wound up they are and nervous they are going to get about the whole procedure so when they get brought on to the ward you should go and introduce yourself, just say welcome to the ward, explain what is going to go on, say that we are slightly	Hesitancy – time to reflect? Link to patient experience Good communication

(raw data) Role conflict (interpretation)		busy at the moment but we will get back to you in time, is there anything I can do for you right now, just make them, leave them comfortable, just reassure them, if they do have any worries about the procedure just explain what is going on instead of just leaving them sat there completely oblivious to what's happening.	Does she make no attempt to justify the situation because it was personal? Possible conflict between personal & professional?
	I	OK, so can you think of any other of those pre-programme experiences that were particularly good, where you would describe somebody as being a good nurse?	
Communication as a skill (raw data) Personal experience (raw data) Nurse qualities (raw data) Perception of nursing (interpretation)	R	I think communication is one of the key factors of nursing, in fact communication, you can't be a good nurse where you don't communicate well, in my eyes anyway. Um…example for me was when I dislocated, because I suffer from hyper-mobility syndrome, I dislocated my knee cap so I went to hospital with my knee cap on the other side of my leg, as you do, because I couldn't pop it back in a nurse was making, like she was really nice, she could see I was in tears because I was in absolute agony and she explained that she can't pop it back in, but she was really reassuring and did keep me calm and she was there just to talk to me because I was in a huge state. Um…she was really friendly, yeah she did say that she had like paperwork and stuff to do but she thought that it was more important that her patient was comfortable and calm and not screaming the whole hospital down and the paperwork she said she would happily go back to the paperwork after she knows that I'm OK instead of leaving me there in tears because I was scared, it had been like an hour and a half and my knee cap was still the other side of my leg. So yeah, she was really nice.	Communication is key factor Is communication a clinical skill or something required to do skills? Personal health experience Nurse – good interpersonal skills Paperwork again/prioritisation Nurse – holistic recognition What is nice?
	I	OK, so there's some clear experiences from before you started the programme and you said that every since you have been 4 years old you wanted to be a nurse and those experiences encouraged you to go forwards. So you've been on the programme nearly a year. So you have had some experience of being both within the University and in placement. Do you feel as though you have developed as a nurse from where you started to where you are now?	
Personal journey (raw data)	R	I do yes. I've had a lot of ups and downs this year um…but I do feel like I've developed a lot as a nurse.	Possible 'traumatic' journey – still developed
	I	OK, can you explain how, what areas, why do you say you've developed?	
Perception of nurses (raw data) Personal experience (raw data)	R	When I first started I had a set idea of what a nurse is and the role of the nurse um…but actually joining the course it's shaped my ideas differently, it's just like um…because before I had the experience of being in hospital myself with my dad in hospital but I had never actually done the job myself so I only got to see it from an outside perspective so I didn't get to see the nurses running around,	Do all students enter with a set idea of what nurses are & their role? Development of perception of a nurse through experience (practical, not observational)

Personal experience (raw data) Person centred practice (raw data)		doing the paper work, seeing the patients and then watching casualty on TV you get to see a completely different view as well so my thoughts were shaped around that. Um… but actually joining the course you get to see the reality of it and just how busy it is and that it's not all paperwork, you've got to balance the time between patients and paperwork and things like that as well. And just the links between nurses and radiographers and things like that, before I knew it existed but I didn't actually have any idea how it all worked um… but now I've got a bit of an idea of how everything is important. Without a radiographer you can't give the best nursing care, without a doctor you can't give the best nursing care because you need to work as a team in order to treat the patient as a whole.	Difference in perception depending on role How can we influence the 'outside perspective' from the 'inner sanctum'? Collaborative practice
	I	OK, so there are some things that you feel about what has developed and the knowledge of what nursing is and how the profession works. Can you think of what has contributed to that, what has helped you get to that level of development that you are at now?	
Peer influence (raw data) Sources of learning (raw data)	R	Um, when in university studying collaborative practice, I get to talk to students who are radiographers, midwives, so we get to talk about our views and what we thought the professions were and we've then been on placement, they can come back and say, actually this is not what we thought it was at all, this is actually what's happening, so talking to other students is really helpful. But actually going on placement and seeing it and dealing with it every day is, yeah, that's what has given me, has shaped everything, being there. On my first ward I was on, there were doctors there all the time, consultant specialists, radiographers, nurses um…so I got to see it as like the big picture, got to see how it all happened.	Theory / academic – practice link Is there a greater influence from other students as opposed to lecturers? Something about reality?
	I	So, thinking about some of the people you've worked with then. Is there anybody that sticks out in your mind that you feel has had a particular influence on you?	
Memorable experiences (raw data)	R	I've had one particular person who has stood out in a bad way and one who has stood out in a really good way.	'Stood out' – good and bad
	I	OK, can you tell me about the bad way first?	
Valuing students (interpretation) Relationship with mentor (raw data)	R	Um…the bad way was my mentor in my first placement. She, for me wouldn't spend any time with a student, she didn't see the point of us training as, in hospitals in our first year because we can't do anything (*stress on the 'do'*) so that affected like our relationship. But then her attitude towards patients as well, they should listen to her and do exactly what she said, when she says, they don't have any input into their care and instead of having two way communication it	Attitude of nurses to students? Usefulness of students Emphasise 'do' for functionality What is or should be the relationship between students & nurses/mentors? Person centred practice

Person centred practice (raw data) Service user experience (raw data) Recognition of student status (raw data)		was all one sided, it was 'I'm telling you what to do, I'm telling you this', instead of asking questions and things like that and the patients didn't get on with her. Quite a lot of them asked if they could see somebody else instead and I had one patient who um…we was working together that day and he needed um some suppositories because he was severely constipated and he started crying and begged for that nurse not to give them to him because of exactly, just because of what she is like and begged me to do them instead. Um…which I agreed to but I had to ask permission first and she couldn't understand why the patients were getting so upset um…but she's the type of nurse I do not want to be.	Patient choice What does this say about the choices we give to patients, or not? Recognition of limitations as student / authority
	I	So was there anything else in that, you said that you spoke to her after the patient asked you to give the suppositories and she didn't understand why the patient was so upset. Was there anything else within that conversation? What else happened within that situation?	
Leadership/management influence (raw data) Ongoing professional development (interpretation) Recognition of student status (raw data) Relationship with mentor (raw data)	R	Um…this happened a few times, quite a few of the patients would ask if they could see somebody else or they would grab somebody else as they were walking past instead of her and um…she actually had, the ward manager had a discussion with her and me saying that it's not that, you need to sort of improve your communication skills because she's been qualified for four years so she got told that she should have learnt to communicate with patients and it was explained to her that she can't just be telling people what they've got to do. In some situations that's OK but it's got to be a two sided conversation most of the time. Um…and I got asked um…what I felt about the whole situation and how I felt being put on the spot like that, asking if I could do something instead of a trained nurse to which I said, in some situations yeah that's fine for like giving suppositories I can give suppositories that's fine but if somebody's asking me to do something which is out of my comfort zone of something that I'm not actually capable of doing then that's a whole different situation and I need to be able to rely on my mentor to be able to do it instead and I need to feel safe that she's going to do it but also feel that my patients are going to feel happy with her instead of me. And yeah, she said that she would go away and think about everything that had been said but I didn't see any change in her.	Leadership role Continuing development post registration What does this say about the vital aspects of initial nurse education and then continuing development? Surely the fundamental skills must be learnt before registration? Should circumstances of poor practice be used to educate students? Education / recognition of students' role & responsibilities Relation to mentor Is there a tension between relying on the mentor whilst they make a judgement about the students' practice?
	I	Can you think at all about why she may have been like that, why the communication was at that level 4 years after qualifying?	
Justification for poor practice (interpretation)	R	From talking to her she said that when I'm busy it's just easier to tell them what to do instead of asking them or standing there for 20 minutes and getting their	Justification for poor communication

		answer out of them, because some of them had difficulty in getting their point across and they would just talk and talk and talk. Um…and she was like yeah, it's just quicker doing that way and I said well that's not best for the patient.	
	I	So what did that tell you about her as a nurse?	
Nurse qualities(raw data) Communication as a skill (raw data)	R	That to me isn't a good nurse; she was really good at the whole clinical side of it but the communicating with patients' side of it she lacked in. It taught me not to be like her yeah, I learnt from that, it made me realise just how important communication is, it's not just being able to do the skills, you need to be able to communicate with your patients as well.	Some good, some poor in same nurse Is communication perceived as a sole, separate entity and not classed as a clinical skill?
	I	OK, is there anything else about that, which made you think I don't want to be like that?	
Service user influence (raw data) Relationship with service user (interpretation)	R	The reactions that I had off the patients themselves made me not want to be like her. The gentleman who cried, it just made me realise that actually he's obviously really upset by the way she is with him. Then hearing the way she talked to him, it clicked in my head that actually I'd be upset if I was in that situation as well, I'd want somebody else to approach and say, can you just do this for me or if I was in pain ask for relief, yeah, I'd want to be approachable, not somebody who I would want to run away from.	Patient influence through reaction How much do 'we' listen to patients and act on that feedback? Personal recognition with patients
	I	Do you feel as though there is anything positive that you took from working with that particular individual?	
Teaching through reflection (interpretation)	R	Um…I've learnt what not to be rather than how to be a good nurse. I learnt what I shouldn't be like so I think that's made me realise the importance of communication skills and um…yeah being approachable but it didn't teach me how to communicate with the patients and how to be approachable. It learnt me what not to be but not what to be if that makes sense.	Do we facilitate reflection with all students enough? Checking clarity – seeking affirmation?
	I	Yes, OK. So you said that there was one particular individual who has had quite a positive influence on you. Can you tell me a bit about that?	
Relationship with mentor (raw data) Theory-practice continuum (interpretation) Theory-practice continuum	R	That was my mentor, but my mentor just before she left on the placement that I am on now. Um…she…I'll tell you a little bit about her…she suffers from confidence issues and she's a really , really quiet person and she reminds me of me because I suffer from confidence issues as well, especially in real work situations. She taught me ways in which to cope with certain situations. So if we have an upset patient um…because we always get told to detach ourselves and she finds that trying to detach herself makes it a lot worse for her because she just turns cold for her and then there's no um…relationship with the patients, so she said, don't detach yourself but put yourself in a situation of you're just	Feels explanation is warranted Personal connection to mentor through personality trait Importance of 'matching' mentor with student? Detach from patient emotionally Hesitancy – searching for term? Advised differently to what told to do

(interpretation) Learning through observation (raw data) Relationship with service user (raw data) Learning through observation (raw data)		talking to a friend because it's easier to comfort a friend than it is a random stranger that you've never met, if you just talk to them the way that you would a friend um…then you will be more comfortable in yourself and they will see that and be more comfortable talking to you. Because I struggled, we had a patient whose daughter got rushed into hospital as well, she obviously couldn't go because she was poorly and she got really upset and I got completely lost. I was trying to like comfort her and talk to her but I didn't know what to say, I didn't know what to do, and my mentor took me aside and said if I was doing that this is what I'd do, this is how I'd be and then they can see that, and she actually showed me so she went and sat talking to her, put her arm around her, just stroked her back and tried to calm her down, talk to her as if she is a friend and I've tried that since and that worked for me. From the communication side she is, she seems to know how to communicate really well in all the different situations. So how to talk to a patient whose got dementia, um…so instead of, because I've seen some other people who start to get, like you can hear the frustration in their voice when and, and she said if they hear that they are going to get frustrated and they're just going to keep doing what you are not wanting them to do, so just try talking to them in a calm voice and just try to calm them down because usually someone with dementia is going to get themselves all agitated because you're not understanding their point, they are wanting something and it's easier to get frustrated than it is to stay calm and she showed me how, just watching her communicating with all the different people has taught me arrange of ways of communication from people with learning disabilities to um…people with dementia and people who are hard of hearing, so using hand gestures and things like that. On the communication side she is amazing to watch, she really is.	How do students deal with differences between what taught and what seen? Who do they listen to and what influences that? Is feeling 'lost' in new situations a common feeling? Support/advice of mentor – set up role modelling and then observe What is the boundary? Should we treat our patients as 'friends'? Variety of communication styles Observation of communication
	I	You said that was a particular connection because she reminds you of you in terms of not being as confident in communicating. When you first started, how did that relationship develop, how did you get to that stage of knowing that about her and recognising that?	
Relationship with mentor (interpretation)	R	On my first day, because on my first week we got alternate shifts from some reason, so on my first day she started on a late whilst I was on an early so there was a little bit of an overlap. Somebody asked me who my mentor was so I said and she told me that she was shy and not to be in her face straight away because that would scare her a little bit. So because I knew that, because I had been told that, I approached her and just sort of said, Hi, I'm your student, introduced myself, just said I'd be with you for 13 weeks and then told her a little bit about	Prior knowledge of mentor Relationship between mentor/student? Matching of student/mentor in terms

Relationship with mentor (raw data)		me and then she told me a little bit about her, how long she had been in the job and we just walked around a little bit together and we just talked as we were doing different jobs just to get to know each other a little bit better.	of similar traits or qualities? Getting to know each other
	I	Is that a common experience for you in terms of sharing information about each other? How do you view that getting know each other on a personal but professional level?	
Student anxiety (raw data) Student anxiety (raw data) Valuing students (interpretation) Relationship with mentor (interpretation)	R	That helped me, made me even more comfortable from where I am on the ward, because I was a bit nervous when I first started, I didn't know anybody, it was all a new atmosphere to me, I didn't know anything about rehabilitation nursing, so it made me a little bit more comfortable in my surroundings. On my last placement my mentor couldn't even remember my name half the time because she didn't want to talk, she would send me off with anybody else that she possibly could. So there was no relationship there, I couldn't feel that I could approach her but like the mentor in the placement that I'm in now because we talked a little bit and I knew a little bit about her and her job there I felt like I could approach her if I had a problem, or I could ask her questions. It just helped relax me a little bit yeah.	Comfort Is there a true realisation of how difficult it is for students in a new environment? Link with workplace culture & socialisation – staff well socialised – infiltrator & reaction? Direct contrast with last mentor Do students often feel undervalued? Do mentors realise students' value? Importance of approachability Relationship mentor-student?
	I	The distinction that you have seen between your two mentors, the mentor on your first placement which wasn't such a good experience and the mentor you recently had on your current placement that has been a good experience for you, do you think the distinction is a personal fact about the way that they work or are their other influences that might have impacted on how they've worked and presented themselves and work with you within that particular environment.	
Justification for poor practice (raw data) Preparation of students (interpretation)	R	I think it's a little bit of both. I think it's something to do with their personality as well but it was completely two different settings, one was in an acute setting and one was in a community hospital. So one was fast paced all the time and one was not so fast paced it was just steady so you do have time to talk as you are not running here, there and everywhere. So I understand that she didn't have time to stand around and talk as much as we do at the place I am on now so I think it was a little bit of just the pace of the place we were on as well. Um…and the things like you've got to do because there are so many things to think about and keep focused on in my first placement where as in this placement, you've got to keep focused but you can have a few minutes where you can stand around, you can discuss what's happening with the patients, discuss a little bit about the ward, why you are doing things that you are doing. On my first placement it was	Justification for interpersonal skills & communication by different environment How much do we consider different preparation & expectation in different areas? Understanding why Are all students able to provide a justification?

Environmental influence (interpretation)		literally, this is what you've got to do, you need to go and do it now, there was not time to think why I am doing this.	Environmental influence
	I	So, you've kind of talked around this already but just too kind of clarify. That poor experience in the more acute area and your mentor, reflecting back on it now and the experiences you've had subsequent to that, and also thinking about the experiences you've had pre-programme where you've seen those good nurses, what would have made that experience better for you?	
Student anxiety (interpretation) Recognition of student status (interpretation) Person centred practice(raw data) Relationship with mentor (raw data) Valuing students (raw data)	R	Um…I think actually being able to understand why we are doing the things that we do because I have a little bit of time with my mentor to understand what we actually do on the ward, because for a whole week I knew what the jobs were but I didn't have any understanding of the patients or what they had or anything like that. So having that little bit of extra time to have communication with my mentor um…and be able to build like a professional relationship so I could approach her to ask questions if I needed to or anything like that. I just didn't feel like I fit in there at all, I felt like I shouldn't be there because I was just in the way and to have a sense of I'm there to learn and them appreciating that because I would have a few things explaining to me would have helped as well.	Do nurses in more acute areas understand the difficulties faced by students when new? Is there recognition of previous experience? Recognition of holistic practice Mentor-student relationship Approachability Place/value of students Do mentors value students?
	I	What do you understand by the word professionalism? What have you learnt about professionalism or professional practice in relation to nursing?	
Professional-personal identity (raw data) Relationship with service user(raw data) Student individuality (interpretation)	R	Professionalism is um…for me, there are two sides to my personality. I would say there are my professional personality and my social personality. So I wouldn't bring aspects of my personal life to work or, so whilst I'm at work it's strictly, I mean I'm in my uniform, I'll talk to the patients about them and the care they are getting but if they want to know a bit about me I'll tell them that I am a first year student and that I'm from *** because they might think that my accents a little bit funny (laughs). I would tell them a little bit about me but know that there is a boundary so I'm not going to go on about my home, history and things like that and just acting professionally as well, so not running up and down the wards, screaming and just things like that.	Hesitancy again – time to think but then incorrect focus (clarity of question?) Work-life distinction How much do we acknowledge the importance & value in self-sharing? Possible insecurity about different accent – obvious difference and not from area
	I	So have you had experiences where you have seen that kind of distinction of work and home personalities, have you seen where there has been a blurring of that in people that you've worked with?	
Professional-personal life (raw data) Relationship within the team	R	Yes, on my last ward a lot of the staff would stand in the clinical room just behind the nurses station and discuss what they were doing that week, where they are going, what they are going out with. They would all have their phones with them and they would all be using their phones because they thought that	Observation of work-life 'blurring' Disassociation – talking about 'them'

(interpretation) Role model influence (interpretation) Valuing students (interpretation)		nobody could see them because they were in a room, but obviously if you are going to walk past and the door is open then they are going to see you using your phone whilst at work. Um…and everybody there was really friendly with each other but they would talk about every aspect of their life and not necessarily like out of earshot of patients neither. They would stand just outside the bay and start talking about what they did that weekend and who they are going to see. Similar to the ward that I'm on now but on the ward I'm on now the patients are in longer so the patients and staff have known each other longer, we've got a few patients who have been in for like a few months so they know a bit more about the staff because if they ask questions most of them will answer them. Then they'll go away, and something will trigger a thought in their brain, so they'll go away and just start talking to the other staff about something that happened at the weekend, what they're going to do but not out of earshot of patients. Especially the health care assistants, not to put them down or anything, but they would stand around and you could hear them laughing, it doesn't matter where you are on the ward you can hear them laughing, um…or you can hear them talking about when they are going out, which pubs they are going to and things like that.	Recognition of personal life impact on patients How much do we recognise how our behaviours impact on others? Particularly when comfortable in the environment? Do we acknowledge 'outsider' view – different perspectives?
	I	So in relation to professionalism, what do you think about that?	
Service user influence (interpretation)	R	I think that if they do want to talk about their personal life they should do it out of earshot of patients. On the ward that I'm on now it's not fair that they are going on about going to the pub when most of the patients would like to go to the pub and they can't. Most of the patients on the ward that I'm on, it's just a rehabilitation ward so they don't have that many acute problems, it's just more, they've got a fracture leg so they can't walk and they need help.	
	I	OK, why is that so important that it should be out of earshot of patients?	
Service user influence (raw data) Person centred practice (interpretation)	R	Thinking of the rehabilitation ward if some of the staff are on about going to the pub or going to see this person live in concert, some of the patients, a lot of them don't want to be there anyway and they think I want to go home, I want to go to the pub, I would like to…it's like rubbing salt in wounds really, it's like haha I can do it and you can't. So I don't think it should be where patients can hear because you can see them getting really frustrated because they can't do them things. Um…	Impact on patient experience Concept of putting ourselves in the position of the patient
	I	Where did you learn that wasn't right?	
Learning through observation	R	Where I am on placement now. I knew there were boundaries but I didn't know what you could talk about, what you couldn't talk about and um…really, but then hearing people say oh, we're going to meet up Friday night at this pub and	Learning from observation – more effective than being told?

(raw data) Service user influence (raw data) Service user experience (raw data) Service user experience (raw data)		just observing patients faces and their reactions to that. Like we have one man who actually said, if you're going to talk about going to the pub can you go and do it somewhere else because actually I'd like to be going to the pub and I can't um…and just actually hearing that you think if that's going to upset or distress my patients then you shouldn't be doing it. It's just knowing the patients that you're with and knowing what they want to hear you talking about, what they don't want to hear you talking about.	Patient influence through reaction Impact on patient experience
	I	Thank you, that's really interesting. What do you understand by the concept of role modelling?	
Role model perception (raw data) Role model perception (raw data)	R	Um…for me being a role model is important. I want to be somebody who somebody else can look up to and think I want to be like her or I want to work with her so I can become a better person, nurse, whatever. For me, I want to be able to look up to people and see that in other people, think OK this is where I am supposed to be going, what I am supposed to be doing instead of saying, to me that's not quite what or who I want to be. So a role model to me is somebody who you can look up to and think, this is what I want to be, this is where I want to be in a few years' time, and that's how I'm going to get there.	Thoughtful/Hesitancy – more difficult concept? Immediate referral to being a RM Do we think of ourselves as RMs? Description of what a role model is or should be RMs as where want to be in future?
	I	OK, so there's something there about aspiration about what you want to be but also how that journey is going to happen. So can you think of specific elements that give you that sense of what a role model is?	
	R	Um…	
	I	Are there specific characteristics that you look for?	
	R	It's dependent on the person really...	Individuality? Deflection?
	I	OK	
Relationship with mentor (interpretation) Service user experience (interpretation)	R	A role model, for me, if I'm going to try to be a role model um…I'm going to try and communicate in ways which they understand so they can understand why I am like I am, how I've got there um…and just I'm going to try and focus on showing the right thing and not, Oh I'll just cut a corner here or there. Yeah, doing things correctly instead of not so correctly.	Again, being a RM Knowledge of mentor/RM & their journey Direct link to patient care
	I	OK, and have you seen that? Have you had experiences of that?	
	R	Yeah	
	I	Can you tell me about that?	
	R	More so in the acute hospital, they cut corners a lot to save time, and it's not the best….yeah…um…some patients because a lot of them have been in for	Hesitancy – buying time as concerned

Learning through observation (raw data) Role of a mentor (raw data) Role of a mentor (raw data)		angioplasty's and stuff like that so they need their surgical wounds checking every 15 minutes but because it takes so much time they don't do it, they do it every half an hour instead, and one person started bleeding and it had been bleeding for about 20 minutes and nobody had noticed. It was only a little bit, but it was still there and should have been noticed and dealt with and because they cut that corner and thought we don't need to do it every 15 minutes, we'll do it every half an hour it wasn't detected. Sometimes it's not the best being able to look at somebody and them being a role model because at the end of the day mentors should be a sort of role model because you are supposed to be working with them to learn how to do things correctly and how to communicate correctly and how to become that nurse because that's the trained nurse who you are working to be. And to see them cutting corners and doing things incorrectly it's not productive, it makes you realise that's what not to do but again it doesn't teach you what you should be doing so it feels like you're taking two steps forward and a step back.	re: topic area? Practical clinical example Is she mentioning this as an example because of experience with father? What is a role model? Separation of communication again Role modelling as a means to 'produce'? Are RMs there to 'produce' good nurses?
	I	So, can you think of people you would say are role models for you?	
Role model qualities (raw data) Justification for poor practice (interpretation) Role model influence (raw data)	R	In practice on the ward that I'm on now, there is a few people that I would say have been role models because they will explain things to me so. One of them who has just done her degree, she went through everything of what made her want to do a degree, how she did it and she just explained the whole three years to me, what she learned through the three years and she then went on to say, if you see anybody cutting corners, actually point out that you shouldn't be doing it like that, you should be doing it in a different way, it's not right to cut corners, because it's not, so she'll show you the correct way, she says sometimes we do cut corners to save time if you are in a rush but most of the time this is what you should be doing and she will go out of her way to it correctly so I can learn the correct ways of working and not how to cut corners.	Is a key element of role modelling about knowledge exchange? Relating to mentor Journey together? Contradiction in explanation Do as I say, don't do as I do?
	I	What did you think about that, if I understand you correctly, that she said to you, you shouldn't cut corners but sometimes we do…?	
Justification for poor practice (raw data)	R	Yeah, I understand that all the time can be quite difficult to do everything to the gold standard and occasionally things will be changed slightly but she did explain what the slightly would be, Instead of changing the times of when you are supposed to be checking an area, they wouldn't do that because that could be detrimental to their care. She would be saying if we are going to cut corners by, what is an example, I think she used the aseptic technique, and instead of	Do we justify not following procedure? Is this then acceptable? Justification of not gold standard

Theory-practice continuum (raw data) Justification for poor practice (interpretation)		washing her hands they would use hand gel instead because that saves that two minutes, things like that, which is OK as long as your hands aren't dirty. It's just little things like that, we get told to wash our hands instead of using hand gel in those situations but you can use hand gel because it's quicker and it's easier than having to get up and go and leave the patient and go and wash your hands and have to do that 6 times or whatever. She said, that in some situations is OK, but you wouldn't use hand gel if you are going to get exudate on your hands or whatever, you use your own judgement of what is right and what is wrong.	Contradiction between theory-practice How do students relate, or deal with situations in practice that contradicts what they are taught? Is it about personal judgement or evidence based practice?
	I	So these people that you can think of that you say have been role models, have they been a conscious decision for you? They've either been role models or they haven't?	
Communication as a skill (raw data) Service user experience (interpretation) Role model qualities (raw data)	R	I think I've thought they could be a role model because they are doing, like I think just from the good nurse and the bad nurse, I see that person isn't such a good nurse because they are not doing this quite correctly or their communication is not what it should be and I think it's all seeing the interaction between the nurse and patients as well as nurse and staff which will make me think, do I want to be that person when I'm qualified, and I think that actually if I'd be happy to be or do the way you're doing it, then I think they could be a good role model but if I think actually I don't want to be like you or I don't want to do things they say you're doing them then they are not a good role model.	Separation of communication Direct relation to patient experience 'Happiness with' as a way of identifying traits to emulate? Relation between 'liking' and role models
	I	Is that in totality? So you would look at someone as a total person and that decision would be made about I would want to be or I wouldn't want to be?	
Human nature & perceptions (interpretation)	R	Yeah, um…I don't think it's right to instantly form from just seeing them because obviously you do make judgements about people as soon as you see them, everybody does, um…I wouldn't just think you're not a role model because I've just seen you outside smoking, I'd say OK, you smoke, I wouldn't smoke myself but you've got really good communication with patients, you're really good at doing this and I would think that's what I would like to be, just without the smoking. But if I see somebody who doesn't smoke I'd think OK you don't smoke but you've got really poor communication skills and you're cutting corners constantly and I actually wouldn't want to be like that then that to me wouldn't be a role model. You look at everything, their personality, their professional personality and their not so professional personality.	Hesitancy – delving deeper, needs time Human nature/judgements/ stereotyping Discern between good/poor traits Is this so clear cut? What about more complex situations? Is the 'not so professional' the same as 'social' mentioned earlier?
	I	So would it be right to say that there are aspects of people that you've worked with that you would think, yes I would like to be like that but not necessarily that in the same person?	

	R	Yes	
	I	How do you make that distinction? How do you make that decision that that element I like and I would like to be like that in the future?	
Valuing students (interpretation) Learning through observation (raw data) Role model qualities (raw data) Role model influence (raw data)	R	I have the idea that not everybody is perfect and they can't be perfect, so you look at, as a first year student, what we pretty much do is observe people. So I observe how they interact and what they do all the time. So for somebody who I saw, because on my first ward I worked with quite a few members of staff and I saw one person who was absolutely amazing at the clinical side so she would be really good at aseptic technique and knowing when someone needs weighing, but she wasn't very good at communicating to her patients, so she wasn't very good at communicating her point of view to staff either and I was like, I would want to be able to do that from the clinical side but for me I would want to work on my communication skills, because she based all of her training on the clinical side, she said I can always work on my communication skills later on, that's not important, because I actually talked to her about this, I said you're really good at your clinical skills, how did you become that and she said that she focused mainly on the clinical skills and perfecting aseptic technique and things like that and she said, I put communication to one side and thought that would just come to me but it doesn't, you do need to work on both at the same time. So she is aware that she's not perfect at good communication but she is a lot better at the clinical side of things. So looking at that I do want to be able to do that but for me I want to be able to communicate as well.	First year experience is observational More observational in first year? Link to 'formative' experience at start? Discern between good/poor traits Communication separate Self awareness How much do we work with qualified staff to address deficits?
	I	OK, that's interesting. We've talked a lot about your practice experience. Can you think of any other influences there might have been that have impacted on your development up to the point that you are at now?	
	R	Everything in my life (laughs), I'm not the person I am today without everything that has happened to me.	Using humour
	I	Think about specifically in terms of your development as a student nurse; think about what has impacted on the person you were in terms of a student and nursing on day 1 of the programme to where you are now.	
Peer influence (raw data)	R	Um…the people I've met at University, so the friends I've made within my group and the support that I've had. Without their support I probably wouldn't be where I am now because I've had quite a few ups and downs throughout this first year with my dad being taken into hospital and things like that um…so without their support I don't know if I would be here.	Peer support Concept of formal buddying? 'Leave to chance' or 'as required'?
	I	So you feel that your peers have impacted on your development?	

	R	Yes	
	I	Can you explain the ways you think they might have had an influence?	
Peer influence (raw data) Peer influence (raw data)	R	When it comes to writing assignments we would sit down and do like little study groups. So we would sit down with our ideas and we would be able to share our ideas and if one of them, if one of my friends had come up with an idea that I hadn't even thought of we would discuss it so then I'd learn much more by actually working with them when writing an assignment other than just sitting down and saying, this is exactly what I think, and this is exactly what I am going to do and missing a whole chunk out. Listening to their experiences as well because most of the people in my group have been care assistants or worked in care before coming to university, actually hearing their experiences of what they have had and what they have been through, it's just has developed me because I can take that on board and just think about a lot more about than I would if I was thinking just about this is what I have been though in my life and these are my ideas. I can take that idea and develop it myself but they are somebody else's ideas.	Peer support Formal study groups/buddying? Peer influence Do we formally share experiences enough – both within and outside practice?
	I	OK, anything else that you can think of that you feel has had an influence on your development as a professional?	
Development of nurse education (interpretation) Sources of learning (raw data) Personal journey (interpretation)	R	Um, other than the lecturers and listening to them teaching you the content of the course and giving you little tips of how to go away and improve and listening to the stories of what they have been through and what nursing was like 40 years ago and things like that and how its developed and they would say this is what you should actually be aiming for in 3 years' time and giving you a path of where to go and how to get there. It's like this is what you've got to learn but you are also going to have to go away and look at this and this as well because it's given me a path and a direction instead of just thinking I do want to be a nurse in 3 years' time and I do want to develop but have about 20 different paths but not have a clue how to get there.	Historical context useful Self-directed learning to support development Concept of 'on a journey' On a journey Does this journey end? Concept of 'not professional' to 'professional' – something about maintaining that or learning to modify situation?
	I	Anything else that you have learnt about your experience at university in terms of professionalism?	
Perception of nurses	R	Not really, I think I learned how to be professional and learned the whole meaning of professionalism whilst actually being in practice and actually doing it. The whole teaching of clinical skills and having to wear your uniform and	Professional identity & 'display'

(raw data) Environmental influence (raw data)		making sure that you are in correct uniform and how you should be out in practice as well taught you before you went the expectations of professionalism and the sense of dress code and OK that's not appropriate in here and it's not going to be appropriate out there in practice either that sort of thing all helps as well but for me being out in practice I feel I've learnt more than I have in university to be honest.	How much do we help students to see where the development comes from? Importance of areas other than practice?
	I	OK, any last points that you want to tell me that you think might be relevant?	
	R	Not really.	
	I	OK, thank you	

APPENDIX 7

Participant 1a subordinate themes

Subordinate theme	Page	Key words	
Communication as a skill	1	bit of a conversation	
Perception of nurses	1	she is caring and he is caring	
Perception of nurses	1	little nurses outfit and stethoscope	
Perception of nursing	1	seen the impact nurses had on father	
Person centred practice	1	they are there	
Communication as a skill	2	introduce yourself	
Familial influence	2	dad went into hospital	
Familial influence	2	with him every 15 minutes	
Perception of nursing	2	not just the paperwork	
Person centred practice	2	care was best for him	
Person centred practice	2	leave somebody	
Role conflict - professional & personal	2	so I went up to the nurses station	lost theme
Service user influence	2	more nervous	
Communication as a skill	3	can't be a good nurse	
Nurse qualities	3	friendly	
Perception of nursing	3	go back to paperwork	
Personal experience	3	I went to hospital	
Personal journey	3	lots of ups and downs this year	
Role conflict	3	instead of leaving them	lost theme
Peer influence through support	4	talk to students	
Perception of nurses	4	set idea	
Person centred practice	4	link between nurses and…	
Personal experience	4	reality	
Personal experience	4	before I had experience	
Sources of learning	4	talking to other students is helpful	
Leadership / management influence	5	ward manager	
Memorable experiences	5	stood out	lost theme
Ongoing professional development	5	should have learnt by now	
Person centred practice	5	I'm telling you what to do	
Recognition of student status	5	had to ask permission	
Relationship with mentor	5	affected our relationship	
Service user experience	5	asked to see someone else	
Valuing students	5	didn't see point	
Communication as a skill	6	communicate with patients as well	
Justification for poor practice	6	when I'm busy	
Nurse qualities	6	good at clinical	
Recognition of student status	6	I'm not capable	
Recognition of student status	6	out of my comfort zone	
Relationship with mentor	6	rely on mentor	
Relationship with service user	6	if I was in that situation	
Service user influence	6	reaction I had off patients	

Learning through observation	7	she actually showed me	
Teaching through reflection	7	learnt what I shouldn't be like	
Relationship with mentor	7	reminds me of me	
Relationship with service user	7	as if she is a friend	
Theory-practice continuum	7	don't detach yourself	
Theory-practice continuum	7	told to detach ourselves	
Learning through observation	8	amazing to watch	
Relationship with mentor	8	get to know each other	
Relationship with mentor	8	she was shy	
Student anxiety	8	new atmosphere to me	
Student anxiety	8	I was a bit nervous	
Valuing students	8	send me off with anybody else	
Environmental influence	9	no time to think why	
Justification for poor practice	9	fast paced all the time	
Preparation of students	9	fast paced and not so fast paced	
Recognition of student status	9	understand what we actually do	
Relationship with mentor	9	I could approach her	
Student anxiety	9	being able to understand	
Person centred practice	10	didn't have understanding of the patients	
Professional-personal identity	10	professional ID and social ID	lost theme
Professional-personal life	10	have their phones with them	lost theme
Relationship with mentor	10	build a professional relationship	
Relationship with service user	10	know a bit about me	
Relationship within the team	10	they would	
Role model influence	10	Especially the HCAs	
Student individuality	10	my accents a little funny	lost theme
Valuing students	10	I'm there to learn	
Learning through observation	11	observing patients faces	
Person centred practice	11	see them getting frustrated	
Service user experience	11	I would like to go	
Service user influence	11	out of earshot of patients	
Service user influence	11	and their reactions	
Valuing students	11	you can hear them	
Relationship with mentor	12	understand why I'm like I am	
Role model perception	12	somebody you can look up to	
Role model perception	12	where I want to be	
Role model perception	12	I want to be like her	
Service user experience	12	upset or distress	
Service user experience	12	doing this correctly	
Justification for poor practice	13	understand it can be difficult	
Learning through observation	13	checking every 15 minutes	
Role model influence	13	this is what you should be doing	
Role model qualities	13	explain things to me	
Role of a mentor	13	it’s not productive	
Role of a mentor	13	learn how to do things correctly	

Communication as a skill	14	communication is not quite as it should be	
Human nature & perceptions	14	you do make judgements	
Justification for poor practice	14	use your own judgement	
Justification for poor practice	14	cut corners	
Role model qualities	14	happy to be or do what you're doing	
Service user experience	14	interaction between nurse and patient	
Theory-practice continuum	14	we get told to…	
Learning through observation	15	I observe how they interact	
Role model influence	15	thought communication would come to me	
Role model qualities	15	amazing clinical……not so good communication	
Valuing students	15	we pretty much observe	
Development of nurse education	16	what nursing was like	
Peer influence through support	16	study groups	
Peer influence through support	16	hearing their experiences	
Peer influence through support	16	probably wouldn't be where I am	
Environmental influence	17	in practice I've learnt	
Perception of nurses	17	correct uniform	
Personal journey	17	given me a path and direction	
Sources of learning	17	got this to learn	

APPENDIX 8

Participant 1a superordinate themes

Development of relationships		
Relationship with mentor	7	reminds me of me
	8	she was shy
	5	affected our relationship
	6	rely on mentor
	9	I could approach her
	10	build a professional relationship
	12	understand why I'm like I am
	8	get to know each other
Relationship with service user	6	if I was in that situation
	7	as if she is a friend
	10	know a bit about me
Relationship within the team	10	they would

Impact of service users on development		
Service user influence	6	reaction I had off patients
	11	and their reactions
	2	more nervous
	11	out of earshot of patients
Service user experience	11	I would like to go
	12	upset or distress
	12	doing this correctly
	14	interaction between nurse and patient
	5	asked to see someone else

Perceptions of role modelling		
Role model influence	10	Especially the HCAs
	13	this is what you should be doing
	15	thought communication would come to me
Role model perception	12	somebody you can look up to
	12	where I want to be
	12	I want to be like her
Role model qualities	13	explain things to me
	14	happy to be or do what you're doing
	15	amazing clinical……not so good communication
Role of a mentor	13	it's not productive
	13	learn how to do things correctly

Teaching and learning		
Development of nurse education	16	what nursing was like
Learning through observation	11	observing patients faces

	13	checking every 15 minutes
	15	I observe how they interact
	7	she actually showed me
	8	amazing to watch
Teaching through reflection	7	learnt what I shouldn't be like
Sources of learning	17	got this to learn
	4	talking to other students is helpful
Preparation of students	9	fast paced and not so fast paced
Theory-practice continuum	7	don't detach yourself
	14	we get told to…
	7	told to detach ourselves

Recognising the student as an individual		
Personal journey	17	given me a path and direction
	3	lots of ups and downs this year
Valuing students	5	didn't see point
	8	send me off with anybody else
	10	I'm there to learn
	11	you can hear them
	15	we pretty much observe

Delivery of safe and effective nursing care		
Communication as a skill	1	bit of a conversation
	3	can't be a good nurse
	6	communicate with patients as well
	14	communication is not quite as it should be
	2	introduce yourself
Justification for poor practice	14	use your own judgement
	6	when I'm busy
	9	fast paced all the time
	13	understand it can be difficult
	14	cut corners
Person centred practice	2	care was best for him
	5	I'm telling you what to do
	1	they are there
	2	leave somebody
	11	see them getting frustrated
	10	didn't have understanding of the patients
	4	link between nurses and…

Perception of nursing and nurses		
Nurse qualities	3	friendly
	6	good at clinical
Ongoing professional development	5	should have learnt by now
Perception of nurses	4	set idea

	17	correct uniform
	1	little nurses outfit and stethoscope
	1	she is caring and he is caring
Perception of nursing	2	not just the paperwork
	1	seen the impact nurses had on father
	3	go back to paperwork

Influences on perception& development		
Environmental influence	17	in practice I've learnt
	9	no time to think why
Familial influence	2	dad went into hospital
	2	with him every 15 minutes
Human nature & perceptions	14	you do make judgements
Peer influence through support	4	talk to students
	16	study groups
	16	hearing their experiences
	16	probably wouldn't be where I am
Personal experience	3	I went to hospital
	4	reality
	4	before I had experience

Recognition of student status		
Recognition of student status	5	had to ask permission
	6	I'm not capable
	6	out of my comfort zone
	9	understand what we actually do
Student anxiety	8	new atmosphere to me
	8	I was a bit nervous
	9	being able to understand

Impact of workplace culture		
Leadership /management influence	5	ward manager

APPENDIX 9

Year 1 recurrent themes

Superordinate themes	1a	1b	1c	1d	Total presence
Perceptions of role modelling	Yes	Yes	Yes	Yes	4
Teaching & learning	Yes	Yes	Yes	Yes	4
Influences on perception and development	Yes	Yes	Yes	Yes	4
Development of relationships	Yes	Yes	Yes	Yes	4
Recognising the student as an individual	Yes	Yes	Yes	Yes	4
Perception of nursing and nurses	Yes	Yes	Yes	Yes	4
Delivery of safe and effective nursing care	Yes		Yes	Yes	3
Recognition of student status	Yes	Yes		Yes	3
Impact of service users on development	Yes	Yes			2
Concept of professionalism			Yes	Yes	2
Impact of workplace culture	Yes	Yes			2
Perception of students					0

APPENDIX 10

Year 1 master table of themes

Perceptions of role modelling	**Participant**		
Role of a mentor	1b	5	you're doing well
	1d	7	nurtured me
Role model influence	1a	10	Especially the HCAs
	1a	15	thought communication would come to me
	1d	3	different approach….same outcome
	1a	13	this is what you should be doing
	1d	4	everything was on her terms
	1c	4	without gloves
	1d	4	aseptic technique allegedly
Role model traits	1d	7	maybe some of those traits
Role model perception	1b	7	when I was in hospital mainly
	1d	7	someone that you look up to
	1a	12	I want to be like her
	1a	12	somebody you can look up to
	1b	7	someone to look up to
	1c	7	I really look up to her
	1a	12	where I want to be
Role model qualities	1a	13	explain things to me
	1a	14	happy to be or do what you're doing
	1a	15	amazing clinical……not so good communication
	1b	5	encouraged us, really enthusiastic
	1b	7	can do attitude
	1b	13	inspiring
	1b	14	enthusiasm
	1d	3	approachable
	1d	8	listened, understood
Role of a mentor	1a	13	it's not productive
	1a	13	learn how to do things correctly
Role modelling by senior staff	1c	5	so admirable
	1b	9	never see her out of her office
	1b	10	she just sits drinking tea
	1b	11	she can avoid as much as she can
Role modelling by students to nurses and peers	1d	9	look at how I respond to situations
	1d	6	students have more time
	1c	3	I was just being polite
	1c	4	so I went up to her

Teaching and learning	**Participant**		
Teaching style	1d	3	bring it back to the table
Development of nursing education	1b	15	graduate student and having compassion
	1a	16	what nursing was like

Learning through feedback	1b	5	didn't feel like a personal attack
	1b	6	just to have someone keep confirming
	1b	9	haven't…
	1c	2	the comments I get from people
Learning through observation	1a	11	observing patients faces
	1a	13	checking every 15 minutes
	1a	15	I observe how they interact
	1a	7	she actually showed me
	1a	8	amazing to watch
	1b	3	just being in the Department
	1b	11	I asked one of the carers
	1b	11	not so hot on admin either
	1c	3	from working with nurses
	1d	2	seen my mentor
	1d	4	sit back, watch, listen
Teaching through reflection	1a	7	learnt what I shouldn't be like
Prior experiential learning	1b	10	my business degree
	1b	8	from watching organisations change
Sources of learning	1c	7	drummed it into you
	1d	11	I'm probably quite insular
	1b	5	TV or radio
	1b	6	purely from life experience
	1b	14	I'm on twitter
	1a	4	talking to other students is helpful
	1a	17	got this to learn
Preparation of students	1a	9	fast paced and not so fast paced
	1b	4	emergency admission at the weekend
	1b	6	something in your toolkit
	1b	8	I could see
	1b	12	expectations were to gain knowledge
	1c	4	I was shocked
	1c	10	shocked me into doing the essays well
Theory-practice continuum	1a	7	don't detach yourself
	1a	14	we get told to…
	1a	7	told to detach ourselves

Influences on perception & development	**Participant**		
Age related influence	1b	1	I wouldn't have been able to deal
	1b	3	didn’t always want to be a midwife
	1b	4	generally standards have improved
	1c	3	because she was so young
	1c	8	so young
	1d	1	it’s been for about 20 years now
	1d	2	it’s about impression
	1d	8	I would say hold on a minute

	1d	10	I'm a lot older and did worry about that
Environmental influence	1a	9	no time to think why
	1b	6	they were so busy
	1b	7	don't get to know your patients
	1b	12	I like the excitement
	1a	17	in practice I've learnt
	1d	5	what is everyone else doing
Familial influence	1a	2	dad went into hospital
	1a	2	with him every 15 minutes
	1b	2	my mother came out with
	1b	13	I had a cousin who was a nurse
	1c	2	he done his training
	1c	5	my dad wouldn't
Human nature & perceptions	1a	14	you do make judgements
Lecturer influence	1b	14	enthusiastic about their subject
	1d	9	her success is through us
Media influence	1b	2	nursing 2000 coming out
	1b	3	brilliant experience…given such bad press
Organisational influence	1b	4	we can't do anything as it's the weekend
Peer influence	1b	2	other girls in my class
	1b	3	midwifery students
	1b	15	poem at RCN congress
	1c	7	she has a lot of drive
	1a	4	talk to students
	1a	16	study groups
	1a	16	hearing their experiences
	1a	16	probably wouldn't be where I am
Personal experience	1a	3	I went to hospital
	1a	4	reality
	1a	4	before I had experience
	1b	1	I had a lot of health problems
	1b	3	when I went into the first one
	1b	13	other nurses I've known
Situational influence	1c	6	I failed

Development of relationships	**Participant**		
Relationship with mentor	1a	5	affected our relationship
	1a	7	reminds me of me
	1a	8	she was shy
	1a	8	get to know each other
	1a	6	rely on mentor
	1a	9	I could approach her
	1a	10	build a professional relationship
	1a	12	understand why I'm like I am
	1b	12	my back up became my mentor

	1c	9	professional relationship was better
	1d	3	you rely on them
Relationship with service user	1a	6	if I was in that situation
	1a	7	as if she is a friend
	1a	10	know a bit about me
	1b	4	empathising with them
	1b	7	common thing was
	1b	12	built a rapport
Relationship within the team	1c	9	know what they are really like
	1c	8	really good relationship with the nurses
	1d	4	the team didn't take to her
	1d	5	understand each other
	1a	10	they would

Recognising the student as an individual	**Participant**		
Personal journey	1d	2	its humbled me
	1a	3	lots of ups and downs this year
	1a	17	given me a path and direction
	1b	8	ups and downs
	1c	2	feel like I've grown up
Career trajectory	1b	1	completely different career track
	1b	3	whole range of things can open up
Inherent personal qualities	1b	5	I won't have the time
	1b	1	always interested in medical type stuff
	1b	2	always strive to get on
	1b	15	I look smart, clean and tidy
	1b	2	I was always the carer
	1b	2	because I was academic
	1d	5	taught to be well behaved
	1d	7	care and compassion
	1c	2	got me a bunch of flowers
Stimulus for nursing career	1b	1	I want to care like I have been
	1c	1	don't put anything back
	1b	1	fleeting moment
	1d	1	make that difference
	1c	1	quite rewarding
Student / occupational pride	1b	13	I like the professionalism in telling
Valuing students	1a	5	didn't see point
	1a	8	send me off with anybody else
	1a	10	I'm there to learn
	1a	11	you can hear them
	1a	15	we pretty much observe
	1d	8	career in management
	1b	10	I've just got to bite my tongue
	1b	10	I'm just the student

Delivery of safe and effective nursing care	Participant		
Communication as a skill	1a	1	bit of a conversation
	1a	3	can't be a good nurse
	1a	6	communicate with patients as well
	1a	14	communication is not quite as it should be
	1a	2	introduce yourself
	1c	3	not really talk
	1c	4	women couldn't hear
	1c	9	didn't communicate well
Justification for poor practice	1a	14	use your own judgement
	1a	6	when I'm busy
	1a	9	fast paced all the time
	1a	13	understand it can be difficult
	1a	14	cut corners
Person centred practice	1c	9	they were competent but not the way they act
	1d	6	how do you want to be treated
	1a	4	link between nurses and…
	1a	2	care was best for him
	1a	5	I'm telling you what to do
	1a	1	they are there
	1a	2	leave somebody
	1a	11	see them getting frustrated
	1a	10	didn't have understanding of the patients
	1c	3	made sure everything was alright
	1c	3	holistic way of making sure
	1c	4	didn't really engage
	1d	7	spoke to that person
	1d	9	think about the wider family

Perception of nursing and nurses	Participant		
Developments in society	1d	3	people are a lot more informed
	1d	5	there are expectations
Nurse burn-out & demotivation	1b	5	he still had that passion
	1b	14	can get stale in a role
Nurse qualities	1a	3	friendly
	1a	6	good at clinical
	1b	4	care and compassion
	1c	3	went back out of hours
	1c	8	challenge other professionals
	1d	5	approachable
Ongoing professional development	1a	5	should have learnt by now
	1c	4	she should have understood
	1c	5	developed more patience
Perception of nurses	1c	8	I didn't really expect it

	1a	1	she is caring and he is caring
	1a	4	set idea
	1a	17	correct uniform
	1a	1	little nurses outfit and stethoscope
	1b	15	putting on the uniform
	1b	9	risen up the ranks…never trained
	1b	14	shouldn't be or can't manage
Perception of nursing	1c	1	made a difference
	1b	2	very much steered
	1a	2	not just the paperwork
	1a	1	seen the impact nurses had on father
	1a	3	go back to paperwork
	1d	2	brings that humanity
	1d	2	there needs to be a balance

Impact of service user on development	**Participant**		
Service user influence	1a	2	more nervous
	1a	11	out of earshot of patients
	1a	6	reaction I had off patients
	1a	11	and their reactions
Service user experience	1a	5	asked to see someone else
	1a	11	I would like to go
	1a	12	upset or distress
	1a	12	doing this correctly
	1a	14	interaction between nurse and patient
	1b	4	knowing when to have a bit of banter
	1b	4	you felt undervalued
	1b	6	I sat with him
	1b	15	as a service user

Concept of professionalism			
Human infallibility and professionalism	1d	6	we all make mistakes
Professional qualities	1c	2	the way I stand, I act...
	1c	6	she would just go on about it
	1c	6	body language, the way she spoke...
	1c	7	the way you act, the knowledge you know...
	1d	6	the way you dress, talk, listen…
	1d	2	how people behave, approach situations

Impact of workplace culture	**Participant**		
Leadership / management influence	1b	8	change to a process
	1b	8	worked with strong leaders
	1b	9	would verbally dress them down
	1a	5	ward manager
	1b	9	never see her out of her office

Team work & dynamics	1b	10	one nurse ends up doing both floors
	1b	9	get complained about a lot

Recognition of student status	**Participant**		
Recognition of student status	1a	9	understand what we actually do
	1b	12	be mindful….give us time
	1d	8	I had to learn to drive once
	1a	5	had to ask permission
	1a	6	I'm not capable
	1a	6	out of my comfort zone
Student anxiety	1a	8	new atmosphere to me
	1a	8	I was a bit nervous
	1a	9	being able to understand
	1d	11	plate of armour
	1d	8	rabbit in the headlights

APPENDIX 11

All interviews recurrent themes

Superordinate themes	1a	1b	1c	1d	2a	2b	2c	2d	3a	3b	3c	3d	Total
Perceptions of role modelling	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	12
Teaching and learning	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	12
Influences on perception and development	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	12
Perception of nursing and nurses	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	12
Recognising the student as an individual	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	11
Delivery of safe and effective nursing care	Yes		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes			9
Development of relationships	Yes	Yes	Yes	Yes	Yes				Yes	Yes	Yes	Yes	9
Impact of service users on development	Yes	Yes			Yes	Yes		Yes	Yes			Yes	7
Impact of workplace culture	Yes	Yes			Yes		Yes	Yes	Yes			Yes	7
Recognition of student status	Yes	Yes		Yes	Yes	Yes	Yes				Yes		7
Perception of students							Yes				Yes	Yes	4
Concept of professionalism			Yes	Yes						Yes			3

APPENDIX 12

British Journal of Nursing publication

Removed for copyright purposes. See Felstead, I., (2013) 'Role modelling and students' professional development', British Journal of Nursing, 22(4), pp. 223-227.

APPENDIX 13

Conference abstract

Influencing Policy through Enhancing Professionalism
Third International Conference on Value and Virtue in Practice-Based Research
9th and 10th July 2013
York St John University, UK

Conference Abstract

Professional development – caught or taught?

This paper is about working towards exploring and capitalising on the positive influences of role modelling in student nurses' development as professional practitioners, and aims to demonstrate the nature and impact of influential factors.

It can be said that teaching and learning within Health and Social Care is a dual relationship, conducted between two people with the majority of learning acquired informally via role modelling (Charters 2000). The term 'role model' is often understood to describe a person who exemplifies behaviour or a social role for others to emulate (Price and Price 2009). This definition raises the question of whether a role model is someone who simply teaches the 'how' within their own profession or whether there is more in terms of the personality traits and characteristics that make up their identity within that particular professional group.

The public need to be confident that they will be cared for by a nurse who is competent and also acts with professionalism and integrity (NMC 2010). Therefore it is imperative that students are educated to develop the professional qualities necessary not only to enhance the quality of care provision but also meet the expectation of service users. Nursing students are exposed to many individuals during their educational programme and therefore the factors that influence the development of their professionalism can be varied and complex.

A structured review of the literature, triangulated with preliminary semi-structured interviews with undergraduate pre-registration students, indicates that a considerable breadth of influences including the characters, physical presentation, conduct and behaviour of those with whom the pre-registration students come into contact can have a significant influence on their development as professional practitioners.

References

Charters, A. (2000) Role modelling as a teaching method, Emergency Nurse 7 (10): 25–29.

Nursing & Midwifery Council (2010) Standards for Pre-registration Nurse Education. London, NMC.

Price, A. and Price, B. (2009) Role modelling practice with students on clinical placements, Nursing Standard 24 (11): 51–56.

APPENDIX 14

Education Faculty Research Ethics Review

Application for full review

MAIN RESEARCHER	Ian Felstead
E-MAIL	ian.felstead@canterbury.ac.uk
POSITION WITHIN CCCU	Senior Lecturer
POSITION OUTSIDE CCCU	n/a
COURSE (students only)	Doctorate in Education - dissertation
DEPARTMENT	Nursing & Applied Clinical Studies
PROJECT TITLE	An exploration of the lived experience of role modelling in Adult Nursing students.
TUTOR/SUPERVISOR: NAME	Dr Alison Smith
TUTOR/SUPERVISOR: E-MAIL	alison.smith@canterbury.ac.uk
DURATION OF PROJECT	2 years & 1 term

OTHER RESEARCHERS:

Names	Contact details	Position in CCCUC	Position outside CCCUC
None			

Note that participatory research involving a possibly as yet unspecified group of 'co-researchers' may treat these as participants for the purpose of completing this form.

GIVE DETAILS OF ANY ACTUAL, PERCEIVED OR POTENTIAL CONFLICT OF INTEREST FOR ANY OF THE RESEARCHERS INVOLVED. (Include also details of how this is to be addressed.)

n/a

GIVE DETAILS OF THE FUNDING BODY, OF THE AMOUNT OF FUNDING AND OF ANY RELEVANT CONDITIONS IMPOSED.

Is this project aimed mainly at achieving an academic qualification?	Yes
Is this project mainly aimed at improving the practice/performance of people or organizations involved in the research?	No
Will the project results be published in academic journals?	Yes
Will the project results be published in professional journals?	Yes
Will the project results be published in other ways?	Yes

GIVE A BRIEF OUTLINE OF THE "SCIENTIFIC", PRACTICAL OR POLITICAL BACKGROUND TO THE PROJECT

Patients expect to be cared for by a nurse who is competent but also 'behaves' professionally and students must be educated to develop professional qualities. The nature of influencers in developing professionalism has not been well demonstrated and yet students are exposed to numerous individuals who have an impact on their development. This study will explore the 'lived experience' of adult nursing students in relation to role modelling and interpret this I the context of the development of their professionalism. This study will add to existing research regarding the impact of role-modelling in health education (generally associated with competency development) and is also related to existing discussions surrounding Fitness to Practice, formal versus informal learning and work based learning.

Give details of literature searches conducted.	A search was conducted of EThOS, the British Library's open access repository for UK doctoral theses. No references were identified that specifically related to role-modelling and the development of nurses' as professionals. The Royal College of Nursing library thesis search was also utilised and failed to identify any related doctoral work. Health and Social Care, Education and Business/Management were the general areas included in the search. Databases included CINAHL (1981 – 2009), MEDLINE (1950 – 2009), British Nursing Index (1994 – 2009), ASSIA (1960 – 2009), British Education Index (1975 – 2009), ERIC (1966 – 2009) and IBSS (1951 – 2009).
Has a similar study been carried out previously?	There were no studies found that have examined role modelling in direct relation to the development of professionalism.
If so, why is it worth repeating the study.	n/a
WHO HAS PEER-REVIEWED THIS STUDY? (Attach any relevant comments.)	Reviewed by supervisor.

GIVE A BRIEF OUTLINE OF THE PROJECT. Include, for example, sample selection, recruitment procedures, data collection, data analysis.

The research questions are:

How do students identify which role models to follow?

a) Who are the role models that students are exposed to during their educational journey and do they change over time?

b) What attributes / characteristics do students look for in the role models they choose and how does this relate to their current position in their educational journey?

c) What is students understanding of professionalism and the perceived influence of their role models on the development of their professionalism?

The data will be collected through in-depth qualitative interviews. The participants will be students from the 1st year, 2nd year, 3rd year and post-registration (n=5 in each group).

- Stage 1 - critical review and analysis of the literature, and structured consensus discussions with relevant colleagues.
- Stage 2 - practice interviews (pilot study).
- Stage 3 – in-depth interviews with two members of each participant group (8 interviews). Two students from the 1st year will be interviewed followed by preliminary analysis of the interview transcripts. If there are common themes emerging then I will move on to the 2nd year students, if not then I will interview another 1st year student (up to 5 maximum) etc.

A maximum of five participants will be randomly sampled from each of the four groups (n = 20). All participants are accessible in my role as Pathway Director for Adult Nursing.

Interview data will be analyzed through Interpretive Phenomenological Analysis.

WHAT IS EXPECTED TO BE LEARNT AS A RESULT OF THIS STUDY

Exploring this area will make a novel contribution to associated research and practice by improving the professional development of nursing students through identifying and capitalising on the positive influences of role modelling.

Exactly what will happen to participants, their products or records about them that goes beyond usual practice.	There will be nothing that will happen beyond usual practice.

Potential risks for participants	There is a potential perceived risk to the student participants in that I am the Pathway Director for their programme of study and they may feel inhibited in their responses. This will be managed through assurance of total anonymity and the fact that I am not undertaking this research in my University role. Interviews will be conducted in a 'neutral' environment (i.e. not my office base).
Potential benefits for participants	Through the interpretive phenomenological process I will be able to facilitate the participants' reflection thereby enabling them to develop a deeper understanding of the influence of role modelling and how this can be used to influence the development of their professionalism. There may therefore be an impact on their overall development as a result of participating in this study.
How will participants be made aware of the results of the study?	Participants will be provided the opportunity to see the completed study or at least a summary of it.

How will participants be selected?	All adult nursing students will be eligible for entry to the study.
How many participants will be recruited?	Up to 20 (see above)
Explain, as precisely as possible, why this number of participants is necessary and sufficient? Where details of a statistical calculation are not appropriate, an equivalent level of detail should be provided.	This study is to illuminate the phenomenon of role modelling and not to achieve saturation of data or generalizable results (given the nature of the topic under consideration). It is envisaged that similar themes will emerge from each participant group and so interim analysis will be carried out after 2 participants to see if common themes are noted, if so I will move on to the next participant group, if not then I will continue to interview up to 5 participants. I want to only interview a maximum of up to 20 participants across all groups as this will generate a large quantity of data and anymore will be

	unmanageable in a project of this size.
How will participants be approached and by whom?	I will email all eligible adult nursing students via the University VLE and select those who are the first to respond.
Will participants be recruited individually or en bloc?	Individually.
Are participants likely to feel under pressure to consent / assent to participation?	No, as the email will be a general invite to take part and be sent to all students enrolled on the VLE and not to specific students.
Will participants include minors, people with learning difficulties or other vulnerable people?	No
How will voluntary informed consent be obtained from individual participants or those with a right to consent for them?	Participants will be required to sign a consent form.
How will assent be obtained from competent minors and other vulnerable people?	n/a

How will permission be sought from those responsible for institutions / organisations hosting the study?	n/a
How will the privacy and confidentiality of participants be safeguarded?	All audio recorded interviews and interview transcripts will be coded and kept under lock and key. These will be deleted / destroyed upon transcription and then completion of the analysis.
What steps will be taken to comply with the Data Protection Act?	As above
What steps will be taken to allow participants to retain control over audio-visual records of them and over their creative products and items of a personal nature.	

Give the qualifications and/or experience of the researcher and/or supervisor in this form of research.	Researcher – PGCLT(HE), MSc Supervisor - EdD

Attach any:

Participant information sheets and letters
Consent forms
Data collection instruments

DECLARATION

- The information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.
- I undertake to conduct this research in accordance with University's Research Governance procedures.

- If the research is approved, I undertake to adhere to the study protocol without deviation and to comply with any conditions set out in the letter sent by the FREC notifying me of this.
- I undertake to inform the FREC of any changes in the protocol and to seek their agreement and to submit annual progress reports. I am aware of my responsibility to be up to date and comply with the requirements of the law and appropriate guidelines relating to security and confidentiality of participant or other personal data, including the need to register when appropriate with the appropriate Data Protection Officer.
- I understand that research records/data may be subject to inspection for audit purposes if required in future and that research records should be kept securely for five years.
- I understand that personal data about me as a researcher in this application will be held by the FREC and that this will be managed according to the principles established in the Data Protection Act.

Signature of Researcher:

Print Name: IAN FELSTEAD

Date:

FOR STUDENT APPLICATION ONLY

I have read the research proposal and application form, and support this submission to the FREC.

Signature of the Supervisor:

Print Name: DR ALISON SMITH

Date:

APPENDIX 15

Faculty of Education ethics committee approval

From: Engelbrecht, Petra (petra.engelbrecht@canterbury.ac.uk)
To: Felstead, Ian (ian.felstead@canterbury.ac.uk)
Cc: Smith, Alison (alison.smith@canterbury.ac.uk); Miles, Emma (emma.miles@canterbury.ac.uk)
Subject: RE: Ian Felstead: ethics application
Date: 13 November 2012 05:37:07

Dear Ian

Thank you for your detailed feedback and approval under chair's action is now given. Good luck with your research!

Regards
Petra

-----Original Message-----
From: Felstead, Ian (ian.felstead@canterbury.ac.uk)
Sent: 12 November 2012 13:37
To: Engelbrecht, Petra (petra.engelbrecht@canterbury.ac.uk)
Cc: Felstead, Ian (ian.felstead@canterbury.ac.uk); Smith, Alison (alison.smith@canterbury.ac.uk)
Subject: RE: Ian Felstead: ethics application
Importance: High

Dear Petra
Thank you for your email. In response to the two points:

1. Please find attached emails from Doug MacInnes and Margaret Andrews indicating their approval for the project. Once I receive official notification from the Education FREC that my project has been approved I will of course forward this to them (they have already received a copy of the application form). If there is anything else that I need to do I would appreciate your guidance.

2. It is acknowledged that even though there is voluntary involvement there will remain a power issue given my relationship to the students. I will clearly acknowledge this in the research and the potential bias that this may introduce. As well as interviewing in a 'neutral' location I will also ensure that I 'dress down' (i.e. jeans etc.) in an attempt to put respondents at ease and further strengthen the fact that I am undertaking this project as a student of the University and not a member of staff.

Please do let me know if further information is required in order to gain full approval for my project.

Kind regards
Ian

Ian Felstead
Senior Lecturer
Pathway Director - IPL Adult Nursing
Assistant Director of Quality for the Faculty of Health & Social Care Canterbury Christ Church
University

Tel: 01227 782776
Email: ian.felstead@canterbury.ac.uk

-----Original Message-----
From: Engelbrecht, Petra (petra.engelbrecht@canterbury.ac.uk)
Sent: 10 November 2012 15:35
To: Felstead, Ian (ian.felstead@canterbury.ac.uk)
Cc: Miles, Emma (emma.miles@canterbury.ac.uk)
Subject: Ian Felstead: ethics application

Dear Ian
Thank you for the submission to the Education Faculty Ethics Review Committee: 'An exploration of the lived experiences of role modelling and its impact on the development of adult nursing students as professional practitioners'.

The reviewers would like to point the following out:

1. Item 5: as the students in the group are not from the Education Faculty, your application form must be copied to the Dean of the Faculty concerned and to the Chair of that Faculty's Research Ethics Committee

2. Item 11: the researcher should acknowledge that even if students decide to take part there will still be a power issue with regard to the relationship between a student (even if now qualified) and a tutor/PhD. The question can therefore be asked how this will influence be addressed or at least acknowledged.

Conditional approval is given and your feedback regarding these points will be appreciated.

Regards
Petra

Professor Petra Engelbrecht
Education Research Directorate
Canterbury Christ Church University
North Holmes Campus
Canterbury Kent CT1 1 QU
Telephone: +44 (0)1227 782912
Fax: +44(0)1227 863462

APPENDIX 16

Faculty of Health & Social Care ethics approval

From: MacInnes, Douglas (douglas.macinnes@canterbury.ac.uk)
To: Felstead, Ian (ian.felstead@canterbury.ac.uk); Andrews, Margaret (margaret.andrews@canterbury.ac.uk)
Cc: Miles, Emma (emma.miles@canterbury.ac.uk)
Subject: RE: Ethics application Ian Felstead
Date: 23 July 2012 17:30:54

Dear Ian,

Thanks for your email. The usual procedure would be for you to go through the Education Faculty Research Ethics Committee route and, once this has been done, send this ethics agreement to me as proof that it has gone through a valid ethics committee prior to getting agreement from the relevant programme manager in the Faculty with regards access. As such, it is appropriate for the application to be considered by the Education Faculty Research Ethics Committee.

Best wishes,
Doug

Dr Douglas MacInnes
Reader in Mental Health & Acting Director of Research (Faculty of Health and Social Care)
Centre for Health and Social Care Research
Canterbury Christ Church University
Cathedral Court
Pembroke Court
Chatham Maritime
Kent ME4 4YH
Phone 01634 894412 (Direct Line)
e-mail: douglas.macinnes@canterbury.ac.uk
website: http://www.canterbury.ac.uk/health/health-social-care-research/home.aspx

-----Original Message-----
From: Felstead, Ian (ian.felstead@canterbury.ac.uk)
Sent: 23 July 2012 14:44
To: Andrews, Margaret (margaret.andrews@canterbury.ac.uk); MacInnes, Douglas (douglas.macinnes@canterbury.ac.uk)
Cc: Felstead, Ian (ian.felstead@canterbury.ac.uk); Miles, Emma (emma.miles@canterbury.ac.uk)
Subject: Ethics application Ian Felstead
Importance: High

Dear Margaret and Doug
Please find attached a copy of my Ethics application (and associated documents) for the final stage of my Doctorate in Education. As this programme 'sits' within the Faculty of Education I am applying to the Education FREC however the form states that once completed it should also be copied to the Dean of the Faculty concerned as well as to the Chair of that Faculty's Research Ethics Committee. This is because I am applying to Education but recruiting students from the Faculty of Health & Social Care.

Could you please consider this application and if so, confirm to Emma Miles (Education FREC secretary) that you are happy for this to proceed to the committee?

I have copied Emma in to this email and would appreciate it if you would cc me in to your response please.

Kind regards
Ian

Ian Felstead
Senior Lecturer
Pathway Director - IPL Adult Nursing
Assistant Director of Quality for the Faculty of Health & Social Care Canterbury Christ Church
University
Tel: 01227 782776
Email: ian.felstead@canterbury.ac.uk