A GROUNDED THEORY STUDY OF NURSING STUDENTS' EXPERIENCES IN THE OFF-CAMPUS CLINICAL SETTING

by

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Abstract

Poor workplace relations are an issue of concern in many workplaces and this phenomenon is not restricted to the nursing profession. The issue of workplace violence in nursing is well documented and there are an increasing number of studies which have investigated the notion of horizontal violence amongst graduate nurses. The impact that poor workplace relations has on the development of a professional identity by nursing students in the off-campus clinical setting is significant in light of the current global shortage of nurses.

There is a dearth of knowledge in understanding how Australian undergraduate nursing students experience the off-campus clinical setting and subsequently develop a professional identity as a nurse. Therefore the aim of this study was to discover and describe the phenomena in order to develop a substantive theory that explains the experiences of the undergraduate nursing students in a regional setting.

Constructivist grounded theory methods were utilised in the conduct of the study. A sample of 29 participants was recruited permitting the formulation of a substantive theory regarding the development of a professional identity in nursing students. This substantive theory contributes knowledge relevant to the undergraduate nursing students, nurse educators, nursing workforce planners, and the tertiary educational institutions offering nursing. This is achieved through discovering, describing and explaining the phenomenon of 'anxiety' which the nursing students experience as a

result of the interrelationship and interactions of *tradition bearing*, *staff* and *student performance*. These interactions intersect to form expectations of where the student fits within the hierarchy of the facility and the nursing profession in general. An understanding of the issues associated with *tradition bearing*, *staff performance*, and *student performance* and the impact that the interaction of these conditions has upon the student's developing professional identity as a nurse is necessary to allow for the implementation of corrective strategies.

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Acknowledgements

Over the last five years I have been on a journey of discovery, both personally and academically as I have undertaken the task of completing this thesis and the associated research. As a result of this at times tumultuous personal and academic journey I have grown both as a person and as an academic. The journey that was this Doctorate has bought both joy and sadness. However at the end of the journey I believe that the end result has been well worth the effort and I will truly miss the challenges which it has posed. The completion of this thesis is not an end, but rather a beginning.

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Declaration

I, Brian John Sengstock, certify that the main text of this thesis is entirely my own work. This work has not previously been submitted for the award of a Diploma or Degree in this, or any other, university. To the best of my knowledge and belief this thesis contains no materials published or written by another person except where due reference is made within the thesis itself.

B. J. Sengstock

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Brian John Sengstock

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Glossary

There are a number of terms used throughout this thesis. These are explained in the following text.

Registered nurse - A registered nurse (RN) is a "person licensed to practice nursing under an Australian State or Territory Nurses Act" (Australian Nursing Council 2000:27).

Enrolled Nurse - An Enrolled Nurse (EN) is a "person licensed to provide nursing care under the supervision of a registered nurse' (Australian Nursing Council 2000:27).

Endorsed Enrolled Nurse – An Endorsed Enrolled Nurse is a "person licensed to provide nursing care under the supervision of a Registered Nurse' (Australian Nursing Council 2000:27). An Endorsed Enrolled Nurse has a medication endorsement.

Assistant in nursing – An assistant in nursing (AIN) is an unregulated health care worker in the nursing sector.

Preceptor – A preceptor is a registered nurse who is employed by a health care facility and provides one-on-one support to a nursing student. A preceptor is responsible for providing the interface between the university and the clinical facility in the supervision of students in a preceptored model of nurse education.

Facilitator – A facilitator is a registered nurse employed by the University to facilitate the educational experiences of nursing students in the off-campus clinical setting. The facilitator works with between eight and ten nursing students and is responsible for providing the interface between the clinical facility and the university.

Off-campus clinical setting - In this study the Off-campus clinical setting was defined as being the practice setting in which students were placed away from the campus clinical laboratories.

Clinical level – Clinical level is the 'rank' of nursing staff overall as a cumulative group. For example assistants in nursing, enrolled nurses and registered nurses. The term is used in the analysis and discussion sections of this thesis and specifically incorporates all of the clinical levels of the nursing profession.

Contribution to New Knowledge

It is a requirement that a Doctoral study provides a significant original contribution to knowledge. The new knowledge identified in this study is summarised below.

1. The informal power of AINs, especially those who have worked for long periods of time in one setting.

2. That BN staff are more likely to be negative to students than hospital trained staff.

3. That length of service is more important than seniority in terms of "tradition bearing".

4. Disclosure of previous nursing experience by students produces varable results.

5. That ENs who were upgrading to BN were particularly at risk of negative behaviours.

6. That there was a dissonance in expectations between RNs and students regarding time management.

7. That students are often allocated AIN work rather than experiencing the full range of RN work for which their clinical experience is meant to prepare them.

8. Students cope with negative behaviours and their anxiety about this by "not ruffling feathers".

Chapter One – The Research Defined

Introduction

This chapter introduces the study that is reported in the following chapters of this thesis. Commencing with background information, the reader is provided with an appreciation of the problem and existing knowledge related to the problem. A limited review of the literature was conducted in accordance with the selected methodology. An in-depth discussion of the use of literature in grounded theory studies is provided later in this chapter under the heading 'Turning to the literature'. The scope and aim of the study is provided along with the research questions. The chapter then concludes with an overview of the organisation of the thesis.

Background to the study

Whilst it could be argued that Florence Nightingale was significant in her contribution to reformation of the status of women through the establishment of paid training and employment in nursing in the late 1800s; her legacy is still felt in the 21st century. Paid work for women in the nursing profession opened up employment opportunities; however it also constrained the nursing workforce due to the rules, regulations and expectations that Nightingale enforced and which continue to be enforced (van der Peet 1995). The rules, regulations and expectations of the Nightingale era are still evident in nursing practice today.

As a profession, nursing is hierarchical in nature. Operating through a defined linear chain of command, individuals within the nursing profession have a particular place on that chain. An individual is either superior to those below them or subordinate to those above. The hierarchy that exists within the overall profession also exists within each clinical level. Historically, hierarchical disciplinary action has been utilised by military and religious leaders to ensure that cultural norms are strictly followed and maintained. Unquestioning attitudes and obedience were rewarded, whilst dissidence and disobedience were met with disciplinary action and humiliation (Hadikin & O'Driscoll 2000). Through the use of punishment leaders ensured that group members adhered to the rules, traditions and values that had become accepted cultural norms. Duffy (1995) argues that hierarchical systems, such as those in nursing, thrive through the use of controlling, coercive and inflexible protocols.

Given that the central focus of nursing is caring, it is paradoxical that the literature reveals interpersonal conflict amongst nurses as a significant issue confronting the profession in the 21st century (Cox 1987; Duffy 1995; Farrell 1997, 2001; Taylor 2001; Sengstock, Moxham & Dwyer 2006). Known as 'horizontal violence', interpersonal conflict is described by Duffy (1995) as hostile and aggressive behaviour by individual or group members towards another member or groups of members of the larger group. Horizontal violence most commonly manifests as covert psychological harassment, which creates hostility, as opposed to overt physical aggression. This harassment involves the use of verbal abuse, threats, intimidation, humiliation, excessive criticism, innuendo, exclusion and denial of access to opportunity, disinterest, discouragement and the withholding of relevant information (McMillan 1995; Farrell 1997, 2001; Thomas & Droppleman 1997;

Quinne 1999). Regardless of the nomenclature that is used to describe these behaviours, they are identifiable as bullying in nature and as such have wide ranging negative effects upon everyone involved, either as a participant, a victim, or through exposure. For consistency in this thesis the term 'horizontal violence' is used as this is the term that nurses often use for bullying behaviours in the workplace.

The Australian model of pre-registration nursing education is now university based. The previous model was more of an apprenticeship. However, in 1985 a mass movement across to the tertiary sector occurred (Bloomfield n.d.) with Queensland largely making the transition in 1987. The approach to educating nursing students in the tertiary sector separated the theoretical and clinical learning environments. Now, nursing students complete a theoretical component as well as a practical skill development component in a 'controlled and safe' university environment. They then complete an off-campus clinical placement where they are expected to apply their knowledge and skills in a 'real' practice setting. Off campus clinical placements allow nursing students the opportunity to integrate the skills and knowledge that they have gained at university and the time to build their confidence. Off campus clinical placement is also a time when nursing students become socialised into the profession through their interaction with peers and the work environment; thus developing their identity both personally and professionally.

As in all professions, there are certain 'norms' that are used by the members of the organisation to provide stability and direction. Nursing is no exception to this cultural phenomenon. Suominen, Kovasin & Ketola (1996) indicate that the structure of the nursing culture remains an aspect that is very much unexplored and is seldom

discussed either in practice or research. The concept of culture is closely interwoven with the values espoused by a community (Robbins *et.al.* 1998) and generally sets the expected behaviours of the members of that community. In the broadest sense, culture is the deep and invisible structures of society which are transferred from one generation to the next (Suominen *et.al.* 1996). Nursing students are taught by nurse academics and are periodically placed in the clinical setting with Preceptors and registered nurses who supervise and assess them on practicum. Both the nurse academic and the Preceptor have been socialised into the cultural norms of nursing by their work environment and peers during the time that they trained and worked as a nurse.

Induction into the cultural norms of nursing is discussed by Holland (1993) and facilitated through the experiential learning that occurs in the off-campus clinical setting. Kovasin (1993, cited in Suominen 1997) found that nurses learned the behaviours that are expected of them by working with experienced nurses and through observing what others were doing. It is through this process that they internalise the routines and rituals of the nursing profession. The 'rules of work' as well as the work roles, tasks and status are controlled by an elite few members of the nursing team, with the rules being enforced through ritual indoctrination that may or may not be overtly apparent (Hutchinson, Vickers, Jackson & Wilkes 2006).

The process of professional socialisation affects the individual's self-esteem through the assimilation of professional norms. Social comparison, according to Randle (2003), plays a central role in the development and maintenance of professional self-esteem. In order to consolidate and enhance their place in the eyes of their peers, it is

highly probable that student nurses will conform to the roles and standards that are expected of them (Randle 2003). This includes behaviours associated with horizontal violence. Hutchinson, Vickers, Jackson and Wilkes (2006) indicate that nursing staff subjected to horizontal violence either resign their positions or acquiesce to survive in the clinical environment. Indeed some perpetuate behaviours that they originally found abhorrent.

Currently there is a critical shortage of nurses worldwide (Delez 2003; Bowen & Curtis 2004) and whilst it is generally assumed that poor wages and conditions are the main contributors, recent research has begun investigating the impact of horizontal violence on recruitment and retention rates in nursing (Bowen & Curtis 2004). An increase in the number of undergraduate nursing students who are not completing their pre-registration nursing program is cited by Bowen and Curtis (2004) as a developing issue over the last decade. Jackson, Clare and Mannix (2002) link recruitment and retention issues in the nursing profession to horizontal violence. Anecdotal evidence suggests that student nurses are subject to negative experiences during clinical placements and this in turn may lead to an increased non-completion rate at university. The impact that the negative behaviours experienced in the off-campus clinical setting have on the nursing students is the foci of this study.

One of the contributing factors to the current shortage of nurses is the ageing of the workforce (Nevidjon & Erickson 2001). In 2001 approximately one third of the worldwide nursing workforce was over 50 years of age (Nevidjon & Erickson 2001). The Australian average age for all employed nurses in 2005 was 45.1 years, an increase from 42.2 years in 2001 (Australian Institute of Health and Welfare 2008).

The proportion of nurses aged over 50 years increased from 24.4 percent to 35.8 percent over the same period (Australian Institute of Health and Welfare 2008). The increasing age of nurses is no longer as pronounced amongst enrolled nurses (ENs) when compared to RNs as it was in the 2001 survey (Australian Institute of Health and Welfare 2008). As the average age of the nursing profession continues to increase, it becomes increasingly important to attract younger people to nursing and then retain them in the profession (Hogan, Moxham & Dwyer 2007). Boychuk Duchscher (2006) argues that there is mounting evidence that the perception of nursing as a challenging and satisfying career is waning amongst society's youth. This is significant in light of statistics which indicate that between 35 and 61 percent of new nursing graduates will leave their place of employment, or the profession, within their first year of professional practice (Aiken *et. al.* 2001).

Many of the longer serving nurses in the present nursing workforce were trained in a strictly disciplined style with a considerable amount of time allocated to the development of practical skills within the hospital environment. Nurses therefore gained extensive experience and competency in their practical skills (Davey 2003). In contemporary preparatory programmes offered through the tertiary sector, students are empowered and gain theoretical knowledge from a wide variety of health disciplines which encourages them to ask questions and challenge. This is quite different from the hospital training and its strict adherence to hierarchy, where hospital trained nurses did not challenge their superiors and if they did they paid the price, often with extended demotion (Madsen 2000).

In the majority of research studies investigating horizontal violence in the nursing profession, the focus has been on the effects of horizontal violence from an oppression theory perspective (Farrell 2001). These studies have also exclusively focused on nurses who had graduated and were working in a nursing environment (McCall 1996; Farrell 1997, 2001; McKenna, Smith, Poole & Coverdale 2002). A study (n=152) of second and third year undergraduate nursing students at the University of Wollongong (NSW) was conducted by Bowen and Curtis in 2004. This study utilised a mixed methods approach to investigate again the effects of horizontal violence. All of the studies examined (McCall 1996; Farrell 1997, 2001; McKenna, Smith, Poole & Coverdale 2002; Delez 2003; Bowen & Curtis 2004) are unanimous in identifying horizontal violence as an ongoing issue of significant concern to the nursing profession.

The problem

In the preceding discussion it is apparent that the issue of horizontal violence and negative interpersonal behaviours in nursing is one of concern for the profession. Changes in the education of nurses and the current critical shortage of nurses on a global scale have affected the way that nurses practise. As a direct consequence of the nursing shortage, the clinical facilities are forced to assign increasing numbers of patients with higher acuity levels to smaller numbers of nurses, resulting in nurses experiencing increased levels of job stress. The increased workloads exacerbate feelings of a lack of control over the situation or work environments (Duffy 1995). A feeling of disempowerment can result and this emotional response can be directed at nursing colleagues and nursing students. As a result of the inappropriate behaviours

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physical and/or psychological illness can result, or nurses may decide to leave the profession completely. Through the course of their program, nursing students may be exposed to behaviours which are less than optimal for learning the skills required to be a beginning RN. In the case of horizontal violence being directed towards nursing students, leaving the program prior to graduation is something that students view as an option.

Nursing students enter the off-campus clinical setting with the expectation that they will be integrating the skills and knowledge that they have gained and applying that knowledge and skill in a practical environment. In the off-campus clinical setting the registered nurse plays a critical role in their education through assisting them to perform tasks and acting as a role model. Positive behaviour has an empowering and confidence boosting effect on the student (Bowman, Thompson & Sutton 1986; Chesser-Smyth 2005; Lusk, Winnie & DeLeskey 2007). However, a display of behaviours which are indicative of horizontal violence can have a twofold impact. First the behaviour leaves the nursing student questioning their choice of career and their position within the hierarchy, causing them to disconnect from the clinical setting. Secondly there is the risk that the nursing student will perceive that horizontal violence is an accepted part of nursing culture and assimilate these behaviours into their own practice thus perpetuating them in subsequent generations of nurses (Boychuk Duchscher 2006).

Literature related to the wider nursing workforce and their experience of workplace bullying fails to explain adequately the experiences of the undergraduate nursing students as they attempt to determine their position within the hierarchy. A dearth of

knowledge in the meaning that undergraduate nursing students assign to behaviours in the workplace and how this behaviour impacts on them is a gap in the knowledge which this thesis fills.

Study scope

This study has been limited to the second year undergraduate nursing students enrolled at a regional university in Australia. Importantly, consideration was given to the number of nursing students enrolled and the degree to which they had participated in the off-campus clinical setting. The choice of second year undergraduate students as participants was therefore based on the rationale that first year students had received limited exposure to the clinical setting whilst third year students had considerable exposure to the clinical setting and may have already assimilated the behaviours of the staff, thus not providing a valid understanding of the phenomenon. Delimiting the participants also ensured that the study was of a manageable size.

The aim of the research

The aim of research was to identify and contextualise issues faced by second year undergraduate nursing students in the off-campus clinical setting and to develop a substantive grounded theory that explains their experiences.

The research questions

Qualitative researchers and in particular grounded theorists tend to generate a 'grand tour' question that states the phenomena to be studied in a very general way (Cresswell 1994). Through the use of a broad research question the researcher has the flexibility to explore the phenomena in an unconstrained manner (Strauss & Corbin 1998). As is common in grounded theory the research question in this study was initially broad and became more focused as the study progressed (Strauss & Corbin 1998; Charmaz 2006). The initial research question set out to discover how undergraduate nursing students experience the off-campus clinical setting. As the study progressed this question was modified and became more focussed.

The following three focussed questions were used to guide the study:

1. Do undergraduate nursing students experience negative interactions whilst in
   the off-campus clinical setting?
2. What do undergraduate nursing students identify as being negative
   experiences in the off-campus clinical setting?
3. How do the negative experiences make nursing students feel?

These three focused questions allowed me to identify the multiple realities of the diverse undergraduate cohort that participated in this study. Through the use of these questions it was possible to meet the study aims as explicated earlier in this chapter.

Turning to the literature

The issue of the literature review in grounded theory remains a contentious one with the classic grounded theorist arguing that a literature review should not be conducted until after the analysis is completed (Glaser & Strauss 1967; Glaser 1978). The rationale for this was based on the potential for 'received theory' or seeing data through the lens of earlier ideas (Charmaz 2006). Strauss and Corbin (1998:48) clarify their position on this by stating, "we all bring to the inquiry a considerable background in professional and disciplinary literature". Charmaz (2006) argues that Glaser's (1992, 1998) position remains somewhat ambiguous with Glaser indicating that the grounded theorist should remain 'uncontaminated' by extant ideas. This is in contrast to Glaser's (1978:72) earlier work in which he writes, "It is necessary for the grounded theorist to know many theoretical codes in order to be sensitive to rendering explicitly the subtleties of the relationships in his [or her] data".

Glaser and Strauss's original pronouncement has been rejected by Layder (1998) and Dey (1999). Glaser and perhaps Strauss are viewed by Layder (1998) and Dey (1999) as naively viewing the researcher as a *tabula rasa*, although in his treatise with Juliet Corbin, Strauss does make mention that there are no *tabula rasa* researchers as all researchers enter the field with underlying knowledge and experience (Strauss & Corbin 1998).

A preliminary activity in this study was the conduct of a limited review of the literature related to workplace experiences of undergraduate nursing students. This review was undertaken to identify existing knowledge in the field and to provide a

rationale for the conduct of the proposed research (Smith & Biley 1997). As a Doctoral research student I was required to present a research proposal for candidature to be confirmed and a requirement of this proposal was a completed literature review. There is also the requirement that a Phd dissertation provides a significant original contribution to knowledge in the substantive area of the thesis and in an effort to identify an area where a dearth of knowledge existed it was necessary to complete a literature review to gauge the existing knowledge. A dearth of knowledge was identified in the literature in the proposed study field and this provided the rationale for this study.

Strauss and Corbin (1998) provide the grounded theorist with the option of returning to the literature related to specific findings in an attempt to supplement the interview data. This approach was utilised in the latter stages of the data analysis to support the findings that emerged in the data. As argued above, turning to the literature could mean the theory may be 'forced'. This therefore contributed to the decision to stay away from the bulk of the literature until the latter stages of the data analysis, thus also ensuring that the theory was grounded in the actual data (Strauss & Corbin 1998).

Towards the latter stages of data collection and analysis a review of the literature was conducted to contextualise the findings of the study to existing knowledge (Smith & Biley 1997; Strauss & Corbin 1998). The research findings were compared with the literature using the constant comparative method of analysis, an approach which did not constrain the analytic conceptualisation of the original data. Literature has been woven into the discussion contained in Chapters Five and Six to integrate it

with the findings of this study and to contextualise how the substantive theory developed moves knowledge beyond boundaries that are already known (Charmaz 2006).

Organisation of the thesis

The remainder of this thesis is divided into six chapters which are organised as follows. Chapter Two describes the design of the research study, the theoretical perspective that underpins the study, the version of grounded theory deemed appropriate and the design considerations. Chapter Three provides details of the participant recruitment process, data collection methods and the methods used for analysis of the data. The sample demographics are also provided in this chapter. Chapters Four and Five provide a discussion of the findings. Specifically Chapter Four presents findings from the data and identifies the basic social problem, the contextual conditions which influence the basic social problem and the basic social process. The substantive theory is also reported in the latter stages of Chapter Four. Discussion of the key findings and the link between these and the literature is then presented in Chapter Five. Chapter Five also discusses the interrelationships between the literature and the findings and identifies where nursing students fit within the profession in the context of the off-campus clinical setting. The thesis concludes with Chapter Six which presents limitations, conclusions and recommendations.

Chapter Two – Research Design

Introduction

This chapter begins with an explanation of the research focus, posing the research question and explicating the constructivist paradigm used in the conduct of this study. Symbolic Interactionism as the theoretical perspective informing the research and its integral links with the grounded theory method are also described. A discussion of the various 'schools' of grounded theory is presented with consideration given to the choice of the grounded theory method used in this study. Researcher objectivity and sensitivity is also discussed.

The research focus

This study was designed to explore the experiences of the undergraduate nursing students in the off-campus clinical setting. Specifically, the study sought to develop an understanding of how undergraduate nursing students experience the off-campus clinical setting and of the contextual factors influencing these experiences. As such, this study is appropriately situated in Guba and Lincoln's (1994, 2005) constructivist paradigm.

Lincoln and Guba (1985) indicate that the central purpose of a study in the constructivist paradigm is understanding where the whole is greater than the sum of the parts and where the accumulation of the parts does not entirely capture the whole. Furthermore, the constructivist paradigm incorporates a relativist ontology

and a transactional and subjective epistemology (Guba & Lincoln 2005). Methodologically, constructivism is hermeneutical and dialectical (Guba & Lincoln 2005). This means that reality is constructed in the minds of individuals (Lincoln & Guba 1985). The inquirer is a "passionate participant" (Guba & Lincoln 2005:196) in the study and the "results of an inquiry are always shaped by the interaction of the inquirer and inquired into" (Guba 1990:26). Therefore the results of such inquiry are co-constructed understandings which are shaped by both the researchers and the study participants.

The 'grand tour' research question "How do undergraduate nursing students experience the off-campus clinical setting?" was asked to elicit information in order to achieve the aim of the research. Such a broad focus is consistent with a qualitative mode of inquiry as it positions the researcher in a place open to the discovery of issues and concepts which are embedded in the phenomenon that the researcher is investigating. A broad research question also minimises the possibility of restricting the study to such a narrow focus that the understanding of the relevant concepts is limited (Glaser 1978, 1992; Strauss & Corbin 1990, 1998).

A broad research question such as the one posed in this study required a research method that was interested in human-context interaction. Given its emphasis on understanding human social interaction, such as the encounters between undergraduate nursing students and nursing staff[1], grounded theory has the potential to provide insight into a complex phenomenon (Glaser and Strauss 1967; Glaser 1978, 1992). This is an ideal methodology to explore the experiences of

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[1] This collective which I label as 'nursing staff' includes the nursing classifications of Assistant in Nursing, Enrolled Nurse, Endorsed Enrolled Nurse, and Registered Nurse.

undergraduate nursing students in the off-campus clinical setting. The requirement of the grounded theory method to consider the influence of structures and processes (Strauss & Corbin 1998) ensures consideration is given to the contextual factors in the design, conduct and outcomes of the study. Symbolic Interactionism and grounded theory are collectively concerned with the construction of meaning through human action and interaction within contextual structures and processes. Constructivist grounded theory is therefore an appropriate framework to explore experiential learning such as that undertaken by students when in the off-campus clinical setting.

Symbolic Interactionism: The theoretical perspective

Symbolic Interactionism is a theoretical perspective that explains human group life and human conduct (Blumer 1969; Denzin 2004). A number of scholars including Cooley, James, Dewey, Peirce and Mead were responsible for the founding of Symbolic Interactionism (Denzin 2004); however Blumer (1969) recognises George Mead as the foremost originator of this theoretical perspective. Blumer further advanced these foundations by clarifying Mead's original work and subsequently established Symbolic Interactionism as a research approach (Blumer 1969). Symbolic Interactionism is a theoretical perspective based on the following three premises:

> …human beings act towards things based on the meanings the things have for them; … the meanings of such things is derived from the social interaction that the individual has with his fellows; … [and] these meanings are handled in, and modified through an interpretive process used by the person dealing with the things he [or she] encounters (Blumer 1969:2).

To understand an individual or group's actions, it is necessary to first discover the underlying meanings that things have for the individual or group. Blumer (1969) proposed that the meanings arising out of the process of social interaction were defined and redefined through an interpretive process involving self-reflective individuals interacting with one another in a symbolic way. This social interaction is achieved through the use of symbols such as objects, specific garments, tools and equipment, and language, with language providing the most symbolic system (Annells 1996). Symbolic Interactionism holds that individuals or groups behave and act/interact according to how they interpret and give meaning to specific symbols (Hutchinson 1986; Denzin 2004).

Nursing students are health care professionals in training; as such a student on a clinical placement may lack confidence and may not see themselves as being all that different from the patients for whom they are learning to care. In part, due to the uniform and the fact that the student is viewed by the patient as being 'knowledgeable and competent', over time the patient – practitioner interaction also moulds the student's professional identity (Andrews, Sullivan & Minichielo 2004). This development of the student's professional identity is described by research conducted by Howell (1997) which investigated why medical students are 'medical students'. This moulding of identity through the student-practitioner relationship continues until they are either fully trained or socialised into the role. Whilst the patient-practitioner example is utilised in the preceding explanation, it is the student-practitioner interaction that forms the basis of this study. As such the formation of professional identity remains a focus.

Charon (1989) proposed that Symbolic Interactionism focuses on the relationships between individuals and the world around them. Understanding that human action is based on the meaning that individuals give to their activities within their environments across time is central to Symbolic Interactionism (Flick 1998). Flick (1998) further argues that representation of the subjective meanings and the processes of interaction are central to any inquiry which is informed by this theoretical perspective. More importantly, Symbolic Interactionism views each human being as an active agent rather than a passive predetermined organism (Charon 1989).

The issue of individuals sharing common situations giving rise to 'joint action', where members of a group display patterned behaviours, was raised by Blumer (1969). The pattern of these behaviours is determined by structural rules, material resources and the structural processes which are connected to class, gender, and community (Denzin 2004). In any study of a collective, the issues of 'joint action' are important, as the behaviours of the individual may be impacted upon by the actions of the group. 'Joint action' is an important consideration in this study as nurses,[2] and nursing students (as a sub-group of that collective), may display shared behaviours that are consistent with Blumer's concept of 'joint action'.

The connectedness of the actions of individuals within the collective group results in joint actions. Joint actions, their formation, dissolution, conflict and merger constitute what Blumer calls the "social life of a human society" (Blumer 1981 cited in Denzin 2004:82). Blumer (1969) warns that any failure by the researcher to

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[2] 'Nurses' in this context is taken to include the nursing classifications of Assistant in Nursing, Enrolled Nurse, Endorsed Enrolled Nurse, and Registered Nurse.

recognise the interrelatedness of the actions and interactions of individuals within the collective group would be erroneous. As a result of Blumer's warning, it is necessary for the researcher to be consciously and consistently aware of the interrelatedness of the actions and interactions of the individuals, both practitioners and students, in the conduct of research. This formed a central tenet of this study.

A level of stability and predictability is provided to social interaction through the concept of joint action. This level of stability and predictability however, is challenged by change as new situations and problems emerge in contemporary society. This is evidenced in the nursing profession by many things, for example through the changes in the educational structure and ongoing technological changes. Blumer (1969) argues that as new situations and problems emerge, the existing rules become inadequate. New rules are required to replace the outdated rules which are no longer valid. Nursing education has changed dramatically in the last two decades, both from an educational perspective and in the numbers of students undertaking nursing which are consistently increasing. This change may be representative of a new situation or emergent problem, thus resulting in an inadequacy of the previous 'rules' related to nursing education. This could lead to a level of unpredictability and instability in the off-campus clinical setting.

Symbolic Interactionism which is premised on the fact that individuals base their actions on their interpretations of meanings is an ideal approach for this research. When there is an interlinking of the actions of the individuals within the group, patterned behaviours occur as a result of group norms. Furthermore, Symbolic Interactionism assumes that people can, and do think about their actions, rather than

just respond in a mechanistic way to external stimuli (Charmaz 2006). Symbolic Interactionism underlies grounded theory methods and as such a major strength of grounded theory is that the methodology allows the researcher to recognise the patterned behaviours, whilst simultaneously maintaining the individual perspective (Morse 2001). As is argued by Charmaz (2006), the single events of the individual become linked as a part of the larger whole. Within nursing, students are a part of the larger nursing profession.

Symbolic Interactionism permeates every level of grounded theory from epistemology and methodology, through to the actual data analysis (Milliken & Schreiber 2001). Using Symbolic Interactionism within a constructivist paradigm determines what can be known, and how it can be known. The constructivist paradigm views becoming an RN as a process; a lived experience whereby the knowledge gained reflects multiple realities which are socially constructed by the individuals. A researcher working within the constructivist paradigm believes that multiple realities exist; leading them to produce one reality, whilst simultaneously recognising that this is not the only reality. This 'one' reality, as co-constructed by the researcher and the study participants through interaction, presents one component of the participants' socially constructed meanings.

The theoretical perspectives of Symbolic Interactionism provided the foundation for the study of the experiences of undergraduate nursing students in the off-campus clinical setting. Symbolic Interactionism therefore provided an important theoretical underpinning to the grounded theory approach used in this research. Like Charmaz (2000a, 2003, 2005, 2006) I concur that we are a part of the world that we study and

the data that we collect, thus we construct our realities and meanings as a result of past and present involvements and interactions with people, perspectives and research practices.

Grounded theory: The methodology

Grounded theory methodology was originally described by Barney Glaser, a quantitative researcher and Anslem Strauss, a qualitative researcher, in the mid 1960s. In their pioneering book, *The Discovery of Grounded Theory* (Glaser & Strauss 1967) these two sociologists articulated the strategies that they had adopted in a collaborative research project on dying (Glaser & Strauss 1965, 1968). First published as "a process that articulated the discovery of theory from qualitative data" (Robrecht 1995:170), the method arose out of the combined research histories of Glaser and Strauss (Dey 1999; Charmaz 2000a; Stern & Covan 2001; Clarke 2005). Grounded theory methodology stemmed from, and is fundamentally linked with, Symbolic Interactionism (Smith & Biley 1997; Charmaz 2000a; Milliken & Schreiber 2001; Ezzy 2002; Clarke 2005). The link between the theoretical underpinning of Symbolic Interactionism and the methods of conducting grounded theory research is represented by grounded theory methodology (Milliken & Schreiber 2001).

Schools of grounded theory

Although grounded theory was originally described by Glaser and Strauss in the mid 1960s, a review of the literature identifies a divergence in the original authors' views

and development of grounded theory since their classic statements in 1967 (Glaser & Strauss 1967) and 1978 (Glaser 1978). Since this time the two authors have taken grounded theory in somewhat different directions (Charmaz 2000a), Glaser alone and Strauss in his treatise with colleague Juliet Corbin.

This divergence of the 'original' grounded theory led to the creation of two 'schools' of grounded theory; the Glaserian version based on the original work and the subsequent writings of Glaser; and the Straussian version based on refinements Strauss made to the original version in association with Juliet Corbin (Benoliel 1996; Heath & Cowley 2003; McCallin 2003; Charmaz 2006). There is however a third 'school' in which scholars have moved, and continue to move, grounded theory away from the positivism associated with both Glaser's and Strauss and Corbin's versions of grounded theory (Seale 1999; Charmaz 2000a, 2005; Bryant 2002, 2003; Clarke 2003, 2005).

McCallin (2003) suggests that the Glaserian version of grounded theory has further developed and been reframed. A similar issue occurs in the Straussian version where in Strauss' later works in association with Corbin, the roots of Symbolic Interactionism in the method grow distant (Clarke 2005). However, there is no indication in the literature that this should lead to consideration of a second school of Straussian thought in a similar way to McCallin's (2003) suggestion regarding the Glaserian school of grounded theory.

When designing a study it is essential that consideration be given to the methodological issues (McCallin 2003). In light of this, wide and extensive readings

in the area of grounded theory methodology were undertaken. Wide reading of grounded theory methodology provided an opportunity to identify and understand some of the differences between the three 'schools'. The review of grounded theory literature highlighted that the differences incorporated both methodological and method issues. The underlying ontological and epistemological assumptions of the original authors of grounded theory were found to be at the centre of the methodological issues.

The Glaserian version of grounded theory has its ontological roots in critical realism. Critical realism assumes that an objective world exists independently of our knowledge and belief and as such the researcher is considered to be independent of the research (Annells 1996). This stance is in contrast to the Straussian version of grounded theory which has its ontological roots in relativism where it is argued that reality is interpreted. In light of this, Strauss and Corbin's (1998) text encourages the researcher to be involved in the method. The Constructivist version of grounded theory (Charmaz 1990, 2000b, 2003; Charmaz & Mitchell 2001), like the Straussian version, has its ontological roots in relativism. However, the Constructivist grounded theorist takes a reflexive stance on the modes of knowing and representing studied life in that they give close attention to the empirical realities and people's collected renderings of them and locate themself within these realities (Charmaz 2005).

Glaser remained consistent with his explanation of the grounded theory method for many years after his divergence with the ideas of Strauss in relation to the direction of the method. Glaser defined grounded theory as a method of discovery; the categories were emergent from the data, the method relied on empiricism which was

often direct and narrow and analysed a basic social process (Charmaz 2006). Strauss (1987) redirected the method to a more verifiable position in his treatise with Juliet Corbin (Strauss & Corbin 1990, 1998). Strauss and Corbin's version focuses on the use of their new technical procedures rather than placing the emphasis on the comparative methods of the earlier grounded theory approaches. Glaser's version is described as a more patient, relaxed approach that waits for the theory to emerge from the data. One of Glaser's criticisms of the Straussian version is that Strauss and Corbin's procedures force data and analysis into preconceived categories (Charmaz 2006).

Constructivist grounded theory adopts traditional grounded theory guidelines however it does not subscribe to the positivist assumptions postulated in earlier formulations of the methodology (Charmaz 1990, 2000b, 2003; Charmaz & Mitchell 2001). In accordance with the apparent paradigm, constructivist grounded theorists take a reflexive stance on the modes of knowing and representing studied life. Therefore the constructivist approach to grounded theory assumes a flexible approach, and is in part a response to Glaser and Strauss's invitation in the original statement of grounded theory method for researchers to use strategies flexibly and in their own way. Charmaz (2005, 2006) provides the researcher with a way of 'doing' grounded theory whilst taking into account the theoretical and methodological developments of the last four decades.

Straussian versus constructivist grounded theory

Upon completion of an in-depth review of literature on grounded theory method it was necessary to make a decision regarding the use of the Straussian version of grounded theory, the constructivist approach, or a combination of the two 'schools' of thought. As a researcher, my philosophical assumptions are more closely aligned with the constructivist orientations of Charmaz than linked with the interpretivist orientations of Strauss and Corbin. The Straussian method is prescriptive and complex in nature from a procedural perspective, potentially leading to 'forcing' the theory rather than letting it emerge from the data.

On the other hand, constructivist grounded theory views grounded theory methods as a set of principles and practices, not as prescriptions (Charmaz 2006). Flexible guidelines are emphasised, rather than methodological rules and requirements. Glaser (2002), in his response to Charmaz and her version of constructivist grounded theory argues that constructivist data, if it exists at all, is a small part of the data that grounded theory uses. Charmaz (2006) countenances that it is possible to use the basic grounded theory guidelines that were originally developed almost four decades ago and combine them with the methodological assumptions and approaches of the twenty-first century. This approach is supported by Bryant (2002) and Clarke (2003, 2005).

Consequently I determined that there was no requirement to mix the versions of grounded theory as the use of constructivist grounded theory would allow the researcher to use the structure of the Straussian version, whilst maintaining the

additional flexibility through the use of a constructivist approach. Strauss and Corbin (1998) specifically warn the researcher against rigidly following set procedures and this warning added to the resolution to use constructivist grounded theory. The structured approach proposed by Strauss and Corbin (1998) also allows for flexibility and creativity, thus the structure of Strauss and Corbin framed the analysis phase of this research whilst maintaining a constructivist mindset to theory development.

Ontological and epistemological assumptions discussed earlier in this chapter and how these assumptions assisted in selecting constructivist grounded theory as the methodology utilised in this study were described. Consideration of such assumptions led to the determination that the reality of the experiences of the undergraduate nursing students in off-campus clinical setting could be best revealed through the use of a constructivist approach. To discover the reality of being an undergraduate nursing student in the off-campus clinical setting this researcher believed that it was necessary to understand how the participants constructed their own understanding of the clinical setting and their interactions with the staff and the off-campus clinical environment.

Constructing grounded theory

Whilst Glaser, Strauss and Charmaz vary in their underlying philosophical approaches to grounded theory and the actual methods used to develop the theory, they do agree on the purpose of the approach. In using grounded theory, the researcher inductively develops theory from interpreting the data generated by a

study of the phenomena that the theory represents (Glaser & Strauss 1967), thus the theory is 'grounded' in data. The resultant theory is usually substantive in that it has relevance to the substantive area from which the data was collected. A substantive theory is modifiable whereas more formal theories are less specific to a group and place and therefore have wider application to disciplinary concerns and problems (Strauss & Corbin 1998). The purpose of substantive theory is to "predict, explain and interpret phenomenon" (Baker, Norton, Young & Ward 1998:548). This study aimed to develop a substantive theory that was relevant to the contextual boundaries of the research question.

The researcher moves between generating categories from data (induction) and the consideration of how these categories fit with other data (deduction). The importance of induction and deduction to the development of a grounded theory is explicated by Glaser and Strauss (1967), Glaser (1978, 1998), Strauss (1987), Strauss and Corbin (1998) and Charmaz (2006); however the role of abduction is seldom explicated by these authors in any detail.

In discussing the work of Pierce, a pragmatist sociologist, Ezzy (2002:13) explains abduction as "the philosophical background to the processes that are involved in grounded theory". Unlike induction, abduction "makes imaginative leaps … to general theory without having completely empirically demonstrated all the required steps" (Ezzy 2002:14). As is graphically demonstrated in Figure 1, once a leap is made, abduction relies upon ongoing inductive and deductive testing for confirmation. If the 'imaginative leap' is confirmed by induction and deduction, the 'leaps' become Glaser's (1978) hypotheses or Strauss and Corbin's (1998:168)

"*plausible* relationships proposed among *concepts* and *sets of concepts*" which form the vital elements of theory.
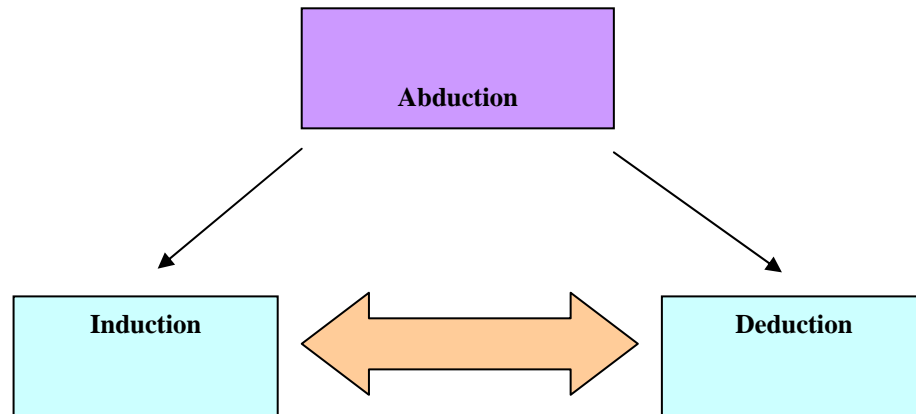
Figure 1: Relationship between abduction, induction and deduction in grounded theory

Induction, deduction and abduction as processes are structured through the execution of the core elements of grounded theory method. Texts written by the originators of grounded theory method, Glaser and Strauss, both separately and as co-authors, describe the core elements of grounded theory as coding, memoing, constant comparative method of analysis, theoretical sampling and theoretical sensitivity (Glaser & Strauss 1967; Glaser 1978, 1992, 1998; Strauss 1987; Strauss & Corbin 1990, 1998). These core elements are discussed in detail in Chapter Three.

Maintaining objectivity and sensitivity – A perspective

Prior to the commencement of a grounded theory study, the researcher needs to recognise their assumptions about what constitutes reality, and how this 'reality' impacts upon their ability to perform the role of the researcher in an objective manner. In a grounded theory study there is a constant interplay between the researcher and the research act, resulting in the researcher being shaped by the data,

as much as the researcher shapes the data (Strauss & Corbin 1998). The grounded theory researcher becomes immersed in the data and plays an integral role in every aspect of the research. Therefore, this raised the issue of maintaining a balance between objectivity and sensitivity during this shaping process. In an effort to achieve the required level of objectivity it is necessary to explicate how the researcher remained open to the emergent themes in the data whilst using the grounded theorists' background assumptions and disciplinary perspectives to sensitise the researcher to the data.

Whilst this researcher has never held employment as a nurse, or engaged in clinical practice as an undergraduate nursing student, the researcher has over a decade of employment experience in clinical care in the pre-hospital emergency setting and as such has worked closely with nursing staff in a variety of contexts. Therefore, the researcher potentially shared a level of common professional experience with the study participants that would potentially allow access to rich data. This common experience within the healthcare sector, albeit in different aspects, assisted in the analytical process through an increased sensitivity to the data. I acknowledged and was continually cognisant of the fact that these previously gained understandings were based on the values, culture, experiences and training that I had encountered and that this could create a barrier to objective and inductive data analysis (Strauss & Corbin 1998). It is my responsibility as the researcher, not the responsibility of the participants, to be reflexive about what is brought to the scene, what is seen and how it is seen.

Strauss and Corbin (1998) argue that objectivity is necessary to arrive at an impartial and accurate interpretation. Sensitivity allows the researcher to "perceive the subtle nuances and meanings in data" (Strauss & Corbin 1998:42). The recognition of these subtle differences allows the researcher to identify the connections between the concepts that are emergent in the data. Objectivity in the research process was maintained by ensuring that the researcher maintained an openness and a willingness to 'give voice' to the participants (Strauss & Corbin 1998). In an effort to maintain this level of objectivity, data was compared with other data, different data collection methods were utilised, and multiple and varied representatives of the cohort were interviewed. Objectivity was also overseen by research supervision. Whilst the study participants were recruited from one university's School of Nursing, they were geographically dispersed and had a variety of educational and professional backgrounds. The demographics of the participants are outlined later in this Chapter.

Charmaz (2006) and Strauss and Corbin (1998) propose that it is impossible for me to disassociate myself from who I am, what I know, or from the experiences that I have had. As a researcher we "*construct* our grounded theories through both our past and our present involvements and interactions with people, perspectives and research practices" (Charmaz 2006:10). In light of this, I considered my perceptions and attitudes, as well as my experiences as a student in the pre-hospital care environment. These analyses were documented in a journal entry prior to the commencement of data collection in this study. This analysis was not put aside to avoid the introduction of bias (Backman & Kyngas 1999), rather it was used to assist in the development of sensitivity to the concepts that were emergent in the data. It is appropriate to use this knowledge and prior experience in enhancing the sensitivity

of the researcher to the meanings in the data whilst not forcing explanations on the data (Strauss & Corbin 1998).

Rigour

Rigour refers to the correct use of research method and is an important aspect of the quality of research processes and outcomes (Ezzy 2002). Glaser and Strauss (1967), Glaser (1978, 1992, 1998) and, Strauss and Corbin (1990, 1998) paid attention to enhancing rigour in grounded theory studies and this is described in detail by the method's co-founders. Whilst grounded theory is becoming increasingly popular with nursing researchers there are problems with how the methodology is being used (Benoliel 1996, Lauder 2003; Elliott & Lazenbatt 2005). Glaser and Strauss's (1967) criteria for assessing grounded theory studies included fit, workability, relevance and modifiability. Charmaz (2005:527) argues that by the researcher "providing cogent explanations how the study meets high standards will advance social justice inquiry and reduce unmerited dismissals of it". As Charmaz's approach to grounded theory was utilised in this study I have adopted the criteria posed by Charmaz to meet "interpretive sufficiency" (Charmaz 2005:528).

Credibility, originality, resonance and usefulness are the criteria proposed by Charmaz (2005) for evaluating grounded theory studies. These criteria account for the empirical study and the development of the theory. The criteria proposed by Strauss and Corbin (1998) for evaluation of a grounded theory study included judging the 'research process' used for the study and 'ensuring empirical grounding' of the study. To enable the reader to evaluate the quality of the 'research process', all

research processes used in this study have been made explicit in Chapter Three (Smith & Biley 1997). The vital elements of a grounded theory study are the use of memo writing, constant comparative analysis, and a continuous cycle of theoretical sampling, data collection and analysis, identification of a core category and development of a theory (Strauss & Corbin 1998). These vital elements are discussed in detail in Chapter Three.

Researcher bias was controlled through the methods described earlier in this chapter which further enhanced the validity of this study (Chiovitti & Piran 2003). Through the use of the constant comparative method the validity of emergent conceptualisations was constantly checked. There is in-built verification and validation embedded in the constant comparative method, so additional member verification and validation was not required. Internal validity was enhanced through the coding process which is fully explained in Chapter Three. In the latter stages of the study a return to the literature and a comparison of the study findings was made with the literature, thus contextualising, grounding, and providing validation of the findings. To further enhance the validity of the developed theory, participants' own words have been used in the report of the findings (Backman & Kyngas 1999).

The developed substantive theory is relevant to the population from which it was developed as it is developed from their experiences and directly attempts to offer insight, enhance understanding, and inform action (Strauss & Corbin 1998; Charmaz 2005, 2006). Strauss and Corbin (1998) proposed that rather than determining generalisability, it is the explanatory and predictive ability of the developed theory that is the area to be critiqued. In accordance with the recommendations of Strauss

and Corbin (1998), further research would be necessary to determine whether the substantive theory developed in this context is applicable in other contexts. This could be an area warranting future research.

Ethical considerations

Ethical clearance to conduct this research study was sought and obtained from the relevant Human Research Ethics Committee. Access to potential participants was gained through application to the Dean of Faculty and Head of School at the recruitment site. Recruitment and data collection activities commenced following the receipt of approval to access participants. The study was explained to participants in plain English via an Information Sheet (Appendix B) and the researcher's contact details were provided to enable participants to access further information if they required it. Written informed consent (Appendix B) was obtained from participants prior to the commencement of data collection activities. Verbal consent was obtained from each participant at the commencement of the interview with this verbal consent being audio recorded. Participants were fully informed that they could withdraw at any time without prejudice.

The issues of anonymity and confidentiality have been addressed in a variety of ways throughout the course of this study. As the recording of the individual interviews was undertaken by EC Teleconferencing, the requirement for confidentiality and anonymity was reiterated with the company's manager. Upon the audio recording being burnt to a compact disc, and the recording being confirmed as successful, an email request was forwarded to the organisation requesting that the

copy of the recording be removed from the organisation's server. To assist in the maintenance of confidentiality the audio recorded interviews were transcribed by the researcher. The transcripts referred to individual participants by the use of a code to maintain anonymity.

Anonymity is not possible in focus group discussions due to the nature of the method; therefore it is impractical to guarantee participants absolute confidentiality because the researcher has no control over the participants after they leave the session (Stewart & Shamdasani 1990; Smith 1995). An assurance of confidentiality on the researcher's part was given to participants regarding the researcher's treatment of the all data and those participating in the focus group discussion were asked to maintain the confidentiality of the discussions. Participants were debriefed prior to the focus groups disbanding as this allowed the participants to gain a sense of closure and reduced the likelihood that participants would discuss the issues raised outside of the group (Stewart & Shamdasani 1990). All participants were assured of anonymity in the presentation of the study findings and any publications that were resultant from the study.

Throughout the course of the study all data were stored securely in the locked office of the researcher. Computer files were stored on a password protected hard drive to ensure that the integrity and security of the data were maintained. Upon the completion of the study, all the data will be stored in a secure area at the university as per policy.

Conclusion

The research focus of this study was presented in this chapter with a comprehensive discussion of Symbolic Interactionism as the underpinning theoretical approach. As described Symbolic Interactionism is intrinsically linked with the grounded theory methodology and permeates every aspect of both the methodology and analytical methods. The paradigm of constructivism was discussed and the appropriateness of a constructivist approach for this research project was presented, subsequent to a discussion of the Glaserian and Straussian 'schools' of grounded theory. A rationale for the selection of constructivist grounded theory as the research methodology in this study was provided and is woven through the discussion that is presented. Maintenance of objectivity and sensitivity, study validity, and ethical considerations were also discussed. In the following chapter, a description of the research process is expanded, including an overview of the setting and participants, data collection and analysis methods.

Chapter Three – Study Methods

Introduction

The previous chapter provided the methodological approach of this study. In this chapter the study methods are explained, commencing with a discussion on the recruitment of the participants and the sampling approaches utilised. Initially a purposive sampling method was undertaken but appropriately, the sampling method subsequently became theoretical in accordance with grounded theory methods. An overall demographic profile of the participants is presented, with a profile of the participants who contributed to both the focus group and the individual interviews. The data collection methods and data collection procedures are also discussed along with the data analysis methods. Although the discussion separates data collection and data analysis, data collection and data analysis were actually conducted simultaneously. Data analysis commenced immediately following the completion of the first focus group discussion and continued until completion of the study; again following the Grounded Theory design.

Selection of the participants – The process of recruitment

In an effort to ensure an adequate pool of participants, all the students enrolled in the second year of a Nursing program were identified as potential participants and were invited to participate. Potential study participants were located in four geographically

dispersed locations. Response rates across the delivery sites were consistent, with an average response rate of 24 percent.

Invitations to participate were mailed to each participant and this invitation was subsequently followed up with an email reminder a fortnight after the invitations were sent. Due to the time lapse between the invitation to participate and actual participation, a number of participants in the latter stages of the study were contacted by telephone to determine if they were still willing to be a part of the study. All participants who had initially consented, and who were subsequently able to be contacted were willing to participate in this study. Two participants who had originally consented were not able to be contacted at the time data collection occurred.

As a result of theoretical sampling, it was necessary to contact a number (n = 15) of participants by telephone. Additional participants were selected from across the four sites. Further recruitment of participants was based on a requirement of theoretical sampling to access two specific age demographics which were initially under - represented. A total of 39 participants were recruited as eligible to participate in the study, although only 29 participants were actually required to achieve full saturation. The rationale for the additional recruitment is discussed fully later in this chapter.

Selection of the participants – The process of sampling

Grounded theory uses non-probability sampling, where the sample numbers or data sources are unknown at the commencement of the study (Glaser & Strauss 1967;

Strauss & Corbin 1990, 1998; Cutcliffe 2000). In accordance with the prescription of Glaser and Strauss (1967) and Strauss and Corbin (1990, 1998) the sampling then becomes theoretical, rather than purposive, in that the sampling is determined by the emerging theory. This study used purposive sampling to access undergraduate nursing students who had a diversity of educational, social and professional backgrounds, whilst also having had some exposure to the off-campus clinical setting.

Purposive sampling was used in the initial stages of this research study to recruit two focus groups of participants who were enrolled in their second year of a Baccalaureate nursing program, who were willing to participate in a focus group discussion, and who had a diversity of demographic attributes (age, prior nursing experience, levels of education, previous employment, diverse placement setting). The use of a purposive sampling method allowed the researcher to select participants for the initial focus group discussions based on the information that was provided in the demographic survey (Tashakkori & Teddlie 1998). As the analysis of data from this sample would direct future data collection, a high degree of diversity in the participants would enhance the potential for a magnanimous exploration of the issues raised in the focus group discussions.

Qualitative researchers frequently use purposive sampling as a method for extending knowledge through deliberately seeking sample participants who are known to be rich sources of data (Roberts 1997; Tashakkori & Teddlie 1998). Theoretical sampling is a form of purposive sampling, and is the sampling method used in

grounded theory after the initial sample is selected and the initial data collection and analysis has been undertaken.

Ambiguity surrounding the distinction between purposive and theoretical sampling in the literature (Coyne 1997), appears to stem from the preconceptions that researchers hold in relation to sampling (Charmaz 2006). Coyne (1997) suggested that theoretical sampling is a 'variation' within purposive sampling, a variation that is a complex, ongoing process which interacts with data collection and simultaneous analysis to identify further data needs which are then met by the sampling strategy. Theoretical sampling is therefore determined by the analysis of the data, rather than being predetermined by the researcher. However, the purpose of theoretical sampling varies, depending on whether the initiator of the further data collection was open, axial or selective coding (Strauss & Corbin 1998).

Theoretical sampling in this study sought out particular characteristics that had been identified through an analysis of the previously collected data as being potentially important for further exploration. Therefore the theoretical sampling in this study was not always based on all of the demographic characteristics of an individual participant. However the broader demographics of the participant were not discounted in the subsequent analysis and comparison of data with data. This approach allowed me to control for the potential bias that was present in the sampling method utilised in this study. Glaser (1992) proposes that the use of constant comparative method, the requirement for saturation of the data and also the linking of the sub-categories to the core category, all reduce the potential bias associated with this sampling method. As a result of the data being so closely linked

to the participants in the study and their experiences of the off-campus clinical setting, the findings of the study are not generalisable to the wider body of nursing students outside the study group.

In one instance of theoretical sampling in this study, participants were selected based on age demographics in an effort to develop an understanding of the experiences of a particular age demographic. The particular participants selected theoretically for this specific interview were not sampled for prior nursing experience, education or the number of clinical placements undertaken. Rather, age was deemed as being more important to determine the experiences of a particular age group in which there was a dearth of data in this study.

It was not the intention of the researcher to imitate the broader demographic of the nursing workforce or the wider regional undergraduate nursing student body. Rather a broad range of participant demographics was sought. Morse (2001) proposed that a well rounded and balanced explanation of the phenomenon can only be produced through sufficient variation in the sample population. The use of a wide range of participants in this study also acted as a validity tool (Smith & Biley 1997). The demographic survey findings are presented in the following pages.

Sample profile – The demographic of the study

Data from the demographic survey were used to profile the 29 participants. Demographic data are presented in four tables. Table 1 provides the overall statistical data of the participants in the focus group interviews whilst Table 2

provides the demographic information regarding the clinical placements undertaken by the participants in the focus groups. Table 3 provides the demographic data of the participants who participated in the individual interviews. The range of clinical placement fields in which participants selected for individual interviews were located is presented in Table 4. [3]

Whilst 39 participants were initially recruited to this study, as a result of theoretical sampling and data saturation being achieved, not all of the participants were interviewed. One participant withdrew from the study at the commencement of the second focus group discussion due to their lack of time and two participants were unable to be contacted after they had initially agreed to participate in this study. Of the 36 remaining participants, 29 participated. In the event that a selected participant's demographic data was incomplete, the missing demographic data was collected at the time of the interview.

Due to participants having completed multiple clinical placements in some instances, and some participants having completed placements in different settings during one clinical practicum, the number of 'placements' far exceeds the number of participants. These data are included to provide the reader with an overview of the diversity of clinical experience. This and the diversity of demographics demonstrated, enhances the quality and richness of the data with reference being made to this in the later analysis and discussion Chapters.

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[3] In Table 2 and Table 4 the total number (n) exceeds the number of participants in the study as participants had undertaken multiple placements in various facilities. This demographic information is provided to demonstrate the distribution of the participants across the various clinical settings in the off-campus clinical setting.

Sample Profile – Focus groups

All the participants in the focus group discussions were female with the majority (70%) being aged over 35 years. This is consistent with the gender and age profile of nursing[4] (AIHW 2008). The remaining participants in the focus groups were aged in the 18 to 25 years age demographic. There were no participants available in the 26 to 34 years age demographic in the focus group discussions. The majority of the participants in the focus groups had no prior nursing experience or had gained employment as an assistant in nursing subsequent to the commencement of the program. Participants were generally enrolled in the full time study mode. Only one participant had undertaken more than two clinical placements and this was due to individual circumstances. Half of the participants in the focus groups had completed secondary education as the highest educational qualification prior to enrolment in the nursing program; however two participants were undertaking this program as a second undergraduate degree.

As alluded to previously, Table 2 (page 43) demonstrates that the participants in the focus group discussions had been placed widely within the range of clinical placements available. It should be noted that each participant has been placed in a combination of the above settings during the period of time they have been in the off-campus clinical setting. Participants were theoretically sampled from both the public and private health care sectors in an effort to identify if there were differences in the two sectors in relation to student experiences.

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[4] This age profile is also consistent with the age of the student cohort that participated in this study. Whilst there were no male students available for interview in the focus groups, the number of male students interviewed was consistent with the wider nursing population and also the student cohort in the study setting.

Gender	n (%)
Female	10 (100)
Age	
18-20	2 (20)
21-25	1 (10)
35-40	3 (30)
≥41	4 (40)
Prior Nursing Experience	
Nil	4 (40)
AIN	3 (30)
Other[*]	3 (30)
Years in Nursing Program	
2	6 (60)
3	2 (20)
4	2 (20)
Clinical Placements Undertaken	
2	9 (90)
4	1 (10)
Highest Educational Qualification	
Year 11	1 (10)
Year 12	5 (50)
Certificate III Course	1 (10)
Bachelor Degree	2 (20)
Other[#]	1 (10)

[*] Personal Care worker in an Aged Care Facility   [#] Tertiary preparation program

Table 1: Demographics of the focus group participants

Clinical Setting	n
Community	5
Aged Care	5
Public Acute - Medical	3
Public Acute - Surgical	5
Public Acute - Paediatrics	1
Private Acute - Medical	2
Private Acute - Surgical	2
Private - Theatre	1
Private – Maternity	1
General Practice	1

Table 2: Clinical Placements of Focus Group Participants

Sample Profile – Individual interviews

Two male nursing students were interviewed during the conduct of the individual interviews, with 19 female participants making up the remainder of the individual interview participants. This ratio was both representative of the larger nursing student cohort and also the nursing workforce in general. The Australian Institute of Health and Welfare (2008) indicates that the Australian nursing workforce remains a largely female dominated profession with only 7.9% of employed nurses in 2005 being male. Participants were recruited from across all of the age demographics with the greatest percentage of participants being in the over 30 year age group which once again is consistent with the demographics of the nursing cohort (AIHW 2008).

Almost even numbers of the participants had no experience in the nursing profession prior to undertaking their clinical placement, or had previous employment experience as an assistant in nursing prior to commencing study in the program. A small number of participants were recruited with experience at the enrolled nurse or endorsed enrolled nurse level; this however generally resulted from the participant having other demographic identifiers, other than clinical experience, that led to the necessity of their recruitment.

Approximately half (47%) of the participants had been in the nursing program for two years with another 32 percent of the participants interviewed indicating that they had been enrolled for three years. The vast majority of participants (85%) had undertaken two clinical placements with the remaining 15 percent having undertaken three or more placements during the period they had been enrolled in the program. Participants who had completed secondary education comprised the largest cohort of

interview participants. One participant had previously undertaken tertiary study; however this was at the Diploma level in the vocational education sector and was outside of nursing. A number of participants however had not finished secondary school education to year 12 prior to commencing study in the nursing program. Table 3 presents the demographics of the participants in the individual interviews.

Gender	n (%)
Female	17 (89)
Male	2 (11)
Age	
18-20	2 (11)
26-30	2 (11)
31-34	4 (22)
35-40	6 (32)
$\geq$41	5 (26)
Prior Nursing Experience	
Nil	6 (32)
AIN	7 (37)
EN	2 (11)
EEN	4 (22)
Years in Nursing Program	
2	9 (47)
3	6 (32)
4	2 (22)
$\geq$5	2 (11)
Clinical Placements Undertaken	
2	16 (85)
3	1 (5)
4	1 (5)
$\geq$5	1 (5)
Highest Educational Qualification	
Year 9	2 (11)
Year 10	2 (11)
Year 11	4 (22)
Year 12	7 (37)
Diploma	2 (5)
Trade Certificate	1 (22)
Not stated	1 (5)

Table 3: Demographics of the individual interview participants

Table 4 provides details of the settings in which the participants in the individual interviews gained experience. It is again apparent that participants were placed in a broad spectrum of clinical settings and as such were theoretically sampled at times based on such breadth of exposure. The majority of participants had been placed in the Aged Care setting and this was representative of the clinical placements undertaken by the students. As was indicated earlier, participants undertake multiple placements therefore a student may have completed an aged care placement in one semester and a medical/surgical placement in another. As in the focus groups, participants were again theoretically sampled for both health care sectors.

Clinical Setting	n
Community	6
Aged Care	14
Public Acute - Medical	7
Public Acute - Surgical	6
Public Acute - Paediatrics	2
Public - Theatre	2
Public – ICU	1
Public – Mental Health	1
Private Acute - Medical	6
Private Acute - Surgical	4
Private - Maternity	2
Private – Day Surgery	1

Table 4: Clinical placements of individual interview participants

Data Collection

Grounded theorists shape and reshape their data collection and, subsequently, refine their collected data (Charmaz 2006). Methods, it is proposed by Charmaz (2006:15) "are merely tools", with some of these tools being sharper than others in a given context. Whilst a method provides the researcher with a 'tool' to enhance what is

being seen, Charmaz points out that methods alone do not generate good research and astute findings, let alone provide some magical insight into the data that is collected. Through the use of grounded theory methods, the researcher is able to adopt a flexible approach to data collection rather than be constrained by a rigid prescription of methods. This allows the emergent data to guide future data collection strategies in accordance with the direction that the data is taking. This flexibility of methods has resulted in grounded theory researchers collecting data through the use of a wide variety of data collection methods. Data were collected through the use of focus group discussions and individual interviews using a theoretical approach to subsequent sampling.

Despite Charmaz (2006) indicating that methods are mere tools in the researcher's toolkit, methods do have consequences and these consequences need to be considered. When choosing methods for a study the researcher needs to consider the appropriateness of the methods in answering the research question that is posed. Effective methods answer the research question with ingenuity and incisiveness (Charmaz 2006). *How* the data are collected will also have an impact on *which* phenomena the researcher will *see*; *how*, *when* and *where* they will be viewed, and *what* sense the researcher will make of them (Charmaz 2006). The data collection methods that were utilised in this study are explicated in detail in the section 'Data collection – Methods' which follows in this chapter.

A variety of potential data collection methods was available to the researcher. These included ethnographic methods, demographic survey, textual analysis, literature review, focus group discussions and interview (Cresswell 1994). Demographic

survey data were collected and used in this study as a form of adjunct data; initially it was intended to use the demographic survey data to assist with the process of purposive sampling. During the process of analysing the data using a comparative approach, it became apparent that the demographic survey data could be utilised to test the emerging concepts and the developing theory through the use of theoretical sampling, as discussed earlier in this chapter.

Ethnographic methods can be utilised in grounded theory research and whilst ethnographic data collection methods such as participant observation would have been possible in the on-campus clinical setting, due to the diversity of the clinical placements in the off-campus setting and the geographical dispersion of the participants, participant observation was not a feasible option due to the tyranny of distance related to clinical placements. As discussed earlier, a varied sample was recruited for the study to provide multiple sources of data based on the varying experiences, both personally and professionally. This approach enabled the researcher to compare self-reported incidents amongst participants. In accordance with the study's underlying assumption of Symbolic Interactionism, the participants' perceptions of the reality of their social world was determined to be of greater significance in the development of theory than accessing any objective reality that would result from participant observation. Interviews would enable the researcher to access in-depth descriptions of the continuous experiences of the participants and this contrasted with the snapshots of data that would have been obtained through participant observation (Morse 2001).

Data collection – Methods

Demographic survey

To assist with the initial purposive sampling a demographic survey was constructed (Appendix C). As discussed earlier in this chapter, this data was useful to the theoretical sampling component of the methodology.

Interviews – Selection of the interview type

There are two types of interview, individual or group, and these can be conducted face to face; by telephone; through internet communication or other forms of electronic communication (Cresswell 1994; Fontana & Frey 2005). Group and individual interviews were used in this grounded theory study, a decision that was supported by the literature (Sword 2003; Kamberelis & Dimitriadis 2005; Charmaz 2006).

This approach resulted in rich data that provided both individual and shared perspectives of the topic. Use of focus groups was further rationalised by the dearth of knowledge in the field relating to undergraduate nursing students' experiences in the off-campus clinical setting. Focus groups often produce data that are not obtainable from an individual interview as the "synergy and dynamism generated within homogenous collectives often reveal unarticulated norms and normative assumptions" (Kamberelis & Dimitriadis 2005:903). Focus groups also take the interpretative process beyond the bounds of individual memory, mining the "historically sedimented collective memories" (Kamberelis & Dimitriadis 2005:903).

This mining of collective memories demonstrated its worth where the narrative of one participant (A2) has led to a fellow participant (A3) relating their memories of an event of a similar nature.

It has been suggested by Nyamathi and Shuler (1990) and Stewart and Shamdasani (1990) that focus groups allow for a less structured interview format than the individual interview. Both focus groups and the individual interview allow the researcher the opportunity to use unstructured or semi-structured question guides (Minichielo, Madison, Hays & Parmenter 2004; St John 2004). Research questions framed in focus group interviews follow the same principles as those used in in-depth individual interviews (Minichielo *et.al.* 1995). The use of an unstructured to semi-structured question guide avoids the potential of the researcher limiting discussion to a set of pre-determined questions based upon researcher bias. Interviewer bias occurs in cases where the emphasis is placed on the researcher's perceptions of the issues being investigated, rather than the focus being on the participants' perceptions of the issues (Morgan 1995).

Focus groups were considered an appropriate starting point for data collection in this study for two reasons. First, this method encouraged the participants to reflect on their experiences in the off-campus clinical setting, whilst enabling the researcher to gather rich data which was based on the perceptions of the participants, rather than the researcher (Denzin & Lincoln 1994; James; Rjenzo & Frazee 1996; St John 2004; Kamberelis & Dimitriadis 2005). Secondly, an objective of the study was to explore the interpersonal interactions of the undergraduate nursing students with the staff in the off-campus clinical setting. The decision to utilise focus groups was

supported by Milliken and Schreiber's (2001) proposal that focus group interviews were ideal in grounded theory studies of the nurses' work life. Two focus groups (n = 5+5) were conducted at the commencement of this study. The remainder of the interviews (n = 19) were individual in-depth interviews.

Focus groups are variously defined as a valid qualitative research method for gathering information from a number of individuals with common experiences, consequently allowing for the investigation of a multitude of perceptions in an area of defined interest (Nyamathi & Shuler 1990; Beya & Nicoll 2000; Minichielo, Sullivan, Greenwood & Axford 2004). In this study the focus groups provided an excellent forum for the generation of authentic, rich data through capitalising on the richness and complexity of group dynamics (Kamberelis & Dimitriadis 2005). Kamberelis & Dimitriadis (2005) propose that the focus group operates in a similar manner to a magnifying glass, inducing social interaction analogous to those that occur in everyday life but with greater clarity.

A review of the available literature on focus groups indicated that ideally focus groups consist of four to twelve relatively homogenous participants (Stewart & Shamdasani 1990; Kreuger 1994; Jamieson & Mosel Williams 2003). As was indicated earlier, each of the two focus groups had five participants. The smaller number of participants was supported by Jamieson and Mosel Williams (2003) and Stewart and Shamdasani (1990) in that time constraints would limit optimal participation by all members of the focus group if the groups were large. Difficulty in getting larger numbers of students able to participate in a focus group in the one

location at the same time was also an operational rationale for utilising smaller numbers in the focus groups.

Homogeneity facilitates group cohesiveness and permitted an open and active discussion in the focus groups (Stewart & Shamdasani 1990). Whilst homogeneity amongst the group members increases the cohesiveness of the group, it is necessary to have a degree of heterogeneity amongst the participants' other characteristics to encourage dynamic group interaction and to encourage diversity of opinion (Kitzinger 1994). Nursing student status was the homogenous characteristic in this study with the heterogeneity developed through an analysis of the participants' demographic profile.

Whilst an unstructured questioning approach was used in the focus groups as the experiences of nursing students in the off-campus clinical setting was relatively unknown, a semi-structured opening question was used to open the focus group discussion. This allowed the participants' responses to guide the interview, rather than the researcher asking set questions that may have led to important perceptions being overlooked or completely missed (de Vaus 2004; Minichielo, Madison, Hays & Parmenter 2004; St John 2004). The opening question for the initial focus group was "*How has clinical been for you, as a student RN, in the off-campus clinical setting?*"

A similar approach to questioning was taken in the individual interviews. In the early stages of the interviews an unstructured questioning approach to elicit the participant's perceptions of the experience was used. As the interview progressed

open ended questions derived from the emergent theory that had been raised through the analysis of previous interviews were introduced. The opening question in the individual interviews was the same as that used in the focus group; "*How has clinical been for you, as a student RN, in the off-campus setting?*" This approach allowed the researcher to develop a rapport with the participant, gain data related to the participant's experiences in the off-campus clinical setting, and validate a construction of themes from already collected data.

There is a close interplay between sampling, data collection and data analysis in the grounded theory method with data analysis directing further data collection strategies in this study (Strauss & Corbin 1990, 1998; Charmaz 2005, 2006). This interplay determined the type of interview that was most appropriate to collect the data that was needed as the study progressed. It was this interplay that also saw the interview questioning become progressively more structured in latter interviews. The increased structure was the result of theoretical sampling and the need to ascertain specific data from the participants in these interviews.

Telephone interviews were conducted with all participants who agreed to be involved in the individual interviews. This approach overcame the tyranny of distance as the participants were geographically dispersed. It also provided flexibility for both the participants and the researcher to conduct the interview at a mutually convenient time. Telephone interviews provided similar benefits to face to face individual interviews, with the exception that the researcher was unable to observe the participants' non verbal gestures. This was overcome by the researcher being acutely aware of the verbal cues that participants provided such as changes in

intonation and expression. As explained, the researcher has a number of years experience in telephone interviewing in a clinical context.

Data collection - Process

Demographic survey

The demographic survey was included in the information package that was forwarded to potential participants at the commencement of the recruitment phase. Participants who consented to participate in this study were asked to return the completed demographic survey with the consent form. In the event that demographic data were missing from the survey and the participant was selected to continue, the missing data were collected at the commencement of the interview. All of the participants selected to continue in the focus groups had provided completed demographic data prior to the focus groups being conducted.

The collection of this demographic data provided the researcher with a basis to theoretically sample the respondent population in accordance with the requirements of heterogeneitity. The collection of demographic data enabled comparative analysis of interview data between and against various demographics. As has been explicated earlier in this chapter, a broad range of demographic data was collected. Findings from the demographical survey were reported and discussed earlier in this Chapter. A graphical representation of the research study process is presented in Figure 2 on the following page.

```
┌─────────────────────────────────────────┐        ┌──────────────────┐
│ Consent Form and Information Sheet       │◄───────│  HREC Approval   │
│ distributed                              │        └──────────────────┘
│ Demographic data collected               │
└─────────────────────────────────────────┘
```

┌──────────────────────────────┐   ┌──────────────────────────────┐
│ **Focus Group 1 (n=5)**   │   │ **Focus Group 2 (n=5)**   │
│   │◄- - - - - - - - - ►│   │
│ How has clinical been for   │   │ Have you experienced, or   │
│ you, as a student RN in the │   │ have you witnessed, any   │
│ off-campus clinical setting? │   │ behaviour or behaviours in   │
│   │   │ the off-campus which you   │
│   │   │ view as being negative?   │
└──────────────────────────────┘   └──────────────────────────────┘

Individual Interviews (n=19)

Based on theoretical sampling as coding was undertaken on a continual basis in accordance with Grounded Theory Methods.

All individual interviews were teleconferenced.

As the research progressed the interviews became more structured towards the concepts which were emergent in the coding.

In your clinical placement what do you view as being negative experiences?

How do the staff demonstrate the negative behaviours to students?

Do you think age mages a difference to the way you are treated in the off-campus clinical setting?

Figure 2: The sequence of the data collection and analysis stages of the study

Wimpenny and Gass (2000) and Charmaz (2006) indicate that the interview process impacts upon the data collected. Establishing a rapport with the participants was critical in getting them to talk openly about their experiences. As an Ambulance Communications Officer and Ambulance Officer, I have skills in interviewing under high stress clinical circumstances; and this skill served me well in this research context.

A casual and relaxed atmosphere was deliberately encouraged immediately prior to, and during the conduct of the interviews. To further assist in the development of a rapport with the participants a conversational tone was adopted. To develop rapport I introduced myself as a peer health care professional with experience in a clinical environment. In every instance the rapport with the participants developed easily and quickly.

Sensitivity, both to the participant and the data, was used to assist me in knowing when to probe and ask questions and when to just listen (Duffy, Ferguson & Watson 2004; Charmaz 2006). This allowed the participants to maintain control of the interview and thus tell their story (Minichielo, Madison, Hays & Parmenter 2004). I remained conscious of my non-verbal communications in the face-to-face focus group discussions to ensure they did not negatively impact upon the interview or guide responses (Duffy, Ferguson & Watson 2004). Throughout the conduct of the focus group discussions I recorded brief observations of the interactions between the group members to ensure that the collected data included the dynamic group interactions as this is central to quality data when using focus groups (St John 2004).

The setting for the focus groups was a conference room on the campus which the participants attended. Careful consideration was given to the appropriateness of this location as if the participants did not feel relaxed and comfortable in the setting, there was potential that the quality of the data would be affected. In consultation with the participants it was agreed that the campus setting was an appropriate venue as the participants felt comfortable and relaxed in that environment.

To facilitate a relaxed and conversational atmosphere, each participant was welcomed as they arrived. As all the participants in the focus groups were known to each other from attendance at lecturers and clinical placements, they were relaxed in each other's presence and conversed freely amongst themselves and with the researcher. The interviews were conducted immediately following lectures. This was the most convenient option for the participants as it did not involve them having to travel back to the campus specifically for the interview. Permission was sought from appropriate personnel at the campuses to utilise a room that was quiet, thus avoiding distractions and interruptions whilst maintaining confidentiality.

The participants in all of the individual interviews were contacted by telephone, through the use of EC Teleconferencing, with all of the participants indicating that their home telephone was the most appropriate contact number. Interviews were arranged in consultation with the participant which then allowed them the opportunity to schedule the interview for a time that was convenient to them.

Face-to-face focus group discussions lasted from 60 minutes to 90 minutes each, with the individual interviews lasting between 20 and 70 minutes. In order to elaborate on the findings from the analysis of the first focus group, the initial question asked of the second focus group was "*Have you experienced, or have you witnessed, any behaviour or behaviours in the off-campus clinical setting that you view as being negative?*" These opening questions were broad enough to commence the discussion and subsequently allow the participants to take the lead. The aim of the focus group discussion, as has already been explained, was to conduct an

unstructured interview so that the participants could tell their stories without restraint.

Both the individual and group discussions in this study were audio recorded for later transcription of the data. Whilst there is continued debate about the benefits or otherwise of audio recording interviews (Schreiber 2001; Stern & Covan 2001), recording of discussions was beneficial to the analysis of the data in this study as I was able to focus on conducting the interview, rather than on the process of taking detailed notes (Schreiber 2001; Charmaz 2006). Audio recording of the interviews allowed for full transcription of the interviews verbatim, a process which greatly assisted with the analysis of the interviews as the exact statements made by the participants were available (Sim 1998). Audio recording the interviews also reduces the risk of the researcher 'forcing' the data based on the researcher's bias (Charmaz 2006) and reliance on memory.

Having a transcribed copy of the interviews allowed consistent immersion in data, permitting retrograde insight into issues that were not immediately obvious during the course of the interviews. Transcription of the interviews also allowed the researcher the opportunity to return to earlier interviews as new phenomena were identified; a process that afforded the researcher the opportunity to ascertain the context of the data. This facilitated the use of constant comparative analysis as the researcher printed a copy of the transcript.

Data Analysis

The grounded theorist is an instrument of the research process and as such, data analysis is reliant on the researcher's analytical skills and creativity so that meaning and the interconnections in the data can be interpreted in order to develop theory (Strauss & Corbin 1998). This study generally utilised the procedure described by Strauss and Corbin (1998) for analysis of the data, however the procedural steps were not rigidly adhered to. Charmaz's (2006) explication of the procedures of data analysis provided valuable guidance in the data analysis. The Conditional Relationship Guide and the Reflective Coding Matrix proposed by Scott (2004) provided a useful analytical tool, which also provided further advancement to the conditional/consequential matrix proposed by Strauss and Corbin (1998).

A special case - Analysis of focus group data

Focus group data are unique in that it results in data based on the interactions of the group members, the dynamics and non-verbal behaviours observed. Whilst the audio recordings of the individual interviews and the resultant transcriptions resulted in data that were available for analysis of individual meanings, focus group data presented some variations to analysis. This variation to analysis is detailed in the discussion below.

Observational notes from the focus group discussions were analysed in conjunction with the audio recorded focus group data and the resultant transcriptions. Whilst the group interaction that occurs during the discussion determined that the 'group'

should be the primary focus of the analysis, St John (2004) argues that data analysis should follow the approach of the underpinning methodology used in the study. Cognisance of individual and group aspects was achieved through the framework suggested by Carey and Smith (1994) and St John (2004) which is explicated below.

Focus group data is analysed at the group level with the lens on interactional and sequential analysis. Consideration is given to censoring, conformity and 'group think'. At the individual level data are analysed without regard for the group context. As a comparison, individual responses are compared against the group data as well as being contextually analysed. To assist with the individual and comparative analysis data were separated into a single document for each participant. This assisted in analysing the data from an individual perspective; the results of which were then compared against the group data.

Preliminary procedures of data analysis

Prior to intensive data analysis, the interviews were transcribed verbatim by the researcher within 48 hours of the conduct of the interview. Whilst it may appear that the data analysis commenced after the completion of all the interviews, in accordance with the grounded theory method, data collection and analysis were actually simultaneous processes as indicated previously in this chapter.

To facilitate confidentiality, all identifying information was removed from the data, with each participant being assigned an alpha numeric code. These codes were assigned at random to participants and do not represent either the sequence in which

the interviews occurred, or the individual's position in the focus group discussion. All alphabetic characters between A and Z, except for 'I", were selected for use in the coding schema. The rationale for not using 'I' was based on the potential for confusion in the reader as 'I' could be referring to the researcher in one instance and to a participant in another instance.

To ensure accuracy of the transcriptions, interview audios were replayed whilst re-reading the transcribed interviews. This approach further assisted the researcher to become fully immersed in the data. Memo writing and comparative analysis was utilised throughout the study and also assisted the process of open, axial and selective coding as suggested by Strauss and Corbin (1998).

Memo writing

Memo writing, Charmaz (2006) proposed, is the pivotal intermediate step between data collection and the drafting of the theory. Memo writing in grounded theory is a crucial method as it prompts the researcher to analyse data and codes early in the research process (Glaser 1978; Strauss & Corbin 1990, 1998; Charmaz 2006). Memos contain "products of analysis or directions for the analyst" (Strauss & Corbin 1998:217). Writing of the memos began at the commencement of the study and continued until the completion of the chapters related to the findings. Memos were kept as notes to self and these notes provided a means of documenting thoughts related to the codes, the emergent categories, and the interaction of the categories as the study progressed. These notes were recorded when they occurred and took the form of both hand written and typed notes dependent on when these ideas surfaced.

The memos were useful as they allowed the researcher to identify leads to follow through theoretical sampling (Glaser & Strauss 1967; Glaser 1978; Strauss & Corbin 1990, 1998; Charmaz 2006). They were also useful in supervision meetings.

Strauss and Corbin (1998) expanded the original notion of grounded theory memoing by identifying various types of memos. Code notes, theoretical notes, operational notes and logical and integrative diagrams were all proposed in Strauss and Corbin's expansion with an expectation that these memos would be at the conceptual level, corresponding to the coding stage that they relate to. Charmaz (2006) indicates that the memos may be free and flowing, with Charmaz encouraging the researcher to write freely regarding the analysis that they are undertaking. This was the approach adopted in this study as the researcher viewed the Strauss and Corbin (1998) approach to memoing as being too procedural and somewhat restrictive.

Clustering

To assist the researcher with the writing of memos, the process of clustering was utilised (Charmaz 2006). Clustering provides a non-linear, visual and flexible technique that allows identification of how the phenomenon 'fits' together. It also allowed the researcher to visually identify how the categories were inter-related. This clustering approach shared similarities with conceptual or situational mapping in grounded theory (Clarke 2003, 2005). Diagramming is an expansion of the clustering approach. An advantage of diagrams is that they provide a visual representation of

the categories and their relationships. The diagrams that are presented in Chapter Four are the end results of the schematic conceptualisations that evolved.

Comparative analysis

Strauss and Corbin (1998) identify comparative analysis as an essential feature of the grounded theory methodology. Throughout the analytic process, the constant comparative method was used to compare incident with incident and to identify the similarities and differences in order to facilitate the development of concepts (Strauss & Corbin 1998; Ezzy 2002). Constant comparative analysis assisted in grouping concepts under higher order categories (Strauss & Corbin 1998).

Through the use of constant comparative analysis data earned its way into the study when the process revealed repeated patterns in the data (Chiovitti & Piran 2003). This technique allowed a comparison of data against itself, against other data and also against conceptualisations (Duchscher & Morgan 2004). Abduction, suddenly understanding the fit between a particular event and its context (Ezzy 2002), was one of the processes used during constant comparative analysis. Whilst inductive strategies predominated, deductive processes were also involved because the grounded theory approach simultaneously validates theory through the constant comparative method (Strauss & Corbin 1998).

Open coding

Open coding is the analytic process through which labels are assigned to data for the purpose of identifying categories, their properties and dimensions. Initial coding remained close to the data (Charmaz 2006) and where possible *in vivo* codes were used. Open coding was used as transcripts were re-read whilst listening to the audio recording of the interviews. This fractured data into sections for closer scrutiny and subsequently, the assignment of a label (Strauss & Corbin 1998; Charmaz 2005, 2006). The labelling of data is synonymous with the creation of a code. These labels either consisted of a participant's actual words (*in vivo* code), for example, *snide comments* or other words which reflected understanding of the data, for example, *covert approach*. Therefore in the initial coding the labels were generally descriptive with some being the actual words used by the participants. An example of open coding is included at Appendix D.

Throughout the process of open coding cognisance was placed on the relationship between grounded theory and Symbolic Interactionism. Meaning given to a particular situation or event, by nursing student participants, needed to be reflected in the code labels that were assigned to the data. An example of this is provided by the following brief discussion. Participants reported two differing approaches to segregation in the off-campus clinical setting based on the attitude of the staff. When it was obvious, through the verbal and non verbal communication, that a staff member did not want a nursing student; the nursing student would actively avoid that particular staff member, thus using deliberate self segregation or isolation as a means of protecting themselves. The other reported form of segregation was that staff

would delegate a menial task to a nursing student or send the nursing student on their break. Upon returning the student would find that a task that was clinically relevant to them had been completed in their absence. Through the use of probing questions and extensive discussion in the interviews it was possible to determine the meaning that nursing students ascribed to this overt and covert segregation by the staff. These meanings were then assigned as code labels during open coding. This is fully discussed in Chapter Four.

Whilst keeping the research question in mind, as many interpretations as possible were made of the data (Glaser 1978; Strauss 1987; Strauss & Corbin 1990, 1998; Charmaz 2005, 2006). Initially, this was done by asking, *What does this mean?* or *What is going on here?* This sometimes meant that the same section of text was assigned more than one code. For example when the nursing student avoided one staff member in particular, the text was labelled *avoidance* as well as *individual attitude*. At times a question was asked of the participant's entire response and at other times the focus was only a couple of words within a response. Impressions and questions about codes were documented in memos throughout the analysis process as discussed earlier in this chapter.

The transcripts were initially coded manually. These codes were then transferred to a computer file using Microsoft Word 2003®. Coding the transcripts by hand was advantageous as it facilitated microanalysis and allowed more of the data to be seen and codes to be assigned simultaneously. This resulted in a more consistent assignment of codes. Line by line analysis allowed careful comparison of new data with what was already coded (Glaser 1978). A code label was assigned to incidents,

events, actions, or objects in the data that were understood as indicators of a particular phenomenon (Strauss & Corbin 1998). These concepts were analysed for common themes. They were then grouped together according to these themes and assigned a higher order label (Corbin & Strauss 1990). Grouping concepts together under a higher order label marked the commencement of category development (Strauss & Corbin 1998). Figure 3, on the following page, provides an overview of how concepts were grouped together. As an example, nursing students talked about *tailing the RN*, *shown our place* and *dressed down*, each code became part of a higher order category labelled *segregation.* This category was later elevated even further to *interpersonal relations*.

'*Tailing the RN*' was apparent in the data in the statement:

> *… you know if you were instead of, if you were showing the ability to follow your mentor around without questioning her and were a passive, docile student then that was all they wanted to see …* (Participant B)

Participant A5 provided evidence of being "dressed down" and "shown our place":

> *Basically we were shown our place … I'm in charge here and you know this is my show and you know, not that I had taken any control away. I felt that was my dressing down …*

Participant B also alluded to the fact that the participants expected to be segregated in the aged care clinical setting through the following:

> *… at the nursing home there was an initial impression from the students that may be we were going to be um alienated because we were RN students working with AINs and learning AIN duties because we are supposed to be able to manage AINs later on if we work in a nursing home and they knew it so we thought that there was going to be a bit of that …*

Through a comparison of the code labels, it was also possible to identify the properties and their dimensions. Properties were "attributes of a category" and "dimensions represent the location of a property along a continuum" (Strauss & Corbin 1998:117). The properties of the category *segregation* and their dimensional ranges were identified. These indicated the extent to which an individual nursing student experienced segregation by the nursing staff.

Tailing the RN

Shown our place

Dressed down

Power relations

Isolation of student

My show
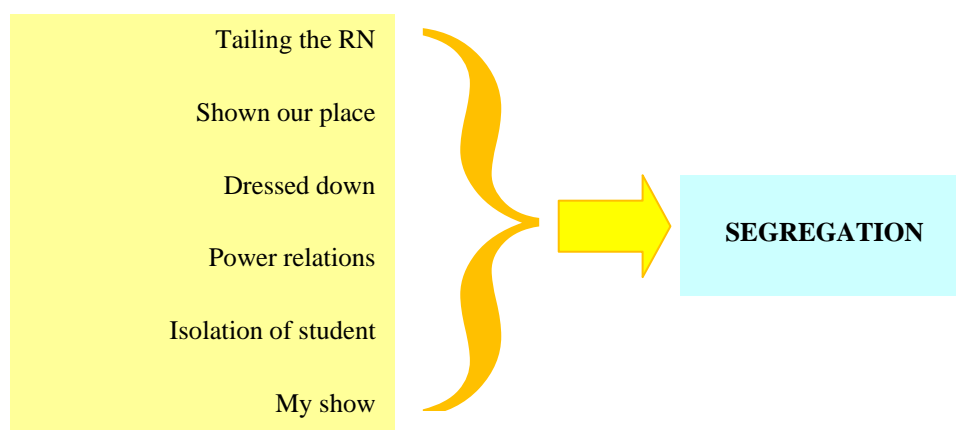
SEGREGATION

Figure 3: Codes raised to the higher category of 'Segregation'

Focused coding

Charmaz (2006) identifies focussed coding as being the second major phase in the coding process. Focussed codes are more directed, selective and conceptual than the initial word by word and line by line coding (Glaser 1978). Focused coding was used to capture, synthesise and understand the main themes in a participant's statement. The code *avoiding disclosure* was selected to capture, synthesise and understand the theme in the following excerpt.

> *I actually make out that I have no nursing experience because I find*
> *sometimes like you know if you say to them I am like an AIN or an EN its sort*

of like oh well you know what you are doing, you don't need us [RNs] sort of thing, so I tend to play a little bit dumb sometimes. (Participant W)

The assigned codes remained active and close to the data allowing movement across interviews and comparison of the experiences, actions and interpretations of the participants.

Coding, in accordance with the framework of grounded theory, is an emergent process and the development of the code *avoiding disclosure* subsequently illuminated other codes. This illumination allowed the researcher to 'see' the interactions between staff and students, who identified as having nursing experience, in a different light. The experiences of students who had 'disclosed' with the experiences of students who had 'not disclosed' were compared. This is discussed in detail in Chapters Four and Five.

Axial coding

Axial coding, the process of "reassembling data that were fractured [and labelled] during open coding" (Strauss & Corbin 1998:124), was performed alternately with open coding (Glaser 1978; Strauss & Corbin 1990, 1998). Axial coding was commenced after the analysis of the first focus group discussion proposed certain categories. The identification of these through the open coding process is essential for the process of axial coding to begin, because the development of categories and relational statements revolves "around the axis of a category" (Strauss & Corbin 1998:125). Axial coding in this study involved the use of Scott's (2004) Conditional Relationship Guide to assist in the development of the subcategories that answered Strauss and Corbin's (1998:125) "when, where, why, who, how and with what

consequences" questions about a category. An example of the use of axial coding is presented below in relation to '*segregation*' with evidence from the data.

Participant G indicated that the participants could be segregated in various ways with varying consequences:

> *I think they just used us as we were extra workers not students, they weren't helpful in showing us anything, in teaching us , helping us with anything, um, and yea if you asked the RN anything such as a question they would fob you off as if they didn't have time for you so yea, I didn't feel that we learnt a lot out of it at all.*

This excerpt provides evidence of 'how' the students are segregated in the off-campus clinical setting and also provides evidence of the consequences of being segregated. At the other end of the continuum was the experiences related to by Participant G in respect of a different clinical setting:

> *Yes, it was good, the hospital was good like you could go to the nurse and they'd just answer your questions and help, all very helpful and if something was going on, they'd come and find you and show us. Yea, no it was really good and that was at the* [facility name removed].

A major point of departure between Glaser, and Strauss and Corbin in their understanding of axial coding is in its exact nature. Glaser (1978) calls this activity theoretical coding, and like Strauss and Corbin (1990, 1998), recommends that this activity be undertaken alternately with open coding. Glaser (1992) argued that theoretical codes precluded the need for axial coding because theoretical codes "weave the fractured story back together" (Glaser 1978:72). As such, Glaser does not agree with the coding paradigm that is proposed by Strauss and Corbin (1990, 1998). Strauss and Corbin's (1990, 1998) coding paradigm is a guiding framework that allows processes, as well as structures, to be considered in relation to the context of

the social phenomenon being studied. Identifying structures and processes in turn allows for an exploration of why certain events happen and how they happen (Strauss & Corbin 1998).

Using the Conditional Relationship Guide as an aid to locate the scope of the study, only those conditions that emerged from the data were identified. Strauss and Corbin (1998) warn against using the proposed axial coding matrix as a prescription for the conditions and consequences to be identified. Using the coding paradigm amounts to preconception in Glaser's (1992) view, in that it predetermines the theoretical codes to be used. Glaser's preference is for the theoretical codes to emerge.

Axial coding provides a framework for the researcher to apply (Charmaz 2006) and this framework may extend or limit the researcher's vision. The framework was used in this study to brighten the clarity of the links between the categories and their subcategories. As an example, *segregation: divided and dividing work practices between students and allied nursing staff* was a contextual condition that impacted upon the nursing students' efforts to determine their position within the hierarchy, both in the clinical setting where they had been placed and within the profession. At the same time, *role ambiguity* influenced the way in which nursing students responded to *segregation: divided and dividing work practices between students and allied nursing staff*. Strauss and Corbin's approach to axial coding also facilitated an exploration of particular actions or strategies that were used by participants when they experienced *segregation*, such as *focusing on getting through*.

Participant W highlighted the issues of role ambiguity when they stated:

> *… as I said to one of the AINs, we are not actually here to be doing this sort of stuff, we are actually here as student RNs … not as AINs. I think I offended her a bit by saying that, I didn't mean it to come out the way it probably did. What I meant was you know, showers and stuff like that, we've all done that, we all know the basics … we were there to learn as a RN, therefore it was a little bit more than showers and stuff like that.*

Participant G further elaborated on '*role ambiguity*' and suggested strategies that could be employed to minimise conflict:

> *… where we're on one level thinking that we need to do our tasks, they're on another level thinking we're extra AINs to work with them … that probably adds to the conflict. So if there was a more even keel, and say well this is what the student is here for, and say to us students this is what you're here to do, but you've got to do this as well …*

Axial coding located the properties and dimensions on a continuum and through this process it became apparent that the participants were using strategies to focus on getting through the placement:

> *They* [AINs] *don't have the level of education that you know if you see a wound it may need further investigation and dressing … you have to, just sort of try to accept that and try not to be confrontational to them and um yea I sort of put that into practice the best I could …* (Participant L)

Participant K had another strategy to assist in getting through placements when staff demonstrated a negative attitude towards students:

> *I don't let that* [negative attitude] *bother me so I just got on , I always had a smile on my face and thought oh well if their going to be like that, that's them but I am not going to do the same thing because I wanted to enjoy my time. So, if they wanted to be like that, well I hope they get something out of it because I am not going to let it come into it.*

As understanding of the relationships between categories developed, these were portrayed in diagrams (Strauss 1987; Strauss & Corbin 1990, 1998). When, how and why nursing students were segregated in the off-campus clinical setting were also coded. Figure 4 portrays an early diagram of the factors relating to segregation of nursing students by nursing staff.

71
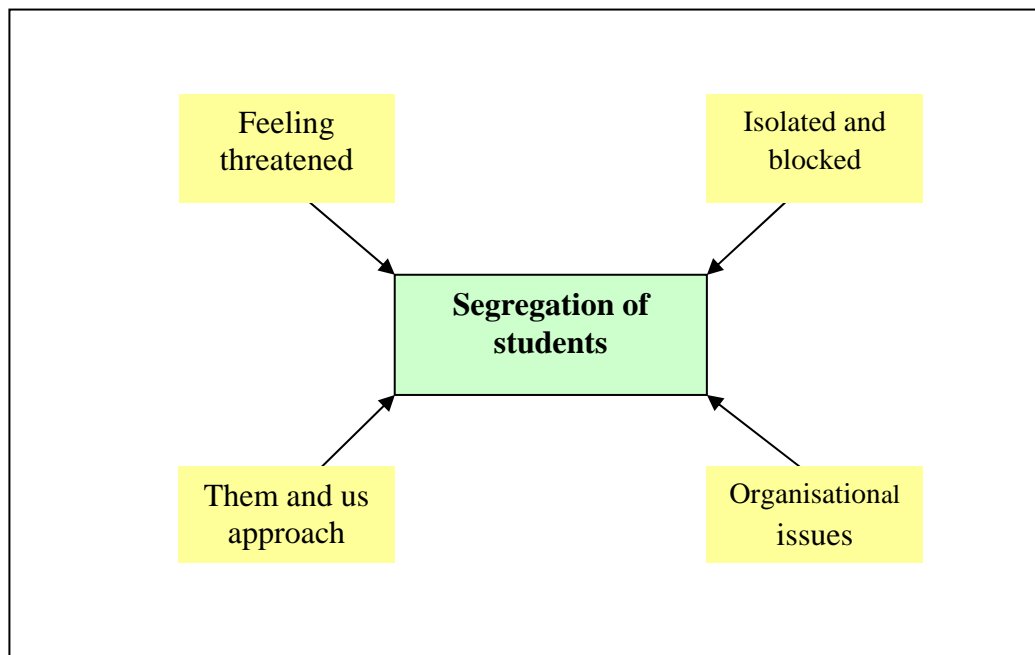
Figure 4: An early diagram of the codes relating to segregation of nursing students by staff in the off campus clinical setting

Selective coding

Selective coding is the "process of integrating and refining the theory" (Strauss & Corbin 1998:143). It involves the identification of the 'core' category or the major theme of the research from which the theory emerged (Strauss & Corbin 1998). The core category is central with all other categories subsequently becoming subcategories and frequently appearing in the data. The core category identified in this study was labelled *'anxiety'* with *'tradition bearing'*, *'staff performance'*, *''student performance'*, *'expectations'* and *'fit/place'* constituting the sub categories which were related directly to and integrated with the core category. In the case of this study the core category appeared in all of the interviews to some extent. This allowed for a logical and consistent explanation of what was occurring in the off-

campus clinical setting through relating the sub-categories to the core category. Through the use of this approach the basic theoretical scheme became apparent from the data.

Once the basic theoretical scheme had been identified, the theory was refined through further theoretical sampling and data analysis until data saturation was achieved (Strauss & Corbin 1998). Selective coding allows the researcher to account for variations both within and between the categories which are identified. The grounded theory that is presented in Chapter Four of this thesis is evaluated through the use of the evaluation criteria proposed by Charmaz (2005, 2006), presented in Chapter Six. Through the evaluation of the theory against this criterion and through the writing of this thesis the theory has been refined. Selective coding continued until the completion of the write up of this thesis.

Conclusion

Charmaz's (2005, 2006) version of grounded theory has been followed for this grounded theory study, with the use of Strauss and Corbin's (1998) coding paradigm and Scott's (2004) Conditional Relationship Guide used to assist with the analysis of data. The methods of theoretical sampling, data collection and analysis have been described. Through the application of the methods explicated in this chapter, six categories emerged from the data: *tradition bearing, staff performance, student performance, expectations and place* with *anxiety* emerging as the core category. The interaction of these three categories led to the determination of the theory that is

presented in Chapter Four. The findings that led to the emergence of the theory are

also discussed in detail Chapter Four.

Chapter Four – Where do I 'Fit' as a Nursing Student?

Introduction

The previous chapters have provided an introduction to the study and justified the design and methods used in the conduct of the research. This chapter presents the findings from the data and identifies and discusses the three emergent categories: '*tradition bearing*', '*staff*' and '*student performance*'. The interactions and intersection of these categories at a given point and place in time resulted in the identification of the basic social problem. This was labelled '*anxiety*'. Furthermore the intersection of the three categories resulted in the identification of '*expectations*', of both the students and staff. As a result of the basic social problem, participants experienced '*internal conflict*' as they attempted to determine where they fitted, as a nursing student, within the nursing hierarchy of the facility where they were completing clinical placements, and also within the nursing profession more broadly, in an environment of negative workplace behaviours. Through an explication of the categories which were emergent from the data, this chapter steps through the development of the theory, commencing with an explanation of the categories and their associated properties and dimensions, followed by a discussion of the basic social problem and then the basic social process.

Tradition Bearing

'*Tradition bearing*' emerged as a category in response to participants' perceptions that a number of the staff employed in various facilities demonstrated what was called a 'matronly demeanour'. The term '*tradition bearing*' was used to describe those staff members and incidents which were aimed at maintaining the traditions of the old nursing ethos through the use of unwritten rules and other behaviours which were aimed at socialising the nursing student into the nursing profession. This will be explained in detail later in this chapter. The role of the tradition bearer was primarily adopted by staff at the assistant in nursing and enrolled nurse levels of the profession with registered nurses being less likely to demonstrate the 'matronly demeanour' that was associated with this role. Further analysis determined that it was not necessarily the chronologically older members of the staff in the facilities who were responsible for ensuring that nursing students complied with the cultural norms of the profession, rather the role fell to younger, although longer serving (in terms of the facility) staff members. The issue of tradition was raised in the focus group discussions and the following excerpt details one participant's perception of a bygone era:

> *The older ones* [longer serving staff, not necessarily chronologically older staff] *have come, obviously from a different time with the powerful matrons and you know where the doctors were kings.* (Participant A5)

Tradition bearing has a number of properties and dimensions and these will now be discussed in detail with a visual representation of these presented in Figure 5 on the following page.
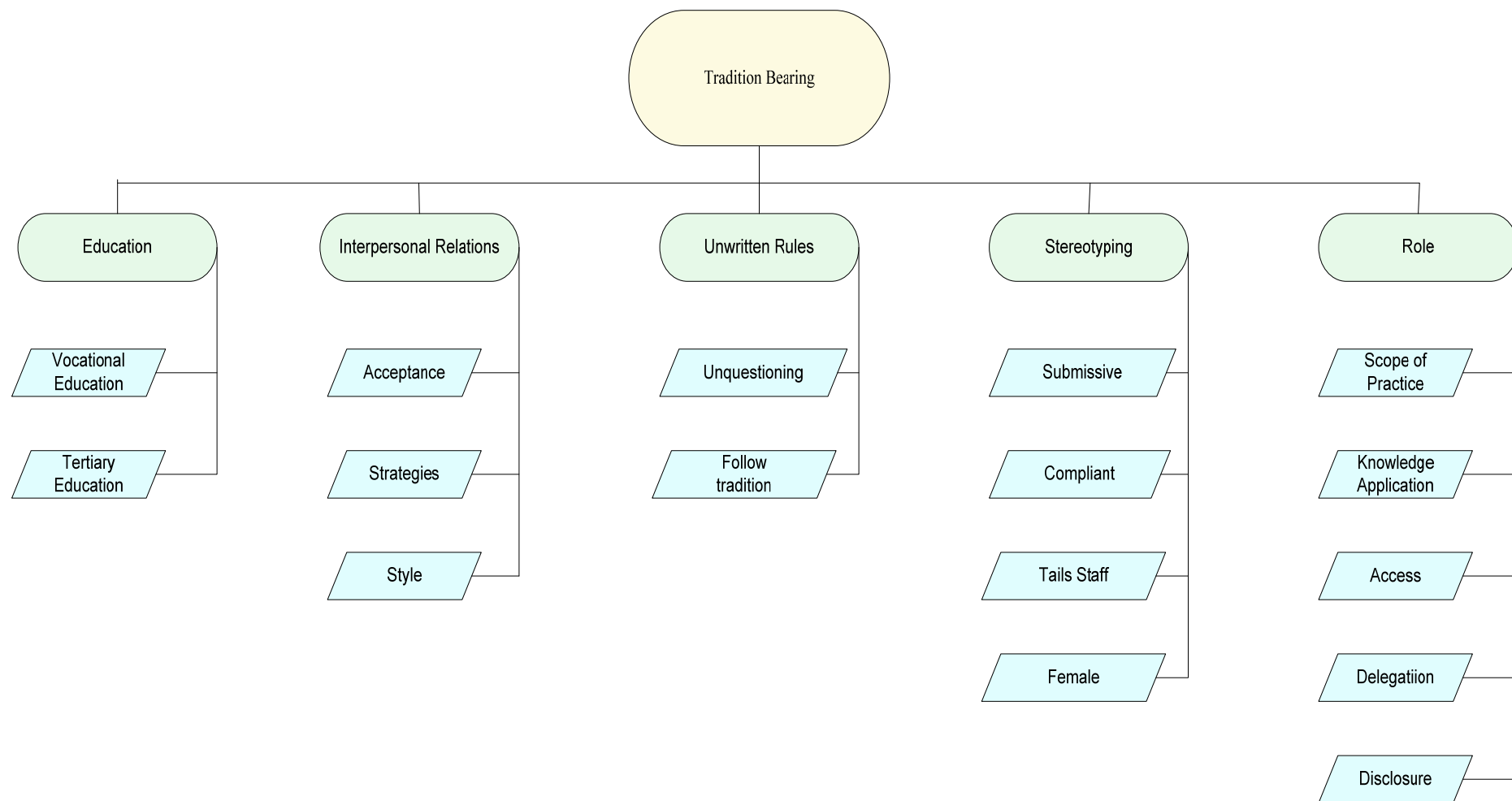
Figure 5: Properties and dimensions of 'Tradition Bearing'

Education

Education was identified as a property of *tradition bearing* and has dimensions of vocational training and tertiary education. Despite significant changes to nurse education in the last two decades it became apparent that a number of nursing staff who were hospital trained were still employed in the facilities. This was apparent by the staff who were trained in the hospital apprenticeship model of training indicating to students that they wished they had had the opportunities available to the current nursing students. Participants perceived that on the whole, whilst the hospital trained nurses were more accepting of university educated nursing students than the nurses who were themselves university educated, there were hospital trained nurses who were also not accepting of students. University educated second year nursing students have a considerable amount of theoretical knowledge by the time they are placed in the off-campus clinical setting. Participants felt that this knowledge had negative effects on the staff in the off-campus clinical setting, some of whom had been hospital trained and this is evidenced in the following excerpt:

> *… I really do feel that this RN had been hospital trained and not university trained and yea was totally threatened.* (Participant N)

Participant N's belief that the registered nurse felt threatened is perceived as:

> *That's it, they don't want us, like a lot of them seem, don't want us in the clinical setting but they don't believe that, um, university trained nurses are any good either, so its catch 22 for us.* (Participant N)

This perception was supported by a considerable number of other participants.

> *Yea it all comes back down to that uni thing, I've even heard different staff say, "Those bloody students think they're something because they go to uni",* (Participant G)

Participants felt that the nursing staff could be stigmatised depending on whether they were trained in the hospital system, or in the tertiary education sector.

> *I mean we are trained at university and to me it doesn't make a difference but with some people it does. That stigma of being or not being university trained or hospital trained.* (Participant V)

Whilst this participant indicated that they, personally, did not discern between staff who were hospital trained or university educated they were still conscious of this issue and raised it. Others though, did discern that there was a difference and in a number of cases there appeared to be an obvious difference attached to being hospital trained. Whilst there is a difference in the education levels of university educated and hospital trained registered nurses, there is also a difference in the level of education between the assistants in nursing and the enrolled nurses. Assistants in nursing and enrolled nurses are primarily trained through the vocational education and training (VET) sector and are awarded a Certificate or Diploma level qualification on successful completion of their program.

The difference in educational levels was noted by a number of participants. One participant who had undertaken multiple clinical placements said:

> *I think there was still very much that atmosphere of uncertainty and fear of the unknown with uni trained students entering that workforce, um as opposed to the hospital trained nurses. I really don't see too much of that now but there is the odd one who possibly feels threatened by, by the fact that they've got students coming from the university ...* (Participant S)

This participant had undertaken placements in the late 1990s, shortly after one of the last nurse teaching hospitals[5] in Queensland had closed. This fear of students on the part of the supervising staff, which participants described as a fear of the unknown, was still felt by the participant. Nurses were traditionally trained in the hospital setting and the nurses were fully aware of the level of training that the nursing students received. However, with the tertiary sector, there was uncertainty in staff about levels of competence.

Participants reported that they were very quickly reminded that they were just a student:

> *… remember that you're just a student and I've been here six years, type of thing, and OK, sorry I asked.* (Participant L)

The use of this approach ensured that the students realised their position in the nursing hierarchy and remained within that position. This was perceived to be a control mechanism as the nursing staff felt threatened by the level of university education received by nursing students. It became apparent that whilst many of the nurses whom the students were working with were themselves university trained, they had assimilated the practices which were dominant in their workplace. This assimilation of the culture is a consequence of professional development and hospital in-service training. As a result of these in-service programs nurses would have had exposure to vocational education and this may well have an impact upon how they view the university education experience of nursing students.

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[5] This was one of the last facilities to close its doors to nursing students being trained under the traditional hospital based training model.

Participant R provides the following description between hospital trained nursing students and the university educated nursing students.

> *I suppose between the old hospital trained nurses and we who go in as university students, we are always students whereas in the hospital they were actually nurses and they nursed at a certain level, where they took more and more responsibility.* (Participant R)

Hospital trained nurses gained and were given more responsibility as they progressed through the apprentice model. Participants of this study perceived this did not occur so much with them and rather than being accepted as nurses they were only ever thought of as students. This resulted in feelings of anxiety in the participants. This anxiety is clearly reflected in the following excerpt from Participant Q:

> *I dreaded going to that place* [the clinical facility] *… I just dreaded it and could not wait for it to be over.*

It is clear from the findings identified in the preceding discussion that the differences between vocational and tertiary education play a significant role in the experiences that participants had in the off-campus clinical setting. The origin of education of hospital staff continues to play a role in the experiences of the nursing students as the AINs and ENs continue to be trained in the vocational education sector rather than the tertiary sector.

Interpersonal Relations

Participants were concerned about the poor interpersonal relations which existed at times in the off-campus clinical setting between the staff and the nursing students.

Participants also raised concerns in respect of the poor interpersonal relations between the staff. One participant described the experiences of many participants:

It's like, it's almost, it's like it is genetically deficient, you know you start thinking, "Why is this not happening?", it's part of professionalism, you've got to communicate, you've got to look after other people beside yourself because they're your team, you've got to help them, they've got to help you, keep them informed ... (Participant A5)

This participant then went on to state:

... taking into consideration other human beings that you work with, um their thoughts and their feelings and how you might approach them is just not there, they don't do that at all. (Participant A5)

Another participant relived a number of separate incidents involving the Preceptor in the facility where they were placed. These incidents ultimately culminated in a critical incident.

... when she was talking to me about it she was not happy with just saying what she had to say, she harped on about it until I had tears in my eyes. (Participant Y)

Whilst this participant's experience was an extreme example of the effect that poor communication could have on students, other participants also indicated that they had left a clinical placement at the end of a shift in tears as a result of their experiences at the hands of staff.

The excerpts from the participants, which are presented above, provide an insight into the issues of perceived non-acceptance by the staff of the students in the clinical setting. It is apparent from the data that the staff utilise various strategies in an effort to ensure that the nursing students are aware of their place within the clinical setting and also within the profession as a whole. The style of communication which the

staff utilise in this strategy also has a drastic impact on the levels of anxiety which a student experiences. Communication styles are discussed in more detail in the following discussion.

Analysis of the data found that staff in the off-campus clinical setting used both verbal and non-verbal communication strategies when interacting with students and also in the context of interacting with other staff. When questioned about these communication styles the participants of Focus Group A responded with comments like:

> *You know not to go over and talk to them, you can feel it.*

> *They don't lack comfort[6] and communication* [skill] *in communication they choose to use. When they decide to start doing the eye contact thing, when they want to present full body image, open and friendly stuff is not there, just with their hands and simple smiling seems to be genetically deficient … yes they are definitely giving it out.*

> *… you can feel it; it's like a sweat that comes off them.*

Participants reported that it was the non-verbal communication which caused the greatest distress to them whilst they were in the off-campus clinical setting. The data proposed that the participants questioned their perception of the behaviours which were demonstrated by the staff when non-verbal communication was utilised. Participants doubted whether they had actually witnessed the behaviours or if they

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[6] This participant referred to 'comfort' in the context that the staff were quite capable of, and comfortable with, communicating when they wanted to.

had simply perceived something that was not actually present. These led participants to self doubt and double guess what had occurred.

> *… I don't know if it was just a misunderstanding or a perceived thing on our behalf …* (Participant L)

This does not form the basis of a positive learning environment.

Participants felt though that the staff can and do communicate verbally with students in a positive manner when they want to get a particular point across; however they were more likely to use negative communication in an effort to get their point across. When the participants were asked about what they viewed as being negative behaviours in the off-campus clinical setting one participant indicated that it revolved around the verbal communication used by the staff.

> *It's the comments they make, the snide comments they make, um, like you ask a basic question, I don't know in regards to medication or something and it's just the smart comments that come with "Oh, you should know this, you're a student nurse."* (Participant P)

and:

> *Things like "Oh, you wouldn't want to do that, you know that's not part of your job!" Yea, just very sarcastic comments more than anything.* (Participant W)

Participants perceived that by making these comments the staff were inferring that the students would not undertake menial tasks as these were perceived as being below the standard of task in which the nursing students expected to participate. Participants felt it was not necessarily what was said (the words) to the students, but rather the manner in which it was stated. Another participant stated:

> *… from personal experience, um, I heard a couple of smart arse comments, a couple of "Gees you're useless!", things like that …* (Participant E)

In other cases the staff tended to be even more overt in their verbal communications, both directly towards the nursing students and within hearing of them. Comments which were perceived as derogatory included:

You students are too noisy, get out of here! (Participant G)

Oh no, I'd rather get someone else! (Participant K)

I don't know what she's [referring to a nursing student] *doing, but I need you to help me because she's useless.* (Participant K)

Can you look after her [referring to a nursing student] *for the day because I don't want her hanging around?* (Participant M)

Whilst the participants perceived that the non-verbal communications had the most impact on them in the off-campus clinical setting, it is apparent that the negative verbal communication also had a considerable impact on the participants.

From the findings presented in the discussion above it is apparent that the staff in the facilities utilise various strategies and styles of communication in an attempt to maintain the traditional power relations experienced in nursing. Participants also indicated that the staff demonstrated their acceptance or otherwise of students through the use of positive and/or negative interpersonal skills.

Unwritten Rules

There were a number of unwritten rules which the nursing students were required to observe if they were to succeed in the off-campus clinical setting. Participants

perceived they were caught in a dichotomous situation. They thought they were expected to know things on the one hand, however on the other, if they did demonstrate any level of knowledge they were potentially ostracised by the staff to ensure that they 'knew their place'. The unwritten rules are intertwined with the properties and dimensions of this category and are intrinsically inter-related with all aspects of nursing culture and practice. Participant G related their experience in demonstrating knowledge of a clinical concept of which a RN was unsure:

> *… somebody* [RN] *said this lady had come in with a false aneurysm, anyway she said "I wonder what a false aneurysm is?" and we had just done that so I told her what it was and she said "Bloody students know everything don't they", got up and walked away.*

This demonstrates that whilst there is an expectation that the nursing students will be knowledgeable in a clinical sense, when they do demonstrate this knowledge in the off-campus clinical setting they risk being sanctioned by some of the staff. Participants felt that these ever shifting sands were very hard to navigate. This also links to the condition of anxiety as students felt anxious when confronted with behaviour like this.

Another of the apparent unwritten rules was that students do not 'question' the RN. This was apparent when Participant A5 stated:

> *This is the way it's going to be done. Don't challenge me you know, whereas I can't imagine a student actually challenging anyone. Just trying to enquire.*

Participant B supported this statement:

> *… if you were showing the ability to follow your mentor around without questioning her and were a passive, docile student then that was all they wanted to see …*

Participant B felt that questioning, and seeking further information from the RN that they were being mentored by, resulted in certain sanctions being imposed on them in the form of receiving low grades. This was evident in the following statement by Participant B:

> *… on that particular rotation they have the averages marked out and I received the lowest sort of grade out of all my peers …*

In an attempt to avoid these sanctions it became apparent that the participants would avoid questioning certain RNs in the clinical setting, opting to comply with the old ways when nurses did not question persons of authority. The analogy to nurses traditionally not questioning authority relates to the hierarchal structure in which the nursing students find themselves. Within this structure they are viewed as being below the RN and therefore they should be seen to not question the RN. This was consistent with tradition where the RN did not question the doctor.

Participant B discusses the issue of nurses traditionally being subordinate to Doctors.

> *… she did have a patient doctor hierarchical thing in her mind, she did have that sort of hierarchy thing in her mind because she was of the opinion that nurses did have their place … I don't see why we have to be submissive to a doctor.*

Clearly some participants felt that the nurses in the off-campus clinical setting thought that the role of the nurse was subordinate to the doctor and that the nurse should not be seen to challenge this traditional role. It was also apparent that any attempt to change the traditional work practices in a facility would result in strained working relations between the nursing students and the staff. Participant P indicated that whilst students were trained in the correct way to undertake tasks in the on-

campus clinical setting, any attempt to implement these practices in the off-campus clinical setting were likely to be met with objections. This participant indicated that:

> *You can't just walk in from uni and tell them to change everything because they're doing it wrong. Even if their occupational health and safety said you're not meant to do it that way, its like well we're doing it this way.* (Participant P)

From this statement it is clear that participants are wary of attempting to change work practices of the staff in the facilities, with the participants' assuming that even the staff in the facilities charged with effecting change to traditional work practices face similar difficulties.

Stereotyping

Stereotyping emerged from the data and there were both direct and indirect consequences for participants. Participants perceived that if they were able to provide the registered nurse with what the registered nurse thought of as being a 'good nurse', they would not experience what they thought were negative sanctions associated with being viewed as a 'poor nurse'. Participant B explained stereotyping was individual and was different from nurse to nurse.

> *…I reckon, I really do, its got down to something along the lines of how individuals perceive nurses to be …*

Whilst subtle approaches were generally utilised by the staff to ensure that nursing students subscribed to the stereotypical image of what a good nurse was, some nurses would use overt measures to ensure that the nursing students were well aware that they had crossed the line.

Participant B perceived that the nursing staff in a particular placement did not view their (the participants') personality as being conducive to what makes a good nurse. This participant, who through their own admission was willing to question staff in an effort to increase personal understanding of the clinical condition of patients, or the treatment being administered to patients.

> *… I think she* [the nurse] *took some of the things that I said as me trying to cross her path when in fact I was trying to complement the knowledge that was being dispersed to us. She* [the nurse] *may not be accustomed to somebody like myself who wants to get to the truth immediately and wants to get more …* (Participant B)

Participant H indicated that it was acceptable for the nursing staff to question the students, and berate a student in the event that they were wrong; however Participant H proposed that this approach made the nurse look bad in the eyes of the student.

This view of what constituted a good nurse seemed to connect with the historical context of nursing. Participants' felt that staff thought a 'good' nurse was someone who followed the doctor in an unquestioning manner. In the case of nursing students, the ideal nursing student was perceived as being someone who 'tailed the RN' in an unquestioning manner.

> *She* [the nurse] *did have a patient-Doctor hierarchical thing in her mind … because she was of the opinion that nurses did have their place … often the nurses are just standing behind following them around the ward.* (Participant B)

The nursing students did not necessarily accept the traditional medical dominance model where the nurse is viewed as the 'unknowing carer' who passively tails the doctor and carries out orders without question.

> *I don't see why we have to be submissive to a Doctor ... all of the textbooks and everyone is saying that we should be a part of a team.* (Participant B)

Participant B felt that the staff however often still acted passively in the presence of Doctors.

> *I don't hesitate to shake hands with a doctor when he does rounds whereas the other ones are, often the nurses are just standing behind following them around the ward ......I am happy to shake hands with the doctor to let them know where I am, I am just a student nurse but I am a person.* (Participant B)

Participant B indicated that this passivity may be due to being trained in a bygone era when the nurses were viewed as being the hand maiden to the doctor when the medical model of health care was the dominant model.

> *... then I realised that* [the facilitator] *was making her assessment based on um almost your archetypal presentable nurse um hand maiden type of, you know if you were instead of, if you were showing the ability to follow your mentor around without questioning her and were a passive, docile student then that was all they wanted to see and that was probably her experience ...* (Participant B)

This example of the participant perceiving the registered nurse in a facility acting as a tradition bearer enforces the traditional nursing ethos of being a submissive individual. Participant B further expanded on the tradition bearing role:

> *She didn't have any sort of vindictive agenda in her mind... and she let me know this clearly, that she did have a patient doctor hierarchical thing in her mind, she did have that sort of hierarchy thing in her mind because she was of the opinion that nurses did have their place.* (Participant B)

This places students who do not ascribe to this belief under an increased pressure to conform or risk sanctions for being defiant. Such sanctions may include failing the clinical placement which obviously no student wants to happen.

Traditionally, the nursing staff were female, however in the late 20th Century there was an increase in the number of males entering the profession. In 2005 the AIHW reported that males made up 8.5 % of the nursing workforce in 2001 (AIHW 2005). However, the number of males entering the profession in the 21st Century has decreased with males constituting 7.9% of the nursing workforce in 2005 (AIHW 2005). Participant B felt that as a male, he was viewed differently by the nursing staff:

> *… although I have worked in female dominated industries as a care worker before, sometimes I think that nurses who have had really strong female domination feel like, well I feel that they feel like men communicate with other men differently to women* [compared to] *how they communicate with each other and sometimes I feel as though my personality was interpreted as a person who would be, what's the word, would be difficult to deal with rather than someone that would be a joy to have around you know.* (Participant B)

Participant B felt that as a male he was different to a female nursing student. He elaborated further:

> *I must come across as being a little bit less, more, not touchy feely and maybe that is how she* [the RN] *perceived me, I was more, I approach caring in a … and I don't know if this is the right word to use, in a more masculine sense, I am a more get my hands in there get it done, um yea I can talk with a patient as well to make them feel more comfortable but I am more likely to be practical about it …*

This approach to care giving by the male nurse involved demonstrates his perceptions of a traditional nursing attribute and warrants further research in its own right.

Role

Nursing students are legally required to undertake tasks in accordance with their scope of practice (QNC 2005) throughout the time they are placed in the off-campus clinical setting. Two issues emerged in relation to this in the data. As some of the participants in this study were also employed as enrolled nurses, as students they were required to restrict their practice to within the scope for nursing students at their level. They remain aware though that they had to wait for the registered nurse. Although this caused frustration they complied. Registered nurses though, expected them to do more. This resulted in internal conflict and role confusion.

> *I am already an EEN and because I work in the private sector, the place where I work I have a lot of responsibility, I actually have a patient load and do the drug administration and so on and then coming back and being a student it just, I feel as if I am always waiting for the RN so I can do things. You know you can't, a lot of things you need the RN to supervise you, um because you are always a student and that is the difference.* (Participant R)

It became clear that nursing student scope of practice was not well understood by facility staff. As mentioned, participants perceived that the staff felt that the students were restricted to the completion of tasks at the assistant in nursing level. It was evident that the students would sometimes work outside of their scope of practice under the direct supervision of the registered nurse in order to fulfil expectations. A participant related their experience of working outside of their scope to gain a favourable learning experience, however suffering the consequences of doing so at the time of assessment.

> *But because I touched the buttons, I was outside my scope of practice but I had a good learning experience from my prac, um again she* [Preceptor] *didn't fail me, but she marked me down.* (Participant V)

Whilst at times nursing students perceived they had the ability to work outside their scope under direct supervision, there were often consequences from other members of staff who felt that the nursing student may have stepped outside the accepted and legal limits.

The staff, including registered nurses, were largely unaware of a student's scope of practice, both at the individual nursing student level and at the wider level of university educated nursing students in general. Participants reported that there did not appear to be an actual structure within the facilities delineating what a nursing student could, or could not, do. Participant D6 indicated:

> *I was placed in a private setting in aged care, um, I found that a lot of the staff did not know what we were capable of doing, or allowed to do, um there was no clear setting or no sort of written down on paper what we were allowed to do, um I found that I had to keep on referring back to my competency book just to show them what I could do and reassure them that OK you're* [nursing student] *allowed to do this.*

This was a common theme in many of the off-campus clinical settings where nursing students were placed.

Participants perceived the role of the off-campus clinical setting was to allow them the opportunity to apply their theoretical knowledge. Staff in the facilities appeared to be confused as to the role of nursing students

> *In the* [practice setting removed] *that I am in now I find it more the RN feeling that I am a volunteer, because I am not getting paid I really shouldn't be doing things for her. It's their job and I am there to give a hand or watch*

> *so they really don't, they don't have a clear understanding of what their role is in the clinical experience.* (Participant A2)

Another Participant stated:

> *The other thing that I noticed was that by the middle of the term there, the facility was using us much more as extra bodies on the floor and there was a big notice put up that students could not work with a RN between certain hours because they* [the students] *were needed on the floor to help with the ADLs and that was that. I didn't see that as fair because our role there was as students who needed to follow directions and see the maximum number of learning opportunities and at these times these were difficult to manage because there were some activities ... which were not a PC* [Personal Care worker] *duty.* (Participant D5)

Nursing students perceived that they were in the off-campus clinical setting to gain learning experiences and apply theory in a real life setting. Participants felt that they were present as unpaid helpers. This incongruence was explained as:

> *So that's the confusion, where we're on one level thinking that we need to do our tasks, they're on another level thinking we're extra AINs to work with them.* (Participant G)

Participants felt that whilst in the off-campus clinical setting they were there to work with the registered nurses. One participant identified the confusion experienced by both staff and students as being related to the differing perceptions of why nursing students are placed in the clinical setting.

There was an expectation on the nursing student's part that they would have access to appropriate clinical experiences, whilst the facility management determined that it was more appropriate to utilise the nursing students on the floor as an extra staff member to attend to patients' basic needs. Whilst these two participants clearly perceived that their role was one in which they were placed in the off-campus

clinical setting to learn and gain the practical experience that they required, the participants perceived that the clinical staff were not as clear as to the role of a nursing student.

In some instances participants felt that the staff perceived that nursing students were simply there to undertake menial nursing tasks. The above example from Participant D5 is an indication of this with Participant P concurring.

> *You will still get, you will still get the odd nurse who thinks oh well we've got students here, we'll make them make all the beds, we'll make them do all the toileting, um but we won't let them go and do, put an IDC in or something, when that comes up they'll say, we forgot.* (Participant P)

It was apparent from the data that a number of the enrolled nurses and endorsed enrolled nurses in the various settings where this level of staff were employed were under the impression that it was acceptable for a staff member at this level to delegate tasks to nursing students. This delegation of tasks to nursing students raised two issues in the data; one was a lack of understanding in relation to scope of practice[7] and the second was a desire to maintain a level of power and control over nursing students. In response to an endorsed enrolled nurse attempting to delegate to nursing students a participant reported:

> *… it had very much been drummed into us that we were not to accept anything delegated to us from an EN, it had to come from a RN because otherwise it was outside our scope of practice and when being told to do something by an EEN we then had to go and ask the RN can we do it* [the task]. (Participant C)

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[7] Staff at the EN and EEN level have no delegated authority to delegate tasks. Delegation of tasks at this clinical level is outside the employee's scope of practice.

Role confusion was not only confined to a lack of understanding of the students' scope of practice, but rather a lack of understanding in relation to the learning needs of the nursing student on the part of the registered nurse. The assistant in nursing views of nursing students and their role in the off-campus clinical setting also demonstrated a lack of understanding in relation to the learning needs of a student rather than scope of practice issues:

> *… they thought they could delegate to us, um so there was and I think that remained, they still had a bit of a thorn in their side that we weren't there to do whatever because we weren't getting paid and you know we felt like we were slaves but, um we were there to learn and we were there to look after so many residents and if we had time we could help them, but not when it suited them …* (Participant K)

This participant perceived that the assistants in nursing felt that they could delegate tasks to the nursing students as the nursing students were viewed as being the lowest level in the hierarchy. Participants felt that they could be directed by all nurses in the facility including personal care workers, despite the students being aware that the scope of practice did not allow for a staff member below the level of registered nurses to delegate tasks.

The discussion above highlights the issue of delegation to nursing students and raises the issue of whether this is an issue of poor knowledge of the scope of practice or whether it is a perception of where the nursing student fits within the professional hierarchy. It is apparent that whilst the participants' perceived that the issue was related to delegation of tasks, there were also aspects of enforcing the hierarchical structure through ensuring the students knew their place. This raised the issue of

competing goals and needs in relation to the staff and the nursing students. From the staffing perspective the role of the student is to assist in getting the job done whilst the students perceive that they are in the off-campus clinical setting to learn.

A small number of the participants in the study (as disclosed in Table 3) already held qualifications as either an enrolled nurse or an endorsed enrolled nurse and had work experience in those particular roles in various facilities. This raised the question as to whether these participants were treated differently in the clinical setting in the event that it became apparent that they had prior knowledge and understanding of the nursing role. A typical perception of the nursing students with this level of nursing experience and qualification was:

> *… some of the older ENs who have been ENs forever and have no intention of ever doing their RNs, um for some of them, they kind of come across to me as if like, I've crossed the line. Because now I'm going to cross links and become a RN and then I'll think that I know more than them …* (Participant P)

Another participant related their experiences of how the assistants in nursing treated them when they realised the nursing student had some level of clinical experience:

> *… well of course they're different, like some just treat you um like you're part of the staff, see you as an RN or whatever, some of the older ones, older as I'm talking the ones in their 50s that have been nursing for 30 years, I think some of them find it more difficult, um and maybe feel a bit threatened.* (Participant R)

The staff felt that if a nursing student had prior experience in the clinical setting they had an assumed level of knowledge:

> *Um, yes sometimes they um like if they know that I am an EN and another girl that I go to uni with, I work with her as well, um sometimes they sort of*

think well you're an EN already, you sort of know what to do there but um, … really like I have even said that although I am an EN at the moment I am a student and there's things here that I really don't fully understand or I don't really know, um but they just sort of think oh you're an EN so you do know and they just assume that you know. (Participant T)

This assumption that the nursing student had knowledge and knew what to do was not always accurate as there are clinical aspects that were outside the nursing student's knowledge base and experience. As the above excerpt also demonstrates, the students wanted to expand on what they knew as an enrolled nurse or an endorsed enrolled nurse to bring their knowledge up to the level of a registered nurse.

Disclosure (or non-disclosure) of the previous clinical experience impacts upon the student's ability to identify where they fit within the profession. Staff in the facilities viewed these nursing students as already having some knowledge, regardless of whether or not the knowledge is at the required level. Participants described being trained as an enrolled nurse and then having to undertake clinical placement as a registered nurse student as building upon an already laid foundation in that the staff identified that the participant had the basic skills and knowledge of a nurse.

…ok you sort of have an overview of what you're doing, we [nursing staff] *can work with that, we're not having to build you up from the ground level, you have a few blocks on the ground that we can build on.* (Participant S)

Whilst Participant S indicated that having some previous experience as an enrolled nurse or an endorsed enrolled nurse was viewed in a positive light by the staff in the off-campus clinical setting, another participant indicated that disclosure of previous nursing experience impacted negatively upon their clinical placement. The decision not to disclose prior experience was rationalised by this participant as:

I actually make out that I have no nursing experience because I find sometimes like you know if you say to them I am like an AIN or an EN its sort of like oh well you know what you are doing, you don't need us sort of thing, so I tend to play a little bit dumb sometimes. (Participant W)

This approach of acknowledging the staff was also undertaken by another participant.

I deliberately don't try to come across with the attitude that I am a student at uni, I am better than you. I am aware that there might be that kind of thing going on, so if they tell me something, even if I already know it, I will just say "Thank you very much". To let them know that they have bothered to try and teach me something even though I already know it and so it helps them … (Participant Y)

This participant perceived that by acting like this staff would be more willing to provide assistance when it was needed. Through not actively disclosing their previous experiences in either clinical placements or nursing in other facilities, students were attempting to demonstrate that they did not think they were above the staff in knowledge and skills. This enabled students to 'fit' within the facilities hierarchy without ruffling feathers and experiencing anxiety. Fitting into the culture was paramount to the students as a sense of cultural belonging is an important consideration in developing a professional identity (du Toit 1996).

Staff

'*Staff*' emerged as a category as a result of how their actions and interactions with nursing students could affect the experiences of the nursing student in the off-campus clinical setting. The emergence of this category is presented graphically on

the following page. Participants identified their interactions, both positive and negative, with staff as being a major issue in determining where they fitted within the profession as a whole and also within the actual facility where they had been placed. A number of properties and dimensions were identified as impacting upon the category of '*staff*' these are discussed in the following section of the chapter with a visual representation presented in Figure 6 on the following page.
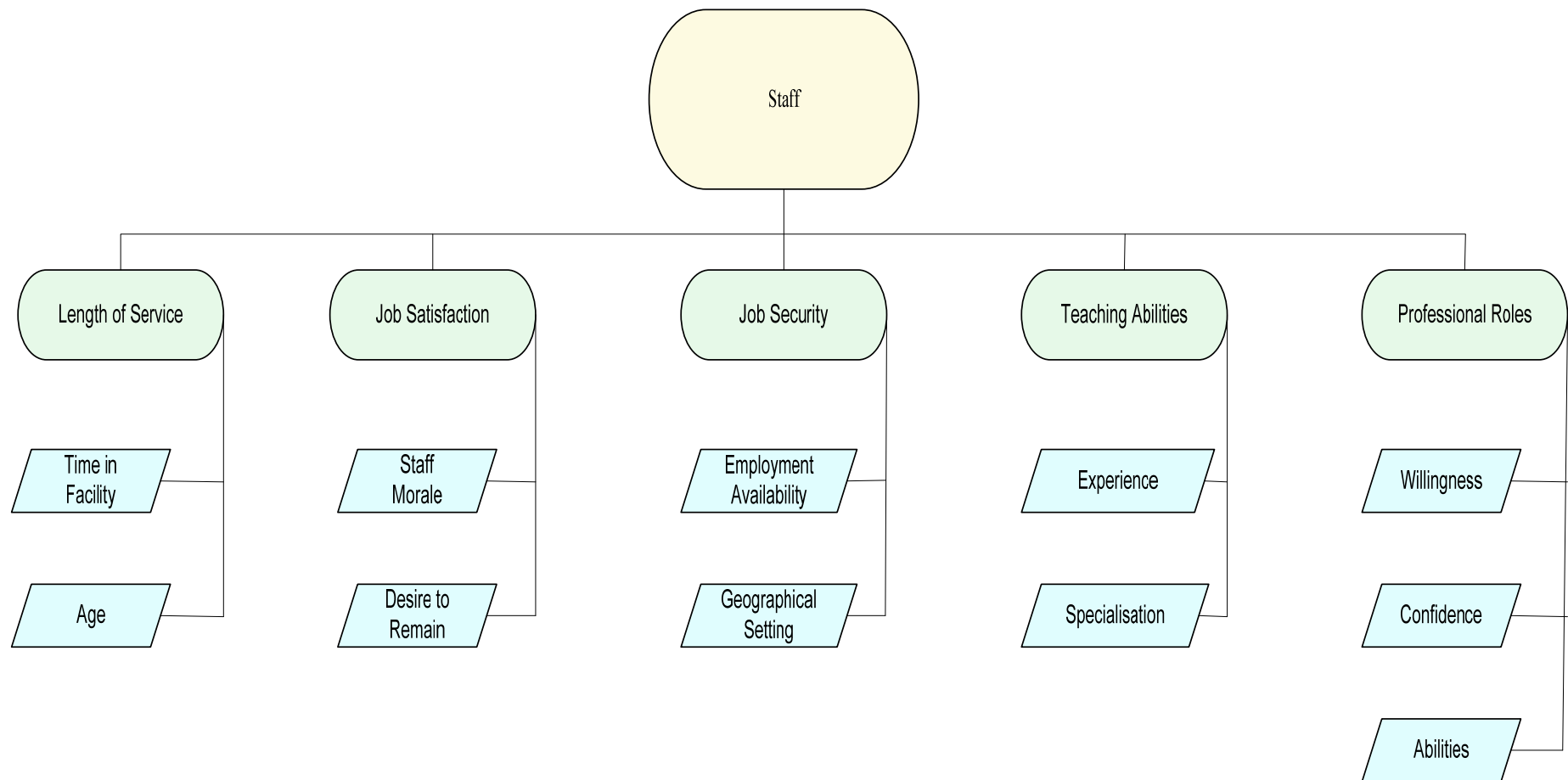
Figure 6: Properties and dimensions of 'Staff Performance'

Length of service

Longer serving staff members in a facility were likely to have a greater impact on the experiences of students in the off-campus clinical setting. Participants indicated that they could learn more from an enrolled nurse who had been in the clinical setting for 30 years then they could from a registered nurse who had been in clinical settings for two or three years. The longer serving staff in the facilities were not necessarily chronologically old with many of them having started employment in the facilities at a young age.

> *… one lady had 28 years in one nursing home and she wasn't old. She had been in there since she was like in her mid teens … and there were a number of them in this one facility.* (Participant B)

The longer serving staff members adopted the role of indoctrinating students into the culture of nursing as a profession and also into the culture of the facility.

> *…the nurses that'd been, you know, out for ten years … was a bit more Matronly.* (Participant K)

Participants perceived both positive and negative aspects associated with the longer serving staff. The positive aspects included the students being able to access staff with an extensive knowledge of nursing; however the negative aspects indicated that the staff with longer service were more likely to enforce the cultural traditions of nursing.

Significantly, long serving staff in the facilities were not necessary chronologically older then the other staff members, or the participants. These staff members adopted

the role of tradition bearer, not because of their age, rather as a result of the length of their service. The longer serving staff members had a significant impact upon the experiences of the participants in the off-campus clinical setting. Length of service is directly related to the experiences that the participants had when interacting with the staff in the various off-campus clinical settings.

Job Satisfaction

Job satisfaction as a reason for some staff remaining in the same facility for extended time frames also emerged from the data. Participants perceived that job satisfaction occurred across all levels of nursing from the assistant in nursing level through to the registered nurse level. If the staff were satisfied working in an aged care setting, or any of the other clinical settings, in which nursing students were placed, those staff members tended to remain in that setting. There were however instances in the data that indicated that some staff were experiencing less than optimal levels of job satisfaction. Due to a lack of employment opportunity in the community where these staff members resided, they often had little choice but to remain in the facility.

> *It wasn't a particularly well run nursing home, it was very low budget, very under staffed, very bad staff morale, it was just horrible.* (Participant N)

The impact that this had on the clinical experience for nursing students was perceived as being negative.

> *Well because you, I know you're only super numerary but you rely on permanent staff to guide you in an area that you're not familiar with and if they're not enjoying their place of work and are set aside, well that just impacts on you the whole time that you've been with them. Because they're in*

a negative frame of mind to begin with and then they've got a student trailing behind them and you know, that just exacerbates things. (Participant N)

Participants indicated that the job satisfaction level of the staff was higher in facilities where the staff appeared to be supported by the organisation. Organisational support in the form of on going training and education improved the job satisfaction levels of the staff and this in turn had a positive impact on the nursing students' experience in the off-campus clinical setting. Therefore, the participants perceived that if the facility staff felt secure in their job and staff morale in the facility was good, the clinical practicum for the student was a more positive experience. This positive experience resulted from the staff being more responsive to the students' learning needs and a willingness by the staff to engage with the students in the facility. There was also an increased level of positive communication instead of the negative remarks which some of the participants had grown to expect in the off-campus clinical setting.

Participants' perceived that the desire of staff to remain in clinical settings in which they experienced negative behaviours was low. Participant C reported that a RN who had made the decision to leave the facility was further isolated from the staff in the last two weeks of their employment in the facility. The dimension '*desire to remain*' is further explored in '*job security*' as this property also has links with this dimension.

Job security

Job security arose as a property of *staff* in relation to the experiences of the participants when they were placed in the off-campus clinical setting with assistants in nursing. Employees at the level of assistant in nursing are primarily employed in the aged care sector (AIHW 2007) and in a number of instances the data indicated that staff at this level had spent considerable periods of time in the same facility. A participant in this study perceived that the staff at the assistant in nursing level chose to remain in the same facility for extended periods for two reasons. Firstly the employment prospects of mature aged females in a regional community were limited, and secondly, the staff were in secure employment and despite the low pay rates, they had a sound level of job security. Participant B indicated that one staff member had been employed in the same facility for 28 years, and there were a number of other long serving staff present in this facility.

The interviewer made a comment that the nursing homes in this particular location obviously didn't have staff turnover issues. Participant B's response to this was:

> *Well I don't know why because they have a reputation for being the lowest paid of all the AINs in all the nursing homes in my town, so for some reason they have stayed on, but they have been offered a lot of good in-house training and you know beggars can't be choosers in a small town for a job so that is another reason.*

Participants felt that some staff felt that their job security was being threatened by the presence of nursing students and that the staff demonstrated a level of defensiveness to protect their position in the organisation. Participants said that a number of students successfully gain employment in the facilities where they

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undertake clinical placement. Participants revealed that the staff at the assistant in nursing level in the facilities were aware that the facility management viewed nursing students as being attractive future employees.

Geographical setting is significant in respect of job security as the participants in this study were placed in regional areas. The number of jobs available in regional areas is limited due to the population base in these areas and as such the AINs who are employed are protective of the positions they hold in the workforce. Participant B indicated:

> *… you know beggars can't be choosers in a small town for a job so that is another reason too.*

Through constant comparative analysis it was evident that the participants who had been placed in the off-campus clinical setting in larger regional centres did not experience the same level of conflict with AINs feeling that their positions were threatened. Furthermore, it is difficult to attract qualified staff to work in regional areas (NSW Farmers Association 2001) and as a result of this the staff experience a reasonable degree of job security.

However, as nursing students quite often obtain paid employment as AINs in the facilities in which they have been placed for clinical practice, the AIN staff sometimes perceive that the students may take employment away from them. In the event that a nursing student did successfully obtain employment as an AIN it would be likely that this would ultimately restrict the existing staff members' ability to maintain employment due to the limited opportunities in regional areas. This lead

participants to perceive that the staff are protective of their employment and lead to perceived conflict between staff and students in some off-campus clinical settings.

Teaching abilities

Participants indicated that in the majority of clinical settings the facilitators were nurses whom the participants perceived as having had little or no educational[8] background, and yet they were expected to teach and assess. In response to a question from the interviewer regarding nurses having the capacity to teach, Participant B said:

> *I think it takes quite a unique person to be really good at lecturing and to be assessing somebody else's clinical skills you know as opposed to being good at doing it yourself.* (Participant B)

This was supported by another participant:

> *… nurses are not teachers, so they don't know how to teach.* (Participant A6)

Participants felt the staff in specialist nursing areas tended to be better educators:

> *I am in Intensive Care at* [facility name removed] *and they have been wonderful. I have not had an issue with a single staff member there and they have just been wonderful, they can't do enough to help you and I think that is because they are used to teaching not only students but their own nurses that come in and work there, they are so used to teaching people and they want to help.* (Participant Q)

Participants perceived that the staff in the specialist nursing areas were better educators as these staff were responsible for the training of other staff in the unit and

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[8] In this instance the term 'education' is used to refer to 'learning management' training or workplace training and assessment qualifications.

a number of these staff also had additional qualifications. One participant perceived that staff in the specialist settings were better educators because of a desire to attract and retain staff within the specialty.

Teaching ability was a significant factor which influenced the experiences of the nursing students in the off-campus clinical setting. The perceived teaching abilities of the staff impacted upon how the students related to the nursing staff, the staff who were perceived as being quality educators were viewed in a positive light by the participants. The experiences of the participants relating to the teaching ability of the staff were summed up by Participant A5:

> You find that there is a fair mix of those that are prepared to show you what to do and even to give you some information. There were a few others that were teaching in other facilities such as TAFE or whatever who were quite happy to give you information and wanted to show you things. If they saw an opportunity for you to learn something they would take you aside to show you where there were others that we were just in the road.

This ultimately impacted on how the students' perceived the clinical setting and upon both their expectations of the staff, and conversely the staffs expectations of the students.

Professional roles

The student's experience in the off-campus clinical setting was affected by the preceptor's and facilitator's confidence with their own abilities and their willingness to mentor the nursing students. Refusal to allow the nursing students the opportunity to access certain tasks affected their performance and confidence as the tasks were

required learning. In some settings the staff were perceived by participants as simply going out of their way to block student access to necessary learning experiences.

> *… some of them went out of their way to do things that we were supposed to be doing or make a point of saying, look, we* [nursing students] *are only there to change the beds and shower people and we are not there for any actual clinical duties.* (Participant E)

In another instance the student's access to tasks was being blocked by the staff actively delegating menial tasks to nursing students when an appropriate clinical case presented.

> *… placement focuses on complex skills and gaining experience doing complex skills and whenever any of those opportunities arose, um, I was um, basically told to go away, um no you can go and make the beds or help um, the EN, um so basically I guess you could say I was denied learning opportunities.* (Participant S)

This denial of access to learning opportunities continued even after the facilitator had explained to the nursing staff that certain tasks were within a student's scope of practice. This is reflected in the excerpt from Participant D6 below:

> *… a lot of the RNs at this particular private setting that um, even with reassurance, even with the facilitator um discussing with them that we were allowed to do these things but they would not allow us to do them.*

> (Participant D 6)

The level of experience that the individual registered nurse had with the supervision of nursing students and the degree to which they were comfortable performing the role had an impact on the nursing students. If a registered nurse was perceived to be comfortable in their role, the nursing students benefited from opportunities to access requisite skills and knowledge. However the opposite was the case if the registered nurse felt that the nursing student may cause issues for them.

> *I believe that it was her first time doing the job and she was concerned that we would be doing things that would cause her problems ...* (Participant V)

This was also supported by a different participant in a different clinical setting:

> *I am sure it had nothing to do with me and she admitted from the very beginning that she was uncomfortable with the role ... ... maybe it all boils down to her being so uncomfortable in an academic role, lets face it, it is quite a skill to assess somebody else with what they're competent in. She must have been uncomfortable and wanted to move on and um do other things and that is only after one three month term ...* (Participant B)

Clearly the ability of a nurse to mentor students in the off-campus clinical setting will have an impact upon the students' experiences of the clinical placement (Aitkins & Williams 1995; Watson 1999). This ability to mentor students could be impacted upon by the perceived willingness of the staff to mentor students and also by the individual staff member's confidence in their own abilities to be an effective mentor for a student. Whilst no specific data was collected from staff in respect of their willingness, confidence and ability to mentor students, participants perceived this as an issue which impacted upon their experience of staff in the off-campus clinical setting.

Student Performance

The category '*student performance*' emerged from the data in response to the volume of commentary that was evident in respect of the time management and task-time imperative that is inherent in the practice of nursing in the clinical setting. The performance of nursing students, both individually and as a group, has an impact on

their experience of the off-campus clinical setting. The clinical level of the staff that the students are placed with impacted upon the students' experiences as did the different types of facilities in which the students were placed. Participants' experiences of their role as a nursing student in their interactions with nursing staff also impacted heavily upon the students ability to perform the role of a nursing student in the off-campus clinical setting. The properties and dimensions of the category '*student performance*' are now discussed with a visual representation of this category presented in Figure 7 on page 113.

Clinical level

Whilst nursing students in the off-campus clinical setting are supervised by a RN, it was not only the RNs in a facility who had a significant impact upon the performance of the participants and their experiences in the off-campus clinical setting. Indeed a number of participants relayed that the majority of the negative experiences in the off-campus clinical setting were perpetrated by staff at the assistant in nursing or enrolled nurse level. One participant stated:

> *… we basically only did one or two days during the whole term with the RN, everything else was either with the AIN or EN and to be honest the majority of the problems came from the AINs*. (Participant E)

This was further supported by another participant relating an incident involving an EN who was a long serving employee in a facility:

> *… it tended to come from the AINs or the ENs and actually there was one EN who was in at the nursing home and that was just dreadful, she was, her behaviour was very poor, um we were all in the nursing station you know doing our notes and she came in and ordered us all out because she wanted to get here book work done. … She actually said "Everybody out!" and it just so happened that two of our lecturers*

were actually visiting that home and were in the nurses station and they were talking and she just ordered everybody out and she was an EN.

Students saw this kind of behaviour as a display of power. They had thought that the RNs were the 'top of the pile' but on a number of occasions it appeared that the ENs or AINs were actually in charge – although in a different way.

Workload

Staffing levels in the off-campus clinical setting affected the amount of time that nursing students are able to spend with the registered nurse in a facility. One participant indicated that there was only ever one registered nurse on a ward and in some cases this single registered nurse was covering two wards. This, coupled with the volume of nursing students in this setting, led to increased stress for both the staff and the students.

> *If there were two RNs it would be a lot less stress, but there is only ever one on each ward and sometimes there is one between two wards and that's even in the day.* (Participant Z)

This was also the case with the clinical facilitators in that they had an assigned number of students but participants felt they were unable to spend enough time with the students. This is reflected in the following:

> *… you know there were, they were run around the whole time, there were what, six or seven or eight of us there and one facilitator.* (Participant A4)

Access to the registered nurse was essential for nursing students to complete the required learning objectives within a given clinical placement.
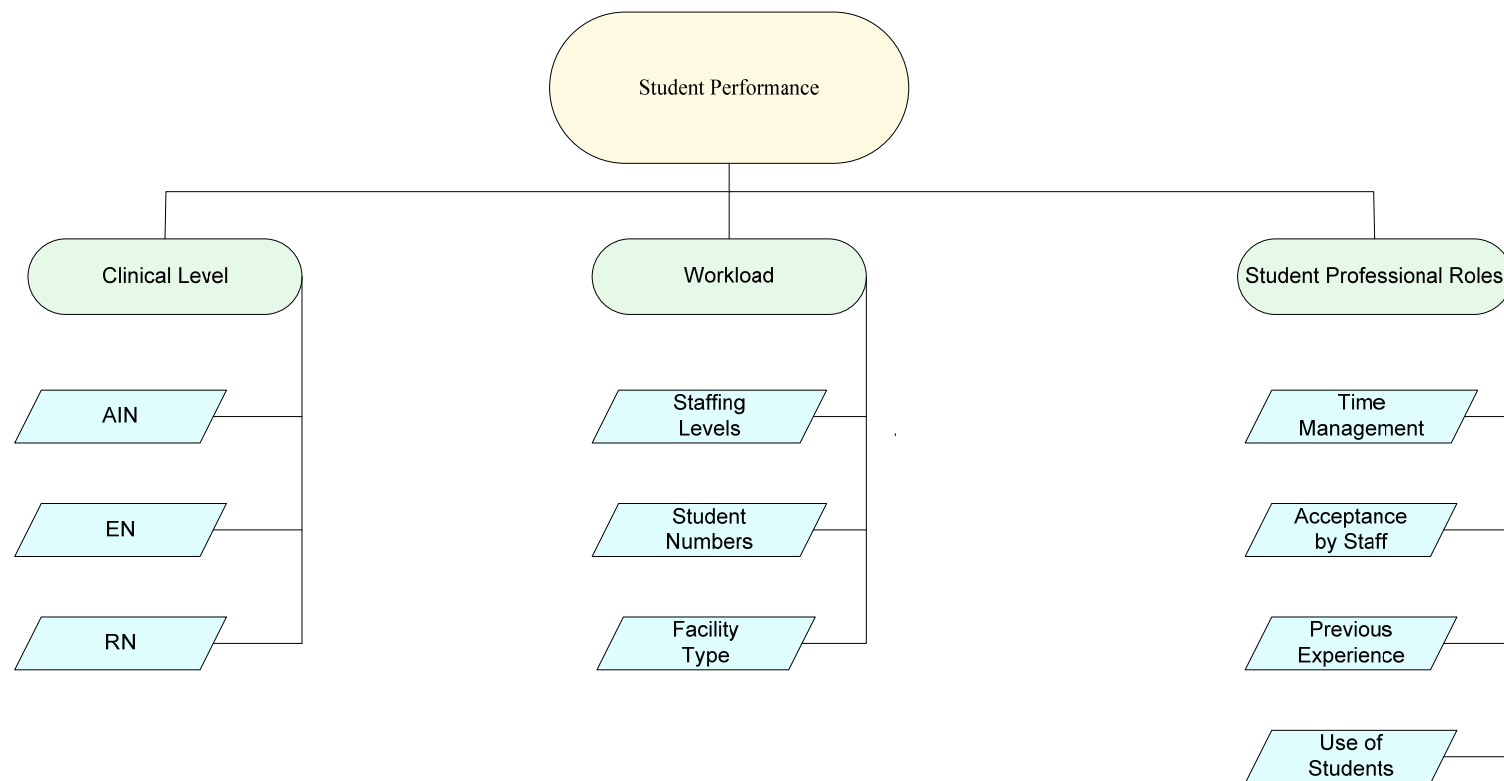
Figure 7: Properties and dimensions of 'Student Performance'

Delegation of tasks to students can only come from a registered nurse and registered nurses are the only level who can assess a student and sign off on assessment items in the clinical setting as competent or not yet competent. As the following excerpt describes, accessing a registered nurse was not always easy:

> *… you know one of the units that I was on in the second term of that placement there wasn't an RN on and that RN had three units to do and she stayed in the middle one and we never saw her …* (Participant E)

This was further supported by Participant N:

> *… you can only have one student with the RN and the rest had to work with the AINs so you got very limited RN time.*

This restriction on the amount of time that the participants were able to spend with the RN in an aged care setting meant that they were largely developing skills at the basic care level and often unable to access the more clinically significant tasks that required the supervision of the registered nurse.

This shortage of registered staff resulted in the nursing students being pressured to obtain as much as they could within the short time frame that they are able to access the registered nurse. This is a particular concern for the nursing students working in the settings where there may be eight nursing students and one registered nurse for the duration of the clinical placement. As indicated previously in this chapter it also placed pressure on the registered nurse. The issue of participants slowing the staff down or being a burden to them while they performed their duties also emerged from the data. One participant related the words of a registered nurse when they stated:

> *It's like "I've got a full workload and I've got a student!"* (Participant N)

The volume of nursing students placed at a facility also impacts on the experiences of the participants in the various facilities.

> *… if there is too many, well not too many, but a fair few students on a ward and there are you know, we have certain skills too, well we probably should do certain skills and there is only one set of staples or a couple of stiches to come out, there is a run towards them.* (Participant V)

This participant went on to say:

> *Like you can imagine what a situation that is, on one hand you are sort of encouraged and pushed to go and do certain things, but on the other hand you kind of got to share as well so …*

Participants knew that they needed to access what were often limited skills practice opportunities and that they may need to share the access with other nursing students. They perceived this competition and sharing of learning opportunities as a negative aspect of their necessary learning requirements.

Student professional roles

As nursing students are still in the process of learning the skills and knowledge required to become an effective registered nurse, they do not have the same level of ability as a nurse who is employed in the facility. They therefore will be slower at completing tasks. The issue of participants slowing the staff down or being a burden to them while they performed their duties also emerged from the data. One participant related the words of a registered nurse when they stated:

> *It's like "I've got a full workload and I've got a student!"* (Participant N)

This was supported by another participant:

You know when you're learning it is very time consuming and well they're pushing you along because they've got six, you know, a full patient load and they don't have time to let you actually, you know go through and in the beginning you are taking your time making sure it's accurate and they are pushing you along saying "Oh here it is" ... (Participant A3)

Another participant offered the following:

... we overheard quite a few comments along the lines of "well, I need extra staff just to take these students around and show them what to do." (Participant E)

Participants revealed that nursing staff indicated to one another that with a student who was slowing them down, they were still expected to undertake a full patient load that would normally be assigned to them even if they were not facilitating the student's learning. Participants raised concerns that the staff were expected to take a nursing student and maintain a full patient load as it contributed to the stress on the registered nurse which then would have an impact on him or her.

Students perceived that the staff viewed them as being a burden, one that they did not need. This had a marked impact on the student's ability to determine where they fitted within the off-campus clinical setting as there were nurses who either did not want to work with students, or nurses who would refuse to accept students. This again places the students in an anxious position. Participant C described the issues associated with being seen as a burden in the following way:

> *… as with everywhere there are always one or two nurses who don't want you there or who don't want to work with you, or just, you know can't be bothered ...*

Another participant stated:

> *…some of the RNs that originally were happy enough to have students with them ended up picking the students that they preferred to work with and put the others off in the end, like some of the other students saying that some RNs saying that "No, I don't want a student with me".* (Participant D5)

A student's clinical experience had an impact upon their time management ability in the off-campus clinical setting and this emerged as an issue of concern. Participants indicated that they felt it was inappropriate at their level of experience to be expected to both effectively manage their time and simultaneously learn the requisite time management skills of a registered nurse. This became evident through statements from participants indicating that they felt they should learn the basic skills first and when they had mastered these, time management skills would develop. A participant expressed this as being:

> *…sort of similar to our postgraduate year when you take on a patient load but you've got somebody there watching over you, that idea is a really good idea for while we're still at uni as well, because that way you're learning about time management.* (Participant A4)

Whilst the majority of staff were willing to accept students, there were some staff who were not, even if they had previously done so. Participants then vacillated between feelings of belonging (being wanted) or negative feelings (being unwanted) associated with being a burden.

Whilst some staff viewed students as being a burden, there were many staff who viewed nursing students as being beneficial to their practice. This is indicated by the following:

> *There are some people who don't want students around and then there are some nurses around, especially where I am at the moment who think it is the best thing having the students on the ward and giving them the clinical experience and go out of their way to make it a positive experience for us.* (Participant C)

This made the student feel positive about their clinical placement which in turn increased their self-esteem and confidence; the outcome from this was an increased feeling of acceptance and enhancement of professional identity.

When I further probed the notion of staff willingness to accept students the response was:

> *… you know if they have a huge workload and they have a student on top of that which slows them down even more, or you can slow them down, it depends a bit on how they make use of us. Some of them, I don't know, maybe they are not informed properly how to make the best use of the student and they're, therefore they are under even more pressure.* (Participant V)

When asked whether the workloads that students had in the off-campus clinical setting impacted on their ability to develop time management skills, Participant P responded:

> *Yes, um definitely, to the point you are accused of being too slow. Especially when you're doing like medication rounds and stuff like that for the first couple of times, you're like the RN that you're with um … will be looking at her watch constantly and going "come on you need to fasten up, you're going too slow", while they're asking you a hundred different questions about the drug you're handing out.*

Participants felt that the relationship they had with registered nurses was at times dichotomous. Students were expected to do the routine medication round quickly, just like a registered nurse, yet at other times, as alluded to previously, they were treated like assistants in nursing. This caused a degree of anxiety within the students as they wondered where they fitted within the profession. The posts always seemed to be shifting. Participant P elaborated:

> *They also ask you a lot of clinical questions as you're going along with it. So that then takes that little bit extra to answer. And they're still looking at their watch going "Oh come on you're still not fast enough."*

This behaviour by the staff caused the participants to perceive the questioning was power based. This is explained as:

> *They've got that power, it's that power, well come on I've told you to hurry up, but I'll just throw this little question in here and see if you can do, you know more than one thing at once. And when you're a student and you're trying to do it properly, sometimes it is hard to do more than one task at a time.* (Participant P)

Participant P thought as students it felt like they were being set up to fail:

> *… sometimes it's just like they're watching and waiting for you to fail so they can basically get back and go "Well, see another student nurse messed up."*

Control was perceived to be central to the RN/student relationship; the registered nurses had all the control in the setting through their ability to delegate tasks and associated workloads. Through this ability to control the students, staff were able to control the students' experiences of the off-campus clinical setting. Students were well aware of this.

Participant V perceived that the registered nurse lacked the skills and underlying knowledge to effectively utilise the nursing students to manage their workload. This is evident in:

> *… it depends a bit on how they make use of us. Some of them, I don't know, maybe they are not informed properly how to make the best use of the student and they're, therefore they are under even more pressure.*

As a result of staff not optimising use of the nursing student they had been assigned, the staff were under increased pressure to complete their workload. This resulted in a negative experience for the student who then felt like a burden.

In the event that the staff were unable to complete their assigned workload for the shift, it was necessary to record the reasons for this in the shift logbook. As one participant reported, this failure was often attributed to the staff member having been assigned a nursing student for the duration of the shift.

> *… one of the factors contributing to that* [negative staff attitude] *was that if the RNs didn't get all of the allocated workload completed, there's a book that they write down what they couldn't get done and why, and a common comment in the last twelve weeks has been "I had a student".* (Participant D2)

This was clarified in a statement by another participant:

> *I don't think they are truthful in some ways writing down their documentation saying that students were the ones that, many things happen, doctors would come in and spend ages sometimes and that would cause it to be a bit tight.* (Participant D5)

Thus nursing students were not the sole reason for the registered nurse and auxiliary nursing staff being unable to complete the allotted tasks within the assigned timeframe. The nursing students were however, assigned the blame for this failure by

the staff to complete the work within the allocated shift. This made the participants feel frustrated, inadequate and angry.

Expectations – The interactions between tradition bearing, staff and student performance

The contextual conditions presented in the preceding discussion intersect to create expectations on the part of the nursing students and the nursing staff in the off-campus clinical setting. The expectations that were raised from the data are presented in the following discussion. It became apparent that there were varying expectations between the students and the nursing staff in the clinical facility. These differences were found to impact upon the basic social problem which was identified as being what the student's '*place*' was within the profession.

The concepts of tradition-bearing as well as the behaviours of staff created expectations in respect of maintaining the traditions of nursing. As discussed some staff behaved in a manner that inferred that such traditions are handed down to the new generations of nurses. Staff, particularly assistants in nursing, expected that these traditions will be observed. Previous discussion demonstrates that the staff in the off-campus clinical setting who have adopted the tradition-bearer role maintain these through the use of unwritten rules and behaviours which are used to socialise nursing students into what are thought to be accepted ways. In the apprenticeship system, which is considered the traditional means of training, nursing students were expected to complete tasks as directed and without question. The traditional way was

not encouraging of a questioning culture and in many instances questioning was not

appreciated in contemporary settings either.

> *… if you were showing the ability to follow your mentor around without questioning her and were a passive, docile student then that was all they wanted to see...* (Participant B)

> *… for some reason nursing seems to attract women who are not backwards in coming forwards and they would tell you straight away in no uncertain terms that you are incompetent or you are, start moving faster, and they would use that language too, they wouldn't be um gentle about it. I mean their workloads were incredible so they had no sympathy for anyone who was showing any weakness or showing signs of not wanting to work, I am sure, it didn't happen to me but … they were just that sort of person they were very strong, colourful language type women who wouldn't hesitate to use that kind of language.*

This excerpt indicates that the participants felt that the staff had expectations of the

students and if the students do not perform to these expectations, there are

consequences that will be spelt out in very definite terms.

Another participant indicated that there were differing expectations of the nursing

students dependent on their age.

> *I am 31 years of age and I know that some of the other younger people, and I say those that are sort of 17, 18, 19 sort of thing, um they in one regard they get looked after very well because people think oh yea you know they have left school they are coming in they want to learn this but in other ways, in other ways not … in one way being older is good, but in other ways it is not so good um because I find that they expect me to know more, um I think they expect a higher standard of me …* (Participant C)

This expectation of a higher level of knowledge and ability because of age was

further translated into a clinical sense by Participant C:

> *I suppose from my point of view being older, I think they feel that I should um you know, know more but then again I suppose they trust me more to do things. I got a lot more participation in the decision making process with the admissions and um just with the general care planning of the person. Um, so*

> *I suppose where as some of the younger people all sort of felt that they didn't get a chance to make, or to help make some of those decisions, you know collaborate together, so I suppose it is both a positive and a negative together I suppose.*

Participant C also indicated that there were both positive and negative aspects to being expected to perform at a higher level than the younger nursing students. This is demonstrated through the following excerpt:

> *… they* [nursing staff] *expect a fair bit of me but I also get a lot in return because I actually get to see the operation and assist in the recovery as well as care for the person when they get back.* (Participant C)

There were assumptions that the students had some previous nursing experience if they were older. There was however no expectation that students had the same assumptions about the nursing staff.

> *I suppose they expect you to know more in some areas, but they don't expect you to know the specialised cardiac stuff that they have done, like ECGs.* (Participant C)

Participant B indicated that as long as the students 'tailed the RN' and did not ask questions, they were accepted and this enabled them to identify where they fitted within the hierarchy in that they were aware of expected behaviours befitting a nursing student, that is, they knew their place. If the nursing students questioned the registered nurse or other staff, thus breaching the unwritten rule of subservience, they experienced sanctions which ultimately led to an increased difficulty in determining where they fitted as the students became confused and frustrated.

Nursing students go into the off-campus clinical setting with the underlying belief that they will be in a supportive environment; one where the registered nurses will act as effective role models and will welcome them as a member of the nursing team.

Participant A2 perceived that the male nursing staff were more supportive of students than their female colleagues.

> *They would stand back and interact with the other kids in the room. They're watching you and what you are doing. They made you feel a hell of a lot more comfortable and were a hell of a lot more supportive of you, um I don't want to generalise too much because not all of the female RN's were at the other extreme. I just found that they were particularly easy to work with in as far as sharing their knowledge and giving you the opportunity to learn that was really good.* (Participant A2)

There were staff in the off-campus clinical setting who would reject the idea of having students outright, even if they had previously accepted a nursing student or would be very selective:

> *… some of the RN's that originally were happy enough to have students with them ended up picking the students that they preferred to work with and put the others off in the end like some of the other students saying that some RN's saying that "No, I don't want a student with me."* (Participant D5)

Behaviour like this, which amounts to rejection, can have devastating consequences on the student's confidence and sense of belonging. Students took the rejection they experienced personally and it affected their self-esteem.

> *I dreaded going to that place every Monday and Tuesday … I just dreaded it and could not wait for it to be over. When you're in an awful place you just don't want to learn.* (Participant Q)

The perception of being rejected by staff effectively saps the student's self-esteem and increases their anxiety levels (Cahill 1996).

Participant E indicated that whilst there are nurses in the off-campus clinical setting who don't want nursing students, there are others who are more than willing to accept them. This made for a positive clinical experience and learning environment:

> *There are some people who don't want students around and then there are some nurses around, especially where I am at the moment who think it is the best thing having the students on the ward and giving them the clinical experience and go out of their way to make it a positive experience for us.*

Participants felt that staff in the facility were expected to accept nursing students even if they did not want a student. This was evident in the following excerpt:

> *… obviously there are a few nurses out that you get buddied up with and you think "Why did you put your hand up?", because they* [the School of Nursing] *tell us that the RNs that we get buddied with have actually volunteered.* (Participant P)

Participant P went on to state:

> *… whether or not* [the staff member had volunteered], *sometimes we think there is no way that could be true because some of the RNs you get buddied with, you think there is no way you* [the RN] *would volunteer to take a student. And when you actually talk to the RN, that is what they tell you in the end, but our university tells us, "Oh no, they've all volunteered."*

There was clearly a belief on the part of the nursing students that they would be placed with staff in the facilities that were willing to accept them and wanted to have them. When they went to the facilities and found the opposite to be the case they were disappointed and confused.

The expectations of the tradition bearers in the off-campus clinical setting have a marked effect on the nursing student's ability to identify where they fit within the nursing hierarchy. It is apparent that the nursing students are often expected to

develop their cultural identity in accordance with the traditions of 'nursing'. Acceptance or non acceptance by the staff in the facilities had a dramatic impact on the participant's ability to identify where they fitted within this hierarchy. Participants reported conflict, both internal and external, as they attempted to determine their place in the profession. This conflict was exacerbated by nursing staff who had been willing to accept students previously, but who were now indicating at varying times that they either would not accept responsibility for a nursing student, or alternatively they would select the nursing students that they would work with. The internal conflict and anxiety that this caused left the participants feeling frustrated, belittled and angry.

Participant Q related their feelings about the internal conflict they experienced:

> *I dreaded going to that place every Monday and Tuesday … I just dreaded it and could not wait for it to be over. When you're in an awful place you just don't want to learn.*

Participants perceived that the staff in the facilities did not understand the students' role and were under the impression that they were responsible to train the students to perform Personal Carer duties.

> *They thought they had to train us to do PC work and I think that caused a bit of conflict, like they're busy enough without having to train us.* (Participant D5)

The participants in this study however did not have expectations of going into the off-campus clinical setting to be trained as PC workers. The following response demonstrates this:

> *… as I said to one of the AINs, we are not actually here to be doing this sort of stuff, we are actually here as student RNs … not as AINs. I think I offended her a bit by saying that, I didn't mean it to come out the way it probably did.*

What I meant was you know, showers and stuff like that, we've all done that, we all know the basics … we were there to learn as a RN, therefore it was a little bit more than showers and stuff like that. (Participant W)

Students and facility staff had differing expectations of what the off-campus clinical setting entailed and this lead to a degree of conflict, both internally within the nursing students and overtly with the facility staff.

This conflict was explained by Participant G:

… where we're on one level thinking that we need to do our tasks, they're on another level thinking we're extra AINs to work with them … that probably adds to the conflict. So if there was a more even keel, and say well this is what the student is here for, and say to us students this is what you're here to do, but you've got to do this as well …

Participant G related the confusion which was experienced to a lack of effective communication between key stakeholders. The participants were aware that they were required to undertake certain clinical skills, however the facility staff were often uncertain about which skills the nursing students were able to undertake within their scope of practice. This leads to role confusion for the students who then questioned their fit or place.

Participants who had previous experience in the clinical setting also reported that the staff had different expectations of their performance in the clinical setting when it became apparent that they had experience beyond the clinical placements they had undertaken. Participant S reported:

I think perhaps there is a difference once they're aware that I've possibly had a little bit more experience than most. I don't know whether respect is the word that is sort of appropriate, but there is a level of appreciation or recognition of some common ground and so possibly there is a little bit of preferential treatment. I mean it is a little bit difficult to speak for others, but you know once I disclose I guess that I have had some experience then people are generally a little bit more accepting, like ok you sort of have an overview

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*of what your doing, we can work with that, we're not having to build you up
from the ground level, you have a few blocks on the ground we can build on.*

Some participants with experience chose not to disclose prior nursing experience as
they perceived that by doing so they were placing themselves in a position where
they would be expected to perform at a higher level than if they didn't reveal and
deliberately refused to disclose previous experience. Different expectations from the
registered nurses contributed to the participant's construction of meaning in relation
to where they fitted within the hierarchy. Because the above participant had previous
clinical qualifications they felt they fitted more quickly within the hierarchy,
however they consciously chose not to disclose the fact in an effort to ensure their
'fit' was as a student as they perceived this would increase their learning
opportunities.

Another area where there was difference between the expectations of the students
and the staff was regarding time management. Whereas the participants had the
belief that they needed more time to complete set tasks, especially medication rounds
and other complex tasks, the registered nurses expected that they would be able to
complete the task as quickly as a registered nurse. A participant reported:

> *I'm glad I am working with you today, like yesterday I worked with so and so
> and … she's so slow, you know, like she took this long to shower Johnny and
> this long to do that and its sort of like does it really matter as long as the jobs
> are done and you know they're out for their meals or you know whatever,
> how long they take you know to me is not relevant as long as those jobs get
> done.* (Participant W)

Participant Z indicated that:

> *… we were doing the medications and she wasn't giving me the time to look
> up what the certain drugs were and she goes "That one, its just for his um*

blood pressure that's all" and I am like, OK that's good and then I'd ask about another one, "Oh I don't know what that one is but he's been having it for a while now". Well I said I could like look it up in the MIMS and she's like there's no time, there's no time so yea we're not supposed to give medication to anyone unless we know what its for and she's not supposed to either.

Students were expected to be able to multi-task and maintain an appropriate level of time management:

> *… to the point of you are accused of being too slow. Especially when you're doing like medication rounds and stuff like that for the first couple of times, you're like the RN that your with um … will be looking at her watch constantly and going "come on you need to fasten up, you're going too slow", while they're asking you a hundred different questions about the drug you're handing out and like it's not just a matter of hand out the drugs as you would if you were the RN on duty. They also ask you a lot of clinical questions as you're going along with it. So that then takes that little bit extra to answer. And they're still looking at their watch going "Oh come on you're still not fast enough". (Participant P)*

It is clear from the excerpts above that the staff had different expectations about time management compared with that of the participants. This raised doubts in the student's minds about their place and what they were doing. A number of participants raised the issue that time management was being assessed in the first clinical placement. There was a belief on the part of the participants that their time management skills would develop over time and that they should not be assessed in the first clinical placements.

> *I find it quite bizarre, especially in our first clinical placement that they've even considered time management because I mean some of the patients were so complicated and you know we're trying to learn the task and learning what to do and they're worried about managing your time and time management. I just found that quite, a concept I found quite weird. (Participant A3)*

The analysis of the data revealed the perceived expectations that the staff had of the students affected their ability to identify where they fitted within the hierarchy of

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nursing as on one hand the participants were being told that they were students, while on the other hand they felt that they were expected to perform at the standard of a registered nurse. Participants expected to enter a supportive environment as a student; however they often found this was not the case and they found that they were expected to perform at a higher level than they anticipated. The unsupportive environment and the conflicting expectations between the staff and the students in relation to the role of the nursing student in the off-campus clinical setting leads to conflict in relation to where the participants feel they fit within the hierarchy. Participants indicated that they questioned their role in the clinical setting and this led to self doubt and questioning of their own abilities. This internalised conflict as a consequence of external stimulus led to the participants becoming anxious about their abilities and subsequently they felt more likely to make mistakes in the clinical setting. They certainly felt as though they were in a game of 'push me, pull me'.

The Basic Social Problem

The categories identified in the preceding discussion interact to form the Basic Social Problem which was experienced by all of the participants in this study, albeit to varying degrees. The Basic Social Problem identified in this study was "*place*" and was reflective of the participants' questioning of where they fitted within the profession as a whole and also within the facilities in which they had been placed to complete the requirements of their practicum.

Unlike the structure that existed when nurses were hospital trained, as a university nursing student there is no actual position designated within the hierarchy, it is a matter of fitting in wherever the nursing student can find a slot. This slot or place varied:

> *… she did have, and she let me know this clearly, that she did have a patient-doctor hierarchical thing in her mind, she did have that sort of hierarchy thing in her mind because she was of the opinion that nurses did have their place…* (Participant B)

Participants were trying to find their place in the hierarchy:

> *… as students we kind of feel like the bottom rung of the ladder … as student RNs we were still deemed as the lowest of the low…* (Participant E)

> *Sort of made you feel really non-accepted, doesn't help you fit in with that role. You are supposed to be a part of a team in the clinical setting however you are being shoved out of the group. They emphasise to you that you have got to work as a part of a team, but if the RNs don't want you working with them you've got to be shifted to another area.* (Participant D5)

The discussion above identified that the issue of finding where they fitted within the hierarchy was not an easy task. It instilled feelings of rejection and negatively affected self-esteem.

The Queensland Nursing Council does not specifically state that there is a hierarchical structure in nursing however, this is implied through the Queensland Nursing Council indicating that workers in the health care arena other than nurses, midwives and regulated health practitioners are part of the unregulated workforce (QNC 2005). The Queensland Nursing Council does however, further imply the imposition of a professional hierarchy by indicating that the Queensland Nursing Council would be concerned if a group of unregulated (students) health care workers

was employed preferentially to a group of regulated health care workers (Enrolled Nurses) (QNC 2005). Whilst the concerns of the Queensland Nursing Council (QNC) may be more closely related to issues regarding the quality and standard of care, education and licensing requirements than hierarchy; this regulation of the profession does impose constraints in that this approach ensures that there are different groups of health care workers.

The QNC is not keen for the creation of a special level of unregulated health care worker to accommodate students, viewing this as being problematic for both the registered nurses required to provide supervision and also for the students themselves. As the regulatory body for the nursing profession in Queensland, the QNC has an expectation that nursing students engaged in clinical experience, perform all aspects of professional practice under the supervision of a registered nurse as part of the student's competence development. Under the current *Scope of practice framework for nurses and midwives 2005 (Framework)* the registered nurse is the focal point for decisions about the delegation of activities from the nursing care plan (also an implication of a hierarchical structure) to unregulated health care workers and any implication that students should perform more 'nursing' related work than the other categories of unregulated health care providers in the nursing profession would be inconsistent with the Framework (QNC 2005). This implies that the nursing student, as an unregulated health care worker, sits outside the hierarchy of the profession and indicates that their place remains unclear and undefined. This contributes to more uncertainty about where the nursing students sit within the

profession when they are engaged in clinical practice in the off-campus clinical setting.

The Basic Social Process

Through the use of grounded theory the basic social process that resulted from the interaction of the contextual conditions and the categories identified and discussed earlier in this chapter emerged. Data analysis revealed that the basic social process that the participants experienced was one of '*anxiety*' as they attempted to determine where they fitted within the profession in their role of nursing student. As a category '*anxiety*' was central to all of the other categories and as such met the criteria to be considered a core category within this study (Strauss & Corbin 1998). The central category, '*anxiety*' appeared frequently in the data and provided structure to the process of what was occurring. Whilst the classic grounded theory texts place the discovery of the basic social process as fundamental to grounded theory method (Glaser & Strauss 1967; Glaser 1978; Strauss & Corbin 1998); Glaser (2002) argues that the pursuit of the basic social process forces the data. The basic social process in this study actually emerged from the data. The conceptualisation of the core category in this study is grounded in the data and the use of excerpts from the data assists in grounding the core category.

The preceding discussion of the experiences of the participants in the off-campus clinical setting as a nursing student has demonstrated that they are not inactive, passive participants in the off-campus clinical setting. Rather, the actions and interactions that the students witnessed and indeed were a party to in the off-campus

clinical setting affected how they perceived nursing and where they fit in terms of their developing professional identity. The contextual conditions that influenced the basic social problem have been clearly examined in the preceding discussion, and the manner in which the participants perceived and reacted to the basic social problem had an influence on the development of their professional identity. Participants were actively engaged in a series of co-ordinated and planned and, at times unplanned behaviours which were utilised as a mechanism in the construction of cultural meaning and the management of potentially negative workplace behaviours. Participants in this study used coordinated and planned actions to construct the meaning of their experiences in the off-campus clinical setting as they attempted to determine their place in both the facility they were placed in and also within the broader profession.

A nurse's professional identity continues to evolve throughout the professional nurse's career. Cook, Gilmer and Bess (2003) argue that it is necessary for the faculty providing the nursing education to provide the experiences which are essential in the early stages of developing a professional identity as a nurse. Glen (1998) posited that the individual's personal identity played a role in the development of the individual's professional identity. Bronfenbrenner (1979) explored the issue of identity development in the context that the environment in which the individual was placed played a part in the development of identity. In a 1998 study (n = 158), Manninen found that students viewed the role of nursing as a professional activity which had a strong scientific knowledge base which advocated the promotion of health and well being. Whilst the students which participated in Manninen's study were in the final stages of their nursing study, their identification

of these components of nursing is significant in the development of a professional identity (Cook *et.al.* 2003). Understanding the development of professional identity in nursing students is of considerable significance given the current shortage of nurses and the rapidly changing healthcare environment.

Anxiety

The process of constantly trying to determine where, as a nursing student, they fitted within the hierarchy resulted in a state of internal conflict. Participants were able to adopt strategies to avoid drawing attention to themselves so as to avoid sanctions; however the adoption of these strategies did not resolve the internal conflict which led to the anxiety that they experienced. There were two factors affecting the level of internal conflict and subsequently anxiety experienced by the students – staff expectations of them and the students' expectations of the clinical setting (and of the staff in the clinical setting). The processes associated with internal conflict appeared to be cyclic in nature with a number of actions/interactions evident in the data. Participants often identified that their expectations of the clinical setting differed from that of the facility staff and this created a state of internal conflict as the participants were unsure of where they fitted within the hierarchy. This manifested in confusion about their role and the tasks they could undertake. Once the participants had identified that there was an issue, they attempted to deal with the internal conflict and anxiety.

Addressing the issues

Once the participants had identified that their expectations of the clinical setting were different from those of the facility staff, they were faced with the dilemma of reacting to the situation in which they found themselves. A wide range of strategies were identified by the participants in an effort to deal with the differences in expectations between the staff and the participants. In an effort to limit the consequences that were perceived to be resultant, the participants adopted both explicit and implicit strategies. Explicit strategies were overt in the data and were easy to identify and explore. The implicit strategies that the participants utilised to deal with the internal conflict that they were experiencing were less evident. These are examined below.

Explicit strategies used by the participants

In an effort to effect change to the 'causal' conditions, the participants commonly applied explicit strategies such as avoidance. The avoidance strategy was particularly identified in the 'tradition bearing' condition whereby the participants would avoid a staff member whom they perceived exhibited a 'matronly demeanour'. Another common practice was the avoidance of staff whom the students thought were not willing to accept them. In one instance a student indicated that they would orchestrate it so that they were working with a staff member that they knew to be supportive. The following excerpt provides an example of how explicit coping strategies were used:

> *… if I was in an acute care setting and I, as a student wasn't sure of you know, a catheter or wasn't sure how to do a blood pressure, there were some people that you wouldn't want to ask because they would be like "Oh my God, you should know this!" or that sort of thing. That's the vibe.* (Participant C)

This participant went on to say:

> *… to manage the negative experience I have tried to orchestrate it that I have been with people who do want to have students so that it is not such a negative experience because when you are with people you know really do not want a student it is very difficult to learn. Because you are constantly thinking I have got to do this perfect, or I have got to say the right thing, or I have got to know this, or you know …, so that you are not putting them out, cause you feel like if you have to get them to explain it, or get them to show you something or explain something again it will validate their not wanting to have a student.* (Participant C)

These actions were a deliberate strategy to minimise the perceived negative effects of the staff's expectations that the student would have certain skills before they arrived in the off-campus clinical setting. Whilst this participant gave particular voice to this deliberate strategy, analysis indicated that a significant number of participants also deliberately avoided certain staff members.

Avoidance was an overt action of choice when students recognised that they were not able to undertake the requisite skills and knowledge that they required for their personal and professional development as a nurse. As an action in addressing this issue of not being able to access the requisite skills and knowledge, avoidance was both deliberate and planned.

> *They'd* [staff and nursing students] *avoid her* [a staff member identified as a tradition bearer] *if they saw her coming down the hallway or something. Yea,*

> *you could sort of tell that they just weren't game enough to confront her,
> because yea she just had this way about her. I don't know like she had Ned
> Kelly style armour on her or something, like she was going to bowl you over.*
> (Participant G)

As indicated above staff also used avoidance as a strategy with certain colleagues.
An advantage of this strategy was the minimisation of the negative feelings that
certain staff triggered in participants.

The above excerpt demonstrates deliberate avoidance but unplanned avoidance of
the staff in the off-campus clinical setting was also apparent.

> *I wasn't comfortable and there was* [sic] *doctors around and she was telling
> me to just hurry up and give it and I was going but it's the wrong person and
> at the end of that I ended up walking out.* (Participant H)

After the participant left the immediate area the registered nurse followed and
discussed the issue with the participant.

> *… she was still sort of lecturing me that I need to trust my own instincts and
> she still believed that she was right … we spoke for probably a half hour or
> hour maybe and she's going "Right, are we now ready to go back in there?"
> and I said "Just let me double check"* [the drug order and the patient's
> details] *and we double checked and I was right.*

This participant went on to state:

> *… by this stage she had basically convinced me that she was right and I was
> wrong and we double checked and I was right and that really made me think
> twice about everything then.*

Whilst the registered nurse was apologetic after the error was detected, the
participant felt that the apology did not help at the time.

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The participant's decision to remove themself from the environment allowed them to clarify the situation in their own mind and avoid overt conflict with a staff member. Whilst this prevented overt discomfort in front of the patient, there was still a degree of conflict experienced by the participant in their discussion with the registered nurse behind closed doors.

As long as the participants kept moving and didn't stand around and were seen on the floor there was less conflict.

> *... as long as we kept on moving and you didn't stand in the corner trying to assess the situation ... they* [the assistants in nursing] *loved it.* (Participant B)

Another participant indicated that:

> *...if you asked if you could go and you know I've finished my duties now um I'd like to go and write some of this up, it was "No!" or something like that; then you might get direct refusal. However the other way that it would happen if someone, if one staff member had been ok with that you know an RN, you know off you go and have a coffee while you're out there, well then when you got back others might say, "Oh been having a ciggie have you?" There was a general looking down on that sort of behaviour doing anything other than being on the floor.* (Participant D5)

The above excerpt highlights the difference in behavioural expectations between the staff and the students. Participants had an expectation that upon the completion of their assigned tasks they could leave the bedside to write up notes which were relevant to their practical experience. Staff on the other hand, had other ideas about what the students were to do if they had completed set tasks. It was apparent from the data that the nursing students were expected to undertake additional tasks even when the students had completed the set workload. This was an overt action on the part of the staff with the participants feeling that this type of behaviour impacted upon their ability to develop as a professional nurse; they were experiencing role

confusion which increased the level of internal conflict experienced by the participants.

The contextual condition of '*student performance*' also led to various strategic actions on the part of the participants. Some participants felt it best not to react to the comments of the staff. However, at times participants found it difficult not to react and they subsequently sometimes responded with a verbal comment that was unplanned.

> *I didn't react you know I just think again, that the situation, the nurse told me to do it one way, so I did it that way and then she pulled me up for doing it like this you know. And yea I just replied "Look, you just told me to do it like that". I just tried to clarify things, that's all.* (Participant V)

Another participant reported using an unplanned interaction when dealing with staff members in the clinical setting could create tension. This was reported as:

> *… they would get a bit shirty and of course we would get a bit shirty …* (Participant G)

The impact on the contextual condition reinforced the mindset and expectations of the staff when the participants responded. This further served to embed differing expectations and left the students feeling confused as to the role they played in the clinical setting.

Anxiety was experienced as a result of the interactions within the contextual conditions. The greatest scope of corrective action and interaction would be focused on addressing this condition and minimising the impact that it had on the

development of cultural identity. A number of explicit actions and interactions, planned and unplanned, occurred in an attempt to address this condition. These actions and interactions are further discussed in the following pages.

Communication was a common strategy employed by the participants in an attempt to minimise the internal conflict they experienced as a result of the differing expectations between themselves and the staff in the off-campus clinical setting. Open and honest communication was seen as an effective strategy to limit the impact that the staff expectations had on the students and was perceived to reduce the level of internal conflict experienced by them. One participant indicated that negotiation was a key component to open and honest communication, as evidenced in the following:

> *… generating um an honest and open dialogue with my facilitator and also the mentors from the institutions telling them about my experiences and negotiating, negotiating a more suitable ah um learning agenda for myself.* (Participant B)

This participant went into the negotiations with an expectation that the request to access further learning opportunities would be rejected. For this reason they planned the negotiations.

> *I assumed that I would be knocked back from the beginning and ahh presented my case accordingly, accepting the fact that I would probably be knocked back.* (Participant B)

This participant, whilst going into the negotiations with the belief that the request would be rejected, was pleasantly surprised when their request was granted. Their approach contributed to what they perceived as a successful outcome.

Defiance was also a strategy to limit the impact that the staff expectations had on the individual participant's levels of anxiety as a result of being unsure where they fitted within the hierarchy. Defiance could be both a planned and an unplanned strategy in dealing with the condition.

> *… not that I was not accepting menial tasks but that I was showing a sense of defiance which never goes down well …* (Participant B)

On the other hand the strategy could be unplanned and be the result of a spur of the moment comment as evidenced in the following excerpt:

> *"Look, you just told me to do it like that."* (Participant V)

This comment could be considered by the staff as being defiance as the participant answers back to the registered nurse.

The participants simply wanted to please the nursing staff who were supervising them. This was a deliberate strategy that was used to negate the negative impact that the staff's expectations had upon the participant's ability to determine where they fitted. This strategy was deliberately used:

> *"Look all I try to do is please these people, but every nurse seems to do things slightly differently" You just can't please them and as a student that is probably what we try to do.* (Participant V)

Another deliberate strategy that was extrapolated from the data was students' attempts at building a relationship with the staff that they worked with to ensure that the differences in expectations were minimised wherever possible. The following excerpt indicates this:

I always try to be really helpful and try to make it, build a relationship with the RN that I am with and try and be really nice and you know what I mean, so make an effort to get on with that person …(Participant R)

The excerpt above is yet another example of the way participants utilise strategies in an attempt to please the staff.

An important strategy was the act of disclosing, or not disclosing, that the participant had prior nursing experience, either as an assistant in nursing or as an enrolled nurse. Disclosure was viewed by students as being an important consideration in the management of the internal conflict that they experienced in the off-campus clinical setting. Disclosure was both a causal condition and a contextual condition with disclosure in the contextual sense, found to have both positive and negative effects. The choice to not disclose prior experience tended to have the most positive impact as the participant was viewed as having little knowledge of the processes of nursing; therefore they could rely on a supportive staff member to assist in their learning; they subsequently experienced less anxiety and were able to fit into the hierarchy as a student. In the event that a participant disclosed their experience, there was the possibility that they would be seen as a 'nurse' and therefore that they knew what to do. This created a situation where the participant experienced increased levels of anxiety as they were in the situation where they were expected to perform as an assistant in nursing or an enrolled nurse in the off-campus clinical setting whilst their role was that of a student. Whilst disclosure of their previous employment experience may have allowed the participant to easily locate their position in the

profession, doing so meant that they would have been unable to engage in the clinical practicum as a student.

This was a deliberate action apparent in attempting to correct the impact of the condition '*student performance*'. By disclosing previous nursing experience the participant was able to access additional learning opportunities that may not have been available if they had, or had not, disclosed their experience.

> *… you know once I disclose I guess that I have had some experience then people are generally a little bit more accepting like ok you sort of have an overview of what your doing, we can work with that, we're not having to build you up from the ground level, you have a few blocks on the ground we can build on.* (Participant S)

This participant disclosed that they had a level of knowledge and with that the negative impact that 'just being a student' could have on the opportunities that the participant had access to was removed. Disclosure, or not, depending on the registered nurse is a planned strategy that participants utilise to control for the impacts of the 'causal' and 'intervening' conditions.

The condition ''*tradition bearing*' was perceived to be outside the control of the students and as such participants did not suggest that they utilised any corrective strategies. Data proposed however that the nursing students did seek advice and support from staff that had 'been around forever' in that some students perceived that they could learn more from an enrolled nurse with 30 years experience in the clinical setting than they could from a registered nurse with two or three years post graduate experience. It became apparent that some participants realised that this

condition could be utilised to reverse some of the negative aspects associated with identifying where participants fitted within the hierarchy. This however was dependent on the individual staff member.

Analysis indicated that the strategies employed by participants to minimise the effects of the problem were not confined to one specific condition. Rather, the strategies involved actions/interactions with the other conditions in the off-campus clinical setting. Just as the conditions are intertwined and interrelated, so to are the strategies that are utilised in an attempt to limit or correct the perceived problems. The strategy of disclosure could have a negative impact on the nursing student's opportunities to learn, in that staff may well believe that the nursing student already had the knowledge required and therefore did not need to practice it. Disclosure could however be positive when the nursing student disclosed in what they perceived to be an appropriate context or to a 'safe' registered nurse. Disclosure in this instance had a positive impact in that the staff realised that the nursing student had some underlying knowledge and was not 'just a student'. They were treated with greater respect and were provided with increased autonomy. Their fit within the nursing culture was thus clearer.

Implicit strategies used by the participants

The implicit strategies utilised by the participants required me to be sensitive to the data. Implicit strategies commonly focused on making changes to the conditions 'tradition bearing' and 'student performance'. Changes in perceptions as to what it

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meant to be a nurse, and issues associated with the development of a cultural identity, were frequently identified as the means for these corrective strategies to be applied. Participants who were exposed to negative staff attitudes began questioning their reasons for becoming a nurse. This questioning led the nursing student to reflect upon their own attitudes and in a number of instances the participant indicated that whilst they may not necessarily leave the program, they would seriously consider not seeking employment in specific facilities or specific units. This could have an impact on recruitment and would benefit from further research.

Many students alluded to the issue of ineffective communication. Participants felt they consistently had to deal with issues related to miscommunication between themselves and the facilities as well as the university. This was a recurrent issue which had widespread effects. Even when the participants attempted to initiate communication with the staff this strategy was not always successful and this fed back to the condition of '*tradition bearing*' and '*staff*'. This issue of ineffective, or negative communication, had a dramatic effect on the nursing student's experience in the off-campus clinical setting and led to increased levels of internal conflict.

Don't ruffle feathers

In an effort to get through the clinical placement with the least amount of anxiety, it became apparent that the participants were utilising strategies, both explicit and implicit, to minimise conflict with the staff. This process of 'not ruffling feathers' was utilised by participants to make adjustments to the causal conditions that had an

influence on their ability to determine where they fitted within the hierarchy of the particular facility and the broader professional hierarchy. The aim of avoiding conflict with the staff was to maintain a degree of acceptance and to gain access subsequently to the requisite learning opportunities required in order to pass the clinical placement. This approach had a twofold effect in that it reduced the amount of internal conflict that the participants experienced; and secondly, it allowed the nursing student the opportunity to access the requisite clinical skills. Whilst the nursing students were attempting to avoid overt conflict with the nursing staff in the off-campus clinical setting it became apparent from the data that they were in a state of conflict which could not be fully addressed by not 'ruffling feathers'. In fact by not wanting to 'ruffle' feathers' students participated in skills that they knew were outside their scope of practice. They knew this was wrong and so this led to increased levels of anxiety and greater internalised conflict. The levels of anxiety experienced by the participant were due to their being worried about doing the wrong thing and subsequently getting caught.

The Grounded Theory – Experiencing the Off-campus clinical setting as a Nursing Student

The preceding discussion has reported on the findings from this Constructivist grounded theory study on nursing students and their experiences of negative workplace behaviours in the off-campus clinical setting. In accordance with the methods of grounded theory, concepts were progressively and inductively derived from the data with these concepts subsequently being grouped under increasingly higher order subcategories and then categories. The relationships between and within

these categories were highlighted. This approach has been utilised to provide the basis for the development of the substantive theory emerging from the experiences of undergraduate nursing students as they experienced the negative workplace behaviours in the off-campus clinical setting. Figure 8 (on the following page) provides a visual representation of the developed substantive theory.
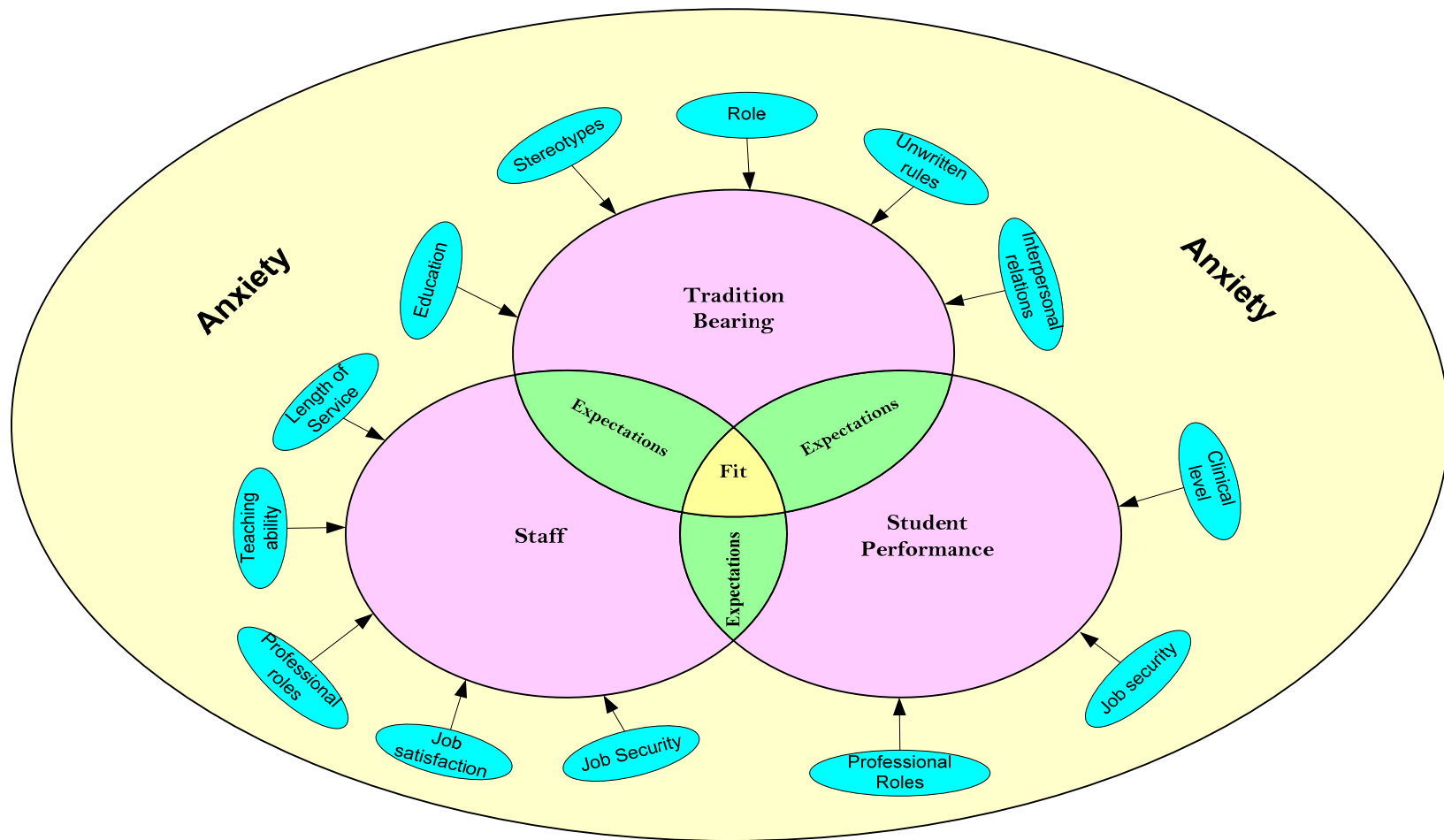
Figure 8: The grounded theory of nursing students' experiences in the off-campus clinical setting

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'*Tradition bearing*', '*staff*' and '*student performance*' interact to form the contextual conditions which leads to the differing expectations of staff and students in the off-campus clinical setting. These differing expectations of where the students fit within the hierarchy of the clinical facility and within the profession resulted in a process of internal conflict which lead to increased levels of anxiety as the students attempted to determine their place in an environment of negative workplace behaviours. Students responded to this situation through a process of compliance with what they describe as traditional nursing culture.

This theory is dynamic in nature and represents the experiences of second year undergraduate nursing students in regional Queensland. The substantive theory detailed above accounts for, and explains a wide variation in the experiences of the nursing students. The theory also explains and accounts for a wide range of conditions and responses that the nursing students experienced whilst in the off-campus clinical setting.

Chapter Five - Discussion

Introduction

The aim of this study was to develop a substantive theory that explained how nursing students experienced the off-campus clinical setting and the meaning that they assigned to these experiences. The text in Chapter Four presented the data that allowed the theory of experiencing the off-campus clinical setting as a nursing student in the regional Queensland context to be developed. This chapter draws on the data and relevant literature to discuss this theory. Appropriate literature is utilised to situate the study and the discussion of the problems of being a student nurse in the off-campus clinical setting. The contextual issues are also discussed prior to the social process that was used by the participants in an effort to address the problem.

Situating the study

Nursing Education

Traditionally nurses were trained in the hospital setting, under an apprenticeship model. This approach to training nurses was a legacy of the Nightingale era of the late 1800s. Whilst the model of nursing education proposed by Nightingale provided paid employment for women, the nursing workforce was largely restrained due to the rules, regulations and expectations which Nightingale enforced (Hektor 1994). Hektor's views are supported by van der Peet (1995:82) who stated that "nursing is still in the process of freeing itself from the bonds of servitude conjured up by the

Nightingale myth." Nursing, according to Nightingale, was a calling, not a profession; however Nightingale believed that nurses deserved training.

Nursing education underwent a dramatic change in the Australian context in the mid 1980s with a mass transfer of nursing education to the university sector. This mass transfer of the responsibility for the education of nurses was the result of the legislated transfer from the hospital based apprenticeship model of training to a degree delivered through the university sector (Sellers & Deans 1999; Daly, Speedy & Jackson 2000). This change to the process of nursing education impacted on the professional socialisation of nurses in that prior to the transfer to the tertiary sector, nursing students were primarily exposed to nursing role models in the practical nursing setting; with periodic exposure to nurse educators in the hospital nursing schools. Realistically this change to education resulted in a move away from 'service for education' to 'education for service'. New role models for nursing students have emerged in the form of nursing faculty in the tertiary sector and an inclusion of new values including a research orientation to nursing (de Toit 1996).

Despite this transition to the tertiary sector, the preparation of individuals as competent, professional practitioners in nursing, by necessity, demands that nursing students undertake clinical placements in a variety of settings to allow the nursing student to integrate theory with practice. As a result, nurses across a wide range of facilities interact with students on an almost daily basis as students are placed in the clinical settings from various undergraduate nursing programs.

The models used in the supervision of students vary between the different Schools of Nursing, however groups of eight to ten students are commonly supervised by a registered nurse acting as a nurse 'Educator'[9] for the nursing students in that particular cohort in a particular facility. In a preceptored model individual students are assigned to, and supervised by, a registered nurse working in the facility. The Preceptor Model is formalised with an individual student being preceptored by a registered nurse for the duration of the placement. The facilitated model, on the other hand, relies upon nursing staff employed by the university to facilitate the learning opportunities for students. This arrangement is often an informal system where the registered nurses within the wards are asked, or in some facilities expected, to work with a nursing student for a shift. Therefore it is the registered nurse on the floor of the ward who bears the brunt of the student's questioning and complaints; and who also acts implicitly as the socialising agent, role model and clinical teacher. This relationship is referred to as a 'buddy' nurse relationship both by students and the experienced nursing staff.

Furthermore, the literature reveals that whilst the Schools of Nursing are expecting the experienced nurses to deliver positive clinical learning experiences, experienced nurses often feel ill prepared or unable to perform the role of clinical teacher (Craddock 1993; Forrest, Brown & Pollock 1996; Tang, Chou & Chiang 2005). It is acknowledged that the interpersonal interactions of the Preceptor, their colleagues, as well as their professional interactions with the nursing students, contribute to both

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[9] In this context the term 'Educator' is used to broadly label the role of this Registered Nurse, it is in no way an indicator that this nurse is in the position of a formal Nurse Educator either with the structure of the profession or academia. This nurse acts in a supervisory or mentor role for both the nursing students and the nursing staff who take nursing students throughout their clinical placements.

the experiences of the nursing students and the student's attitude towards nursing as a profession (Ahern 1999; Tang, Chou & Chiang 2005).

Participants in this study had been placed in the clinical setting under the facilitated model of nurse education with the facilitators being employed by the university to supervise students in the facilitator's workplace. The primary advantage to this model is that the facilitator is already cognisant with the culture and the operation of the ward and/or the facility where they are working. These individuals are generally regarded by their peers as being credible clinical practitioners and therefore appropriate clinical teachers (Baird *et.al*. 1994; Melander & Roberts 1994). Baird *et al.* (1994) argues that the nursing students placed under a facilitated model benefit in that they are able to see the facilitator, an experienced clinician, modelling positive relationships with the facility staff. Nursing students further benefit from having an experienced clinician who is familiar with the culture of the facility.

There are however negative aspects to the utilisation of this model (Baird *et.al*. 1994) with the degree of familiarity being identified as the major disadvantage. Because the facilitators are drawn from within their own facility they are faced with the choice of acting as an advocate for the nursing student in the event of conflict with their nursing peers, or siding with the nursing staff in the event of a conflict arising. The facilitators subsequently run the risk of alienation and experiencing a sense of betrayal from the nursing students if the facilitator sides with their nursing peers (Bain 1996). In the event that the staff act as the advocate for the student they risk being perceived as a 'traitor' in that they are seen to be siding with the nursing student ahead of their peers. Role confusion subsequently results as the staff attempt

to demonstrate a level of support for both sides of the argument, without losing face on either side. Role confusion in professional education is a complex issue which is poorly recognised (Bray & Nettleton 2007).

Similar concerns about role conflict are raised in the literature by nursing staff who view having to mentor a student as depriving them of time to spend with their patients, subsequently resulting in role conflict (Atkins & Williams 1995). Nursing students raise similar concerns in the literature, Forrest *et al.* (1996) found that facilitators may not maintain the quality of the off-campus clinical placement by failing to act on the concerns of nursing students related to quality of care and supervision issues. This inaction by the facilitator was interpreted by the nursing students as them wanting to maintain the status quo of the clinical environment through failing to challenge other nurses in the clinical setting (Forrester *et al.* 1996). Role conflict and the maintenance of the status quo in the clinical environment can lead to strained interpersonal relations between the staff, and the staff and students. It is these strained relations between the nursing staff themselves, and the nursing staff and nursing students, which led the participants to experience varying levels of anxiety whilst in the off-campus clinical setting.

Workplace relations

Strained interpersonal relations in the workplace have been variously described in research literature as occupational violence (Hockley 1998), workplace harassment (Einarsen 1999), bullying (Olsen & Needham 2003), workplace bullying (Baly 1998); mobbing (Einarsen 1999; Zapf 1999; Fynes-Clinton 2003; Shallcross 2003;

Leymann 2005), psychological terrorism (Adams 1994), or horizontal violence (Duffy 1995; Farrell 1997, 1999, 2001). In recent years the term 'workplace bullying' has gained in popularity in nursing literature. Bray (2001) indicates that there are two potential reasons for the adoption of this modified term; firstly the violence in nursing is not always horizontal, it can also be vertical (top – down, bottom – up), or perhaps the term 'violence' is seen as being too strong for this cultural practice.

Workplace violence and negative interpersonal relations between employees remains alive and well in the organisational context, and is not just restricted to the healthcare sector. Horizontal violence is the term often assigned by nurses to describe the poor collegial relationships that may exist between nursing staff. Defined by Duffy (1995) as the hostile and aggressive behaviour by individual or group members towards another member or groups of members of the larger group, horizontal violence is endemic in the nursing profession (Duffy 1995; Thomas & Droppleman 1997; Farrell 1997, 1999, 2001; Hamlin 2000; Bray 2001; Randle 2003; Sengstock, Moxham & Dwyer 2006). This behaviour may be assimilated into the cultural and professional identity of nursing students as they adopt the culture of the workplace and the profession. The culture of nursing is such that it dictates that members of the profession show respect for, and deference to, authority (Keane 1992; Duffy 1995; van der Peet 1995; Kelly 1996; Hadikin & O'Driscoll 2000). Hadikin and O'Driscoll (2000) and van der Peet (1995) propose that the strong religious and military foundations on which nursing is based, have been a major influencing factor which has led to a tradition of obedience in the nursing profession. Nursing is a tradition which has contributed to, and maintained a culture of horizontal violence as a means

of ensuring obedience to these cultural norms (Duffy 1995; Thomas & Droppleman 1997; Hamlin 2000; Randle 2003).

The notion of horizontal violence is frequently referred to amongst nurses and is often explained in terms of behaviours such as isolating certain nurses who are viewed as being 'weaker', making unwelcome comments about other nurses, and not allowing certain nurses the opportunity to access resources (Duffy 1995). Nurses often use the phrase 'nurses eat their young' as a means of describing the behaviours that are exhibited by the experienced nurses in the treatment of more junior members of the profession. Whilst this term is traditionally associated with the top levels of the nursing hierarchy, it is apparent that all levels of nursing staff are capable of negative behaviours towards nursing students. This thesis has already provided examples of such behaviour from assistants in nursing and enrolled nurses in the off-campus clinical setting in their interactions with the nursing students. These behaviours include blocking access to required learning opportunities and abrupt or non-existent communications with nursing students.

Lewis (2004) reported on a previously little recognised phenomenon in nursing, bullying from lower ranking nurses towards the nursing staff and management above. This process of ascending bullying was explored in relation to nurse manager's experiences of workplace bullying. Whilst the theme of ascending bullying is relatively new in the literature, it is worth providing consideration to this phenomenon in this study as it offers insights into workplace bullying and nursing culture from a different perspective to the more commonly reported themes associated with horizontal violence. Participants in this study reported evidence of

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upwards bullying from staff at the assistant in nursing and enrolled nurse level towards registered nurses in the clinical setting. Duffy (1995) and Lewis (2004) argue that regardless of the direction of the bullying behaviours, the reported behaviours are the same.

Nurses use a number of overt and covert behaviours in the execution of the behaviours which are collectively titled 'horizontal violence'. Farrell (1997) and Hadikin and O'Driscoll (2000) identify that intimidation, threatening behaviours, inappropriate jokes and blatant threats are some of the overt behaviours reported. The subtle bullying tactics which have been reported in the literature (Farrell 1997) and in this study are of greater concern than the overt behaviours. Farrell (1997) found that nurses felt intimidated when they experienced covert bullying behaviours such as snide remarks, talking behind colleagues' backs, withholding of information, refusal to assist and the refusal to converse. A number of these covert gestures were reported by participants in this study. Through the increased attention that Farrell (1997) and Thomas (1998) and others have drawn to horizontal violence in nursing, these gestures have become recognised as being integral to workplace bullying.

Workplace relations and oppression

Horizontal violence in the nursing profession has traditionally been linked to oppression and oppressed group behaviour (Farrell 1997, 2001; Woelfle & McCaffrey 2007). Oppression exists when one group with status, prestige and power exploits and controls a less dominant group. The dominant group identifies and enforces the norms, values and beliefs that are viewed as being correct. Over a

period of time the norms of the subordinate group become devalued and are viewed from a negative perspective (Fanon 1963; Freire 1971). Roberts (2000) argues that poor self and group-esteem and identity is one of the major factors preventing the oppressed in nursing from becoming empowered. In oppression theory the dominant group looks, acts and thinks differently from the subordinate group. For this reason those who do not look, act or think the same way as the dominant group are given less value.

Society views doctors, as a group, as being decisive, objective and lacking in emotion; qualities which are traditionally valued (Stevens & Crouch 1998). The traditional view of nurses held by society is the opposite; nurses are warm and caring, qualities which are traditionally devalued by society (Speedy 1987). Traditionally nurses have been oppressed by the dominant medical model of health and patriarchy; as a consequence nurses are participants in a struggle to overcome oppression (Speedy 1987; Hall, Stevens & Meleis 1994; Kulenios & Bowman 1994; Henderson 2002; MacIntosh 2002).

It was asserted by Lee and Saeed (2001) that oppression or membership of an oppressed group results in behaviours which are reactive and irrational, subsequently resulting in the continuation of the oppression and the characteristic oppressed group behaviours that stifle the profession's development. This behaviour was evidenced in this study, as tradition bearing, and is explicated further later in this chapter. Nurses become acculturated into a way of being and fail to recognise their oppression (Henderson 2002; MacIntosh 2002). Henderson (2002) and MacIntosh (2002) argue that regulation of the nursing profession through the professional licensing and

accreditation bodies has further restricted the autonomy of nurses, thus relegating nurses to the role of follower and doer, rather than leader and thinker.

An Australian study (n=150) was undertaken by Bowen and Curtis (2004) to examine the experiences of undergraduate nursing students in the off-campus clinical setting. The study investigated the effects of negative experiences in the off-campus clinical setting specifically on the recruitment and retention rates of nursing students. An increase in the number of nursing students not completing their pre-registration training programs is cited by Bowen and Curtis (2004) as an issue of increasing concern in the last decade. Traditionally, the attrition rates in nursing have been assigned to poor wages and conditions, however contemporary research indicates that the experiences of horizontal violence in the workplace is having an impact on the retention rates as nurses continue to eat their young (Hutchinson *et al.* 2006a).

A profession divided

The professional reality of nursing is such that it is not a homogenous group; there are many groups and sub-groups within the profession. These groups consist of managers, educators, researchers, nurse academics, registered nurses (RN), enrolled nurses (EN), assistants in nursing (AIN) and personal care workers. Each of these groups and sub groups has its own cultural norms, beliefs and rituals which may well be at odds with those of the other groups and sub groups which ultimately constitute the nursing profession. The professional divisions which are apparent in nursing are generally interpreted as being 'divisive' rather than being interpreted as a 'difference' (Speedy 1987). Chaboyer, Najman and Dunn (2001) however, reported

that whilst there was some lack of cohesiveness within the nursing profession, this was similar in other workplaces and some negative perceptions were to be expected.

Divisiveness in nursing is referred to by Speedy (1987) in relation to the lack of cohesiveness between the numerous professional bodies which represent nursing groups. A group of enrolled nurses reported that they experienced divisions between their work practices and that of their registered nurse colleagues (MacKenzie 1997). It is not only enrolled nurses who have experienced segregation in nursing culture, graduate nurses also experience a 'them and us' culture in terms of junior and senior nurses (Abel-Smith 1960; Kelly 1996; Begley 1997, 1998, 2001, 2002; Thupayagale-Tshweneagae & Dithole 2007). This 'them and us' approach in nursing is indicative of horizontal violence.

Participants in this study clearly identified a 'them and us' mentality in the clinical setting as demonstrated by the findings presented in the previous chapter. This divisiveness in the profession had a clear impact on the level of anxiety which was experienced by nursing students. This approach is linked to the traditional role of nurses and perpetuated by the staff in the clinical facilities who have adopted tradition bearing roles and demeanours.

Nightingale drove the implementation of two levels of nurses in the 1800s and it is feasible that the 'them and us' approach that continues to exist in contemporary nursing has stemmed from this segregation (Reverby 1987; Hektor 1994). Hallam (1998) also argues that the two tier system of nursing that was promoted by Nightingale in the mid 1800s, continued to develop into the 1930s with the

segregation of the nursing levels into enrolled and registered nurses. This separation is still witnessed in contemporary nursing in relation to education, qualifications and role designation (MacKenzie 1997; QNC 1999; QNC 2005). Registered nurses are given greater responsibility than their enrolled nurse colleagues (QNC 1999, Nurses and Midwives Board NSW 2007; NBV 2007; NBSA 2007; NMBWA 2008) in a similar manner to which the middle class nurses of 1800s England were appointed to the more respectable position of ward sister. The role segregation between enrolled nurses and registered nurses is only one tier in the hierarchical system which has come to portray the nursing profession. This role segregation however is not specific to nursing with a number of professions having para-professions such as dentists and dental technicians.

As a hierarchical system, nursing operates through a linear chain of command. Individuals within the nursing profession have a certain place on that linear chain, depending on the rank that the nurse holds. They are either superior to those below, or inferior to those above. Duffy (1995) argues that hierarchical systems thrive through the use of controlling, coercive and inflexible protocols. As already alluded to the hierarchical management style that hospitals adopted was inherited from the army and the church (Hadikin & O'Driscoll 2000). Both of these organisations have historically sustained cultural norms or bureaucracy through the use of strict discipline. Obedience and unquestioning attitudes were rewarded with promotion, whilst disobedience and dissidence were met with disciplinary action (Hadikin & O'Driscoll 2000). This approach to management meant that the group members were more likely to adhere to the accepted rules, habits, traditions and expectations that constituted the accepted cultural norms of the profession or the organisation. The use

of humiliation became a culturally accepted norm in the nursing profession (Farrell 1999, 2001). Humiliation was identified as a cultural norm in the nursing profession in the findings of this study with a number of participants indicating that they felt they had been humiliated by nursing staff in the off-campus clinical setting.

This led to the students experiencing anxiety and questioning their desire to be registered nurses. Furthermore the cultural norms experienced by the nursing students in the off-campus clinical setting were seen to impact on how the participants' constructed the meaning of their experiences in respect of the negative workplace behaviours. In accordance with the theoretical underpinnings of Symbolic Interactionism, the students' interactions with the staff in the off-campus setting were largely constructed in response to dealing with the increased levels of internal conflict and anxiety that was experienced.

Humiliation and other negative behaviours directed towards nurses and nursing students from within the profession appears to be commonplace with Thomas and Watt (2005) reporting that nurses continued to be silenced by those in power. Gordon Nuttal, the then Queensland Minister for Health, admitted to the Morris Royal Commission that the Queensland health system was "racked by a culture of intimidation" (Thomas 2005:1). This admission goes some way to explaining the experiences of nursing staff and subsequently nursing students in clinical facilities.

Abel-Smith (1960) and four decades later Hallam (2000) indicate that the hierarchical chain of command has been an integral aspect of nursing from the 1800s to the present. For those who demonstrated commitment and obedience, promotion

through the hierarchy was possible; those nurses who broke with the traditions and rules were punished through humiliation or termination of their employment (Baly 1998). Nurses who questioned supervisors were ostracised and criticised by their manger's and subsequently by the other nursing staff (Duffy 1995; Hallam 2000). Nurses quickly learnt that, as in many other professions, if they were to gain promotion, it was necessary to conform. Participants of this study were aware of the need to conform when they described strategies to deal with the negative behaviours and also in that they knew not to ruffle feathers.

Experiencing nursing culture

The literature discussed above situates the reader in relation to the discussion which follows. This study explored the experiences of undergraduate nursing students in an effort to discover how they experience nursing culture as a nursing student in the off-campus clinical setting. Comprehensively examining the experiences of the undergraduate nursing students, this study reported their actual experiences. There were no studies found which explored the experiences of nursing students in terms of anxiety and internal conflict arising from negative workplace behaviours in the regional Queensland context, and there are a very limited number of studies which explore this phenomenon in the wider Australian context (Bowen & Curtis 2005).

Whilst there are a number of studies which have examined horizontal violence from a subjective perspective, these studies have not examined how the experience of this phenomenon has impacted on the development of internal conflict in nursing students. This highlights a significant gap in the literature and nursing knowledge in

respect of the factors that may influence workplace bullying in nursing as well as the development of a professional identity within the profession in a regional context. The current literature provides an insight into the experiences of nurses in the metropolitan settings; however there is a dearth of knowledge in relation to regional settings.

This study provides a unique insight into the experiences of undergraduate nursing students that has not previously been revealed, as the nursing students' respond to the negative workplace behaviours they are exposed to in the off-campus clinical setting. Findings from the study allowed for the formulation of a substantive theory of the undergraduate nursing students experiences of the off-campus clinical setting as a nursing student in the off-campus clinical setting in a regional Queensland context. This theory provides a more detailed understanding of the phenomena than what has been available previously. The understanding that this theory contributes is a substantial original contribution to knowledge and this is summarised on page xvi. Previous studies investigating horizontal violence in the nursing profession have not considered the issue of internal conflict and the resultant anxiety as a result of students not being able to determine where they fit within the hierarchy and the impact that this has upon the development of professional identity.

The discussion that follows integrates the findings of the study and situates these findings within the existing knowledge through an interrelationship with the literature. Issues surrounding the challenges that are faced by nursing students as they undertake clinical practice in the off-campus clinical setting are discussed. The identified dearth of understanding of the experiences of nursing students as they

attempt to develop an understanding of the cultural issues associated with being placed in the off-campus clinical setting is then presented. A discussion of the Basic Social Process and the factors that were conceptualised as impacting on the Basic Social Problem then follows.

Expectations and experiences

This section discusses the basic social problem of 'place' within the facility hierarchy and the broader professional hierarchy of nursing. Two categories were identified as impacting directly upon the nursing students' abilities to determine where they fitted within both the individual facility hierarchy whilst they were in the off-campus clinical setting and the hierarchy of nursing in general. Expectations, both on the part of the nursing students and on the part of the staff in relation to the nursing students, were found to impact upon the students' ability to determine their place in the hierarchy.

Expectations – Nursing Students

It became apparent through the analysis of the data that both interpersonal relations and interpersonal communication between the staff and the nursing students were key issues of concern in the off-campus clinical setting. It was perceived by participants that staff at all levels in the off-campus clinical setting lacked the ability to communicate effectively with other staff, nursing students and even patients. There was an expectation on the part of students that staff in the off-campus clinical setting would have the necessary interpersonal communication skills to interact

effectively with and teach nursing students. Effective communication between all the stakeholders in the off-campus clinical setting was considered by the nursing students to be essential in their efforts to become registered nurses.

Symbolic Interactionsim holds that individuals or groups will behave and act/interact according to how they interpret and give meaning to specific symbols (Hutchinson 1986; Denzin 2004). In this study the participants identified poor interpersonal communication as a significant issue and reacted to this poor communication by becoming anxious about their interactions with the nursing staff. Language is the most symbolic system (Annells 1996) and this was apparent in this study with the participants indicating that their anxiety levels increased considerably as a result of the staff using non-verbal communication strategies to convey their disapproval of the nursing students.

Whilst effective communication was identified by the participants as being a requirement for effective clinical teaching; to be an effective clinical educator requires more than just clinical competence. Professional competence, interpersonal relationship skills, personality characteristics, and teaching ability are identified by Tang, Chou & Chiang (2005) as requisite skills. The criteria outlined above are weighted differently in various studies, however almost all of the research indicates that these four characteristics are necessary in order to be an effective clinical teacher (Hartland & Londoner 1997; Johnsen, Aasgaard, Wahl & Salminen 2002). Each of the four characteristics identified in the literature has a direct impact on the ability of the nursing student to develop effective interpersonal skills as a nurse in

the off-campus clinical setting. The nursing student's ability to develop as a competent professional nurse is also affected by these characteristics.

Effective interpersonal relations between the staff in the off-campus clinical setting and the participants were viewed as being critical in the evolution of the student into a competent registered nurse. Nursing students viewed the development and maintenance of effective and positive interpersonal relations throughout the clinical placement as being paramount to successful attainment of the requisite skills and knowledge as outlined by the university; and to their subsequent ability to demonstrate the learning outcomes. These factors all have an impact on the experiences of nursing students in the off-campus clinical setting through ensuring that the students are aware of their position within the profession and are allowed to participate in patient care duties (Grealish & Trevitt 2005). The use of Symbolic Interactionism allowed for an increased understanding of the meanings that the nursing students assigned to their social interactions with the staff in the off-campus clinical setting. This aspect is discussed in greater detail in this chapter under the section 'Conditions affecting the Basic Social Problem'.

Despite the indications by the nursing students that interpersonal relations were critically important to their cultural development as nurses, this research found there were considerable difficulties experienced by the nursing students in both the development of, and then the maintenance of, interpersonal relations in the off-campus clinical setting. This led to differing expectations between the students and the facility staff which were identified as two factors which impacted on, and formed, the basic social problem of '*place*'.

Communication is integrally linked to all aspects of the off-campus clinical setting; between the School of Nursing and Midwifery and the clinical facility, between the School of Nursing and Midwifery and the students, and the clinical facility staff and the students. If the communication that occurs is not effective, or mixed communication occurs between the key stakeholders, ultimately the participants perceive that it is the nursing students who wear the brunt of the 'fallout' which results. This 'fallout' generally impacted on the student's ability to determine where they fitted within the hierarchy and this is supported by the findings of Pearcey and Elliotts' (2004) study which found that undergraduate nursing students viewed good communication as being central to good nursing. Being perceived as a 'good nurse' was reported by the participants as being very important to them. Being a good nurse is integral to reducing the level of internal conflict experienced by nursing students in the off-campus clinical setting.

The participants expressed that there was little or no communication to them from the staff on the wards and in the clinical setting unless the communication was initiated by the nursing student. This lack of communication may be a carryover from the old nursing ethos where communication was rigidly hierarchical in an organisational structure whereby nurses were completely bypassed with regards to information (Madsen 2000). The study found that the nursing students were often greeted with behaviour that was less than enthusiastic or welcoming when they arrived on their first shift and they believed that this continued through the entire placement in a number of instances. Reports of students being ignored at the handover meeting were common and participants perceived that they were ignored until it was time to allocate particular low level tasks. This inability of the nursing

staff to communicate with nursing students in what they perceive as an effective manner cannot be overlooked as the nursing students are required to develop their 'caring' attributes throughout the duration of their program of study (Wilkes & Wallace 1993). Davies (1993) argued that the value of effective communication cannot be overestimated.

This study found that whilst communication was an issue of concern between the staff and the students, the staff were perceived to be quite capable of communicating when they felt the need, for example in the allocation of menial tasks. Using a Symbolic Interactionist approach to interpret the allocation of menial tasks to students, it is apparent through the students' construction of meanings associated with these tasks that this was a symbolic approach to ensuring that the nursing students were aware of their position within the structure of the facility and the broader profession. This communication varied between the use of verbal and non-verbal communication strategies with the participants indicating that the non-verbal communication had the greatest negative impact on them as this strategy was covert. Participants began to question whether they had seen the behaviour or whether it was a figment of their imagination which caused anxiety and an inner tension on their ability to be reflexive and correctly judge human interaction. Verbal communication on the other hand was used when the staff wished to get a point across to a nursing student.

Participants perceived that the clinical facility and the students were being given two different messages from the School of Nursing and Midwifery in relation to the requirements of the course and the objectives that were to be achieved in the

placement. Participants indicated that whilst the university was telling the students that they had to meet predefined competencies in accordance with the requirements prescribed by the Australian Nursing and Midwifery Council, in reality the situation was perceived by the participants as being very different. Participants were of the opinion that the staff in the facilities felt that the students were in the off-campus clinical setting to undertake very basic tasks such as showering. This appeared to contradict the information which was given to the students by the university prior to commencing clinical in the off-campus clinical setting.

It also became apparent that whilst the facilitators appeared to be conversant with the requirements, it was the staff at the frontline who were lacking knowledge of what was required. This in turn led to conflict between staff and students as the communication was ineffective. Students perceived that they were being told one thing and the staff were being told something very different. In the eyes of the participants, there was a lack of consistency between the information they received and that which the staff received. Through the difficulties that the participants experienced in the communication of their need to access learning experiences, the participants felt that they were losing opportunities to address the required learning objectives. This lack of communication led to internal conflict within the students as they were unsure of what was required of them and bore the brunt of disgruntled staff who perhaps did not want students in the first place.

This study identified that the participants simply wanted to establish interpersonal relations with the staff which were positive and included a genuine willingness to accept and respect the individual nursing student as a member of the nursing team.

Cahill (1996) supports this outcome, finding that the attitude of the staff is the most important factor for the nursing students. Participants in this study indicated that their levels of anxiety were directly being affected by having the opportunity, or not, to acquire the knowledge and skills needed to achieve the learning objectives for that particular placement.

There was a clear expectation on the part of the participants that the nursing staff in the facilities where they were placed would understand their needs as nursing students. This expectation was also clearly evident in the findings of a study conducted by Brammer (2008) which considered the experiences of nursing students. Whilst this was an expectation on the part of the students it was apparent that a considerable number of nursing staff held a different view in relation to their expectations of what nursing students could, and could not do.

Conditions affecting the Basic Social Problem

Analysis of the data revealed the following contextual issues which were labelled as '*tradition bearing*', '*staff*' and '*student performance*'. These conditions could be causal in that they influenced the problem, intervening in that the condition altered the impact of the problem, or contextual in that a specific set of conditions intersected at a certain time and point. Each of these conditions and the effect that the specific condition had on the experience of the nursing students in the off-campus clinical setting where the nursing student was placed is discussed in the following pages. Relevant literature is integrated into this discussion to place it within existing knowledge.

In an effort to move the issue of interpersonal conflict beyond the notion of oppression, a conceptual framework was developed by Farrell (2001) with the purpose of extending the boundaries of the debate on the causes of interpersonal conflict in nursing. The framework outlines three perspectives with which to examine the occurrence of interpersonal conflict: macro-level, meso-level, and micro-level. The macro-level examines nurses' position in relation to powerful others and the marginalisation and disempowerment that results; the meso-level examines organisational structures, whilst the micro-level acknowledges the individual determinant of aggression (Farrell 2001). This framework provides a useful approach to the consideration of the experiences of the nursing students in the off-campus clinical setting.

The macro-level perspective focuses on the consideration of the position of nursing in relation to medicine and other perceived dominant groups and the violence that these groups inflict, such as denial of power, control, and access to rewards – material or otherwise. Nurses may feel that they do not have control over decisions, or autonomy over working conditions (Duffy 1995). There is a fear of reprisal and an inability to make changes; as a result, staff frustration is manifested as conflict within nursing (Farrell 2001). The category of '*tradition bearing*' generally operates at this level as the staff who have adopted the role of 'tradition bearer' in the facility attempt to maintain the previous somewhat passive acceptance of such traditions where nursing was subordinate to medicine and the nurse was viewed as an unknowing carer. At the macro-level the nursing student is attempting to identify where they fit as a nursing student within the overall profession. There is no longer a

specific position within the Australian nursing hierarchy which is specifically designated for nursing students.

Meso-level perspectives focus on organisational structures and include work practices which nurses can control. One aspect that Farrell (2001) investigates under this perspective is the task/time imperative that is seen in nursing. It was apparent in the data that the task/time imperative and time management generally, were issues which caused considerable anxiety for the nursing students. There are specific times to do specific tasks such as administering medications, feedings and procedures. Farrell (2001) indicates that nurses could potentially become trapped in this routine, and if too much time is spent doing a task, another task or personal time will be sacrificed. If the work is left for the next shift interpersonal conflict is likely to result. According to Farrell (2001) nurses are trapped in the routine and as a result interpersonal conflict is inevitable due to the search for new ways of working and relating being so narrowly focused. Thus, nursing is potentially narrowing its horizons and scope by concentrating on timeframes and tasks. It also locates it within the medical model although many nurses practice in other paradigms and knowledges.

Farrell (2001) indicates that the micro-level addresses the individual determinant of aggression. Student performance was a determinant of aggression in a number of instances within this study and this was evident through the expectations of both the students and the nursing staff in the off-campus clinical setting. The participants raised the issue of time management in the off-campus clinical setting as an issue

that caused conflict. Participants perceived the staff expectations as being unrealistic in that they were still learning and as such required a longer time span to complete tasks which the qualified nursing staff were competent in. Such unrealistic expectations increased the level of anxiety experienced by the participants as they questioned the appropriateness of time management in the early stages of their clinical experience.

The conceptual framework described by Farrell (2001) and discussed above is integrated into the discussion of the conditions identified in the analysis of the data in this study. The integration of the conceptual framework described by Farrell (2001) is utilised to discuss the impact that the phenomenon of negative workplace behaviour has on the experiences of nursing students in the off-campus clinical setting.

Tradition bearing

'*Tradition bearing*' is encompassed within the micro-level perspective in the conceptual framework that Farrell (2001) described to address the issue of interpersonal conflict between nursing colleagues. The micro-level of the framework places the emphasis on the individual interpersonal level of the personal conflict. Individual nursing students do not know what to expect from the staff in the clinical setting and ultimately interpret the behaviours, in an individual manner. This individual interpretation of the 'symbolic system' is consistent with the theoretical underpinnings of the study which holds that each individual will interpret the

'symbols' in their own way. Behaviours that one person views as being inappropriate may well be viewed by another as being appropriate. Whilst the nursing students may feel that the behaviours are directed at them personally, there may well be other contributing factors which are external to the nursing students per se. The perceived negativity of staff directed towards students does however generate stress which has far reaching effects on the other conditions as described.

Intra-staff relationships are a vital component of job satisfaction (Lefton 1994; Robbins *et.al.* 1998; Kramar, McGraw & Schuler 1997; Farrell 1997). A study by Farrell (1997) found that the nursing staff were more concerned about facing a hostile environment than they were about the threat of physical violence in the workplace. A further study by Farrell (1999) found that over half of the participants reported that peer to peer violence was more distressing for them than the other forms of violence that nursing staff may be exposed to. This was supported in this study with participants indicating that the peer related violence that they had either witnessed or had been exposed to had a greater impact on their decisions to continue in the profession than any other aspect. The stress that participants reported feeling as a result of the negative interactions is also reported by Isuenalumhe (2000). The stress reported by the participants has far reaching effects on their development as a registered nurse.

The anger and aggression that is expressed within the nursing profession is associated with the themes of oppression and powerlessness (Duffy 1995; Farrell 2001). Duffy (1995) argues that patriarchal oppression of nurses is seen to underpin the way that nurses relate to each other and how they function as powerless members

of institutions which are "dominated by doctors, male administrators and marginal nurse leaders". Nurses have been identified as an oppressed group (Duffy 1995:8). Droppleman and Thomas (1996) conducted a study looking at anger experienced by women in nursing as a result of powerlessness and an inability to effect change. As alluded to, this resulted in anger, but also in frustration and exhaustion. The resultant anger was found to be misdirected or expressed in ways which the nurses later regretted. Nurses admitted to resorting to fault finding, name calling, back-biting, and subtle sabotage of their colleagues and superiors. Evidence of fault finding, name calling and other forms of negative behaviour were found in the data of this study. When feeling powerless to confront those in authority, a group may fight amongst themselves and may not provide mutual support and empathy (Droppleman & Thomas 1996).

Participants in this study reported they felt a lack of mutual support and empathy amongst the staff in the clinical setting. Nursing students are a particularly vulnerable and non-assertive group and this was particularly apparent in the data collected in this study. Participants indicated that they simply wanted to be treated with respect and not be used as an outlet for the frustration being felt by the nursing staff in the off-campus clinical setting. The behaviours which were experienced by the students led the students to question their intention of completing their degree if this was 'what it would be like' as a graduate nurse. Participant P indicated that:

> *You would have to think really hard about going on … it just makes you wonder is it worth all the hassles we have as students anyway, like all the stress as a student. Is it really worth it to graduate?*

A qualitative, exploratory study conducted by Skillings (1992) looked at the perceptions and feelings of nurses regarding horizontal violence as an expression of oppressed group behaviour. Participants described behaviour as a result of differences between people. These differences included values, education, knowledge, role, sexuality, and the need to feel power. Horizontal violence was described as a result of oppression and oppressive conditions where nurses try to make themselves feel better and either disregard differences in others, or are unable to tolerate, those differences. The literature supports the findings of this study in that the registered nurses and auxiliary nursing staff demonstrated what could be either described as a disregard or a demonstration of the intolerance of differences in nursing students' experience and education levels.

Participants openly discussed the hierarchy that is evident in the nursing profession. This hierarchy is well documented in the literature (Duffy 1995; Farrell 1997, 1999, 2001; Hutchinson *et. al.* 2006a). Traditionally the assistants in nursing are at the bottom of the hierarchy and have no power in their position to effect change. Participants perceived that whilst the assistants in nursing are traditionally at the bottom of the hierarchy, in the presence of students, assistants in nursing were able to demonstrate a degree of power and control over a group which was perceived as being lower in the hierarchy. Participant G reported that the lower qualified staff at the assistant in nursing level felt threatened by the presence of students and the assistants in nursing would lodge complaints with the registered nurses in relation to the students.

In a study exploring anger experienced by women in nursing as a result of powerlessness and an inability to effect change, Droppleman and Thomas (1996) found that such anger is directed at those who are available and vulnerable. As already described, nursing students are a particularly vulnerable and non-assertive group thus making them an easy target. This was also identified by Skillings (1992) in a study investigating the perceptions and feelings of nurses regarding horizontal violence as an expression of oppressed group behaviour.

In Skillings' (1992) study the participants identified the behaviours as resulting from differences between people with these differences including values, education, knowledge, role and the need to feel power. Differences between assistants in nursing and the nursing students are linked to education, knowledge, role and the need for the assistants in nursing to feel power and regain some control of their environment. This perceived attempt at regaining control evidently results in conflict between the assistants in nursing and the nursing students, thus increasing the level of internal conflict and anxiety experienced by the nursing students.

Roberts (1983) argued that the resultant aggression could not be expressed towards the oppressor therefore conflict arose within the oppressed group. This concept is described by Freire (2003) as the duality of the oppressor, the oppressor exists within the oppressed, and so when the oppressed attack they are ultimately attacking the oppressor. In Freire's model of oppression the dominant group sets the norms for what it values so that the subordinate group learns to hate themselves and their attributes. The dominant group in this study, from an oppression model perspective, was the registered nurses. As a part of the culture formation process, the norms of

the dominant group are internalised, the subordinate group believing that to be like the oppressor will lead to power and control (Roberts 1983).

Assistants in nursing and enrolled nurses in the clinical facilities understand that registered nurses have a degree of power and control vested in them through the position that they hold within the facility. In an effort to achieve power and control, the lower qualified staff internalise the behaviours that they have witnessed and experienced from the registered nurses. This behaviour is then directed towards the nursing students thus giving the assistants in nursing and enrolled nurses some sense of power and control in an environment in which they are otherwise essentially powerless. There was however, evidence of staff alliances in the study and this is reported in the following discussion.

In the nursing profession, bullying has been understood in terms of 'horizontal violence' (Duffy 1995; Reeves 2000; Dunn 2003) and this phenomenon has been explicated earlier in this thesis. The constructs of horizontal violence have been used to explain bullying as behaviour between staff who are on the same level within the organisation's hierarchy (Duffy 1995; Dunn 2003; Randle 2003) and who, because of a perceived low personal self-esteem and poor group identity (Roberts 1983, 2000) direct abusive behaviour towards each other. This behaviour was described by participants in the current study; however the study revealed that selected staff members worked together in alliances to wield considerable amounts of power.

Staff working together in alliances is in sharp contrast to the conception of bullying as 'oppressed group behaviour' or 'horizontal violence' (Hutchinson *et. al.* 2006a).

These alliances are often informal in nature and are embedded within informal organisational alliances. This enables the bullies to control the work tasks, roles and status in the hierarchy through enforcing their 'rules of work'. To achieve this the bullies utilise a process of ritual indoctrination, destroying the self confidence and self-identity of those who are targeted, the result being the target either resigns their position or acquiesces to survive.

Participants in this study perceived that there were alliances between certain staff and this was discussed amongst the nursing students. In the analysis of the data it became apparent that students felt strong alliances existed between the assistants in nursing. Evidence of the perceived alliance was found in the comments by participants that the assistants in nursing would rather seek assistance from another assistant in nursing than a nursing student, even if it meant that the assistant in nursing would have to wait for the other staff member to be free. Participants also perceived a definitive indication that the assistants in nursing were controlling a number of the work roles and tasks within the aged care facilities. One participant described the staff that were attracted to the assistant in nursing role as being "colourful language type women", who were not afraid to use this language on the nursing students when the staff viewed them as being unsure of what they were to do.

These alliances in the off-campus clinical setting enforced the 'bully defined rules of work' through wielding the power that their position in the hierarchy provided. It became apparent that the nursing students viewed submission as the most appropriate means of dealing with this indoctrination process. An example is if they

raised concerns about not being given or exposed to the requisite tasks and skills, their requests were essentially ignored. There was evidence that the management of the facilities were aware of the bullying behaviour that occurred but the students perceived that staff told management what they wanted to hear and that management subsequently turned a blind eye to the behaviours. This was supported in the literature (Hutchinson *et. al.* 2006a).

The most frequent action taken in response to aggression directed at nursing staff from other nursing staff was to talk to colleagues, friends, the person concerned, a family member or a direct line manager (Farrell 1999). Delez (2003) found that a significant number of respondents discussed incidents of horizontal violence with a peer or significant other; however almost half of the participants in the study undertaken by Delez (2003) failed to report the incident to nurse academics at the institution where they were studying. This situation was reflected in the current study with a significant number of participants indicating that they had 'debriefed' with their student peers or a significant other; however most had not taken the matter to the nursing academic staff at the university. Some participants indicated that they had approached the preceptors in the facility and advised them of the issues they were having and in some cases they were simply advised that the staff member was 'having a bad day', whilst in other cases the preceptor was supportive and facilitated a re-allocation of the student to another staff member.

Analysis of the data revealed that the staff who had been in a facility for extended periods of time were more likely to be involved in the negative experiences as perceived by participants. These staff were generally employed at the assistant in

nursing or enrolled nurse level; however there were a number of staff in some specific settings such as the medical wards who were registered nurses and had an extensive length of service in the same facility. It became apparent that the length of time in the facility or ward at some levels correlated to the negative experiences that the students endured. In the facilities with low staff turnover, students perceived the staff as having a level of complacency and a level of comfort in their surroundings. This level of comfort tended to give the staff a level of power that they utilised to maintain the hierarchy and the structure of their workplace. Participant P perceived that the staff who had been in the facilities for the longest times adopted a "matronly demeanour". Participants perceived that this demeanour was utilised to control, not only the students, but also the staff in the facility.

This condition fits within the meso-level of the framework described by Farrell (2001) as the condition relates to the organisation structures and the issues associated with hierarchy. The development of professional identity is explicitly linked to the organisational and hierarchical structure of the profession (Turney 2003, Bleakley 2006; Hutchinson *et al.* 2006b, Mooney 2007). Whilst professional identity is explicitly linked to the organisational and hierarchical structure of the profession, it was clearly evident in the data that the anxiety that was experienced by the nursing students in this study was also influenced by organisational structure. As a result of the anxiety the students' experienced, they tried to ascertain where they fitted within the organisational structure of the profession. Anxiety levels therefore fluctuate depending on whether the student perceives they 'fit' and were accepted or not.

Staff members with a lengthy period of service in the one facility or a specific unit of a facility were perceived by the participants as being self-assured and were perceived by the participants as being the 'tradition bearers' of the ward or the facility. Interestingly, participants perceived that the level of seniority amongst the staff members was not based on the professional position of the staff member in the organisation, but rather on the length of service the individual had. This meant that an assistant in nursing could position themselves as higher in the hierarchy than the registered nurses. This concept of hierarchical organisation is not discussed in the literature that formed the literature review in this study. The literature assumes that the hierarchy is based on seniority of rank in the nursing profession and subservience to medicine is expected as a given.

Game and Pringle (1983:99) discuss the role of nurses in relation to medicine when they state:

> In the traditional Nightingale system, nursing consisted of two functions: 'nursing the room' or hygiene, or assisting the doctor. Obedience to doctors was stressed; nurses were not to see themselves in any way as colleagues of the doctors. The Matron was responsible for organizing nursing work, training nurses, and discipline in work and private life between which little distinction was made.

The traditional form of nursing practice discussed by Game and Pringle (1983) can, and does lead to, sources of conflict if the stereotype of nurses as being subservient to the medical profession with the 'Matron' being responsible for enforcing the rules of nursing work and discipline, is still practiced in the contemporary clinical setting. There was evidence in this study that some nursing staff and auxiliary nursing staff who have been in the clinical arena for an extended period of time still practice nursing in a functional manner and in some instances these staff members have

adopted the role of the 'Matron' in the absence of the traditional incumbent of the position.

The 'tradition bearer' tended to assume the role of the Matron and as such this individual assumes the role of enforcing the rules of nursing and discipline. It was apparent from the analysis of the data that in the majority of the cases where the 'tradition bearer' was identified by a participant that the individual who adopted the role was an enrolled nurse who had an extensive work history in the clinical facility. There was one instance where a participant indicated that a registered nurse had assumed the role; in this particular instance the individual worked outside the mainstream of the ward nursing in a specialised field on a particular ward.

> *I found that there was one nurse on the medical ward, she didn't do the general stuff of nursing, she wasn't on shift for the general stuff. She did like day procedure stuff in the ward and she was a bit more 'matronly' … very opinionated woman.* (Participant K)

The medical model imposes a hierarchy and degree of control and participants experience this in various forms. Some nurses and auxiliary nursing staff are still bound by Nightingale's notion of nursing and still practice the old school values and disciplines in the contemporary nursing workplace.

Traditionally, bullies are viewed as being the individuals or groups who have inherent power, usually through their position in the organisation (Rayner 1998; Salin 2001). The finding that the assistants in nursing, as lower qualified staff members, are wielding power is significant in that these staff members are enforcing the rules of work. In the nursing context this finding is especially significant in that traditionally the power in the nursing ranks came from the top down. The most

powerful person in the nursing hierarchy was traditionally the Matron (the historical

equivalent of the present Director of Nursing) (Game & Pringle 1983).

In a bygone era nursing staff were socialised and disciplined by the 'mother-

daughter' relations associated with the profession. Game and Pringle argue that

nursing can be seen as being within the imagery of the family when they state:

> Nurses have been disciplined by mother-daughter relations, particularly under the
> old Matron system. Nurse-nurse relations are analogous to sibling relations:
> 'sisters'. Nurses felt some loyalty to their matrons even if they saw them as 'tyrants'
> (1983:105).

Evidence of this loyalty is witnessed in this study, particularly when students are

discussing the behaviours of the 'older' nursing staff who were perceived by the

participants as having been trained under the traditional apprenticeship model. One

participant in this study described the behaviours demonstrated by the staff,

particularly the staff at the assistant in nursing level, as being similar to the

behaviour in the school yard.

> *Oh there's a lot of bitchiness going on between the AIN's, like you know, like
> it's in the bloody school yard actually, you've got these two over here who'll
> be having a whinge about this one over here because I don't know what she's
> done but she's done something wrong and we'll fix her, well we'll do this and
> she can go and do that on her own.* (Participant G)

Are we to liken the 'rivalry' that occurs in the nursing profession to sibling rivalry or

is it arising from the obvious differences between the traditional (hospital based) and

non-traditional (university based) training? Whilst a number of the staff

demonstrating these behaviours were perceived by the participants as having been

trained in the traditional system, these particular individual nurses were not alone in

demonstrating this behaviour. This was evidenced in the statement by a participant

that they had experienced difficulties with a graduate nurse. This participant stated:

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> *… I did have a problem with a, with a first* [year] *graduate at the hospital. Very unhelpful, knew everything, um … haven't got time for students and she has just come out of first year anyway.*

Participant G went on to state:

> *Well I thought being a first year graduate she'd be very helpful, you know because all that stuff is still fresh in your mind and that's why she, it could have just been her attitude to, you know just one of those people that have a bad attitude.*

Whilst this participant perceived that this individual graduate nurse may have been an exception rather than the rule, data revealed that there were other nurses perceived by the participants as being university trained who were just as willing to restrict student access to tasks.

Analysis of the data revealed that university trained staff were just as complicit in blocking student access to learning opportunities. Analysis supported the notion in the literature that the differences between hospital and university trained staff were a cause of workplace conflict. The literature however, does not indicate that the university trained staff are also responsible for the behaviours in relation to students. Literature also fails to identify the lower qualified staff (assistants in nursing and enrolled nurses) as being an issue in this regard. Analysis of the data in this study did identify that these staff were a source of concern for students, especially those members of the staff who had been in the facility for long periods. It appears that it is the length of time that a staff member has spent in a facility or ward and not the hospital or tertiary training they have experienced which increases the tension between the staff and the participants. Data analysis revealed that some of the hospital trained staff were questioning the nursing students in relation to the changes

in practice. Whilst the participants indicated that the staff were unlikely to change their practice as they had performed the task the same way for so long, they were willing to learn and wanted to understand what students were being taught to allow them to enter into contemporary nursing practice. Participant J indicated that there was a perception that the nurses who were perceived as having been trained in the hospital, or the block placement[10] approach adopted by universities, were envious of the students. This perception of envy was related to the fact that the current students receive hands-on training at university and have clinical placements combined into the course.

The stereotype of nursing that has been carried down by staff who have worked in facilities for extended timeframes is potentially a source of conflict (Game & Pringle 1983). The 'Matron' was responsible for the enforcement of nursing work principles and discipline and, as this study demonstrates, this behaviour is still practiced in workplaces today, although not by the Matron. Traditionally the 'Matron' was a long standing member of staff and whilst the Director of Nursing is now the equivalent of the 'Matron' in that they enforce the hierarchal order in the workplace, they may not have the same length of service that the traditional 'Matrons' had. As has already been indicated, there are some long serving staff that take on the role of the 'tradition bearer' in the clinical setting and maintain the old school values and disciplines of the Nightingale notion of nursing.

Game and Principle (1983:107) state:

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[10] Block placements meant a student was placed in a clinical setting for a period of 2 or more weeks in one 'block' of time rather than being integrated into the facility for one or two days a week during the semester.

Doctors will not often acknowledge that nurses have any skills and knowledge; their power is based on the withholding and mystification of medical knowledge and nurses questioning this in any way threaten them.

It is possible to relate Game and Pringle's (1983) statement about nurses and doctors to the conduct of nursing staff in relation to nursing students. Nursing students perceived that their questioning of the staff was viewed, regardless of level that the staff occupied in the hierarchy, as a perceived threat in a similar manner to the way that a doctor may perceive nurses' questioning them as a threat to the doctor's authority.

There was some discussion in the study relating to the issue of medical dominance in relation to nursing and nursing students. The participants in the study conducted by Howe (2001) indicated that the senior medical officers were reluctant to discuss patient care with the newly registered nurses. Patient care was always discussed with the senior nursing staff, even if junior staff were the primary care provider for the client. This finding by Howe (2001) was in stark contrast to the findings of the current study which found that in the peri-operative setting, the medical officers were more than willing to assist nursing students in their quest for knowledge and skills. One participant indicated that the medical officers were more than happy to assist students and the participant perceived that this willingness to assist students related to the training of medical students on a regular rotation.

Whilst the researcher acknowledges that the participants in the study are beginning professionals and do not have the same level of experience as the graduate and experienced nurses, as beginning professionals it is essential that patient management and decisions regarding care are communicated to the nursing students

in an appropriate manner so that they are able to develop the skills they require for independent practice. It is important that their questioning of the staff is not seen as a threat, but rather as a desire to learn. Participant B indicated that questioning the registered nurse, whilst possibly perceived as a threat by the registered nurse, was this participant's preferred approach to learning.

> *I can actually question a lecturer's interpretation on something … trying to get to the truth without [them] taking it personally. It's a debating environment so it's a wonderful academic environment [the university campus] so I think she took some of the things that I said as me trying to cross her path when in fact I was trying to complement the knowledge that was being dispersed to us.* (Participant B)

Whilst the 'tradition bearers' have a place in the clinical setting it needs to be asked whether their maintenance of tradition should include maintaining the power inequalities that existed in the traditional model of nurse education as students attempt to develop a professional identity as a nurse in the 21st century.

Tradition bearing had a marked effect on the nursing student's ability to develop both their interpersonal and professional identities whilst in the off-campus clinical setting and subsequently this had an impact on the participant's developing identity as a nurse. Participants reported staff advising them to ignore a certain staff member's behaviour, explaining the behaviour away as an individual staff member 'just having a bad day'. Interestingly the participants reported that the behaviour of the staff could be related to a number of conditions, both external and internal to the clinical setting.

Staff Performance

Participants perceived that staff viewed them as being a burden that they could do without. It became evident that whilst the staff in the facilities who acted as preceptors were recruited by the School of Nursing and Midwifery and had effectively volunteered to take on this role on behalf of the University, the nurses on the floor in the facilities often had not volunteered, and in fact did not want to mentor a student for the shift. These individual members of staff were nominated by the organisation; there appears to be dissonance between the organisational perspective that staff will accept a student regardless of whether or not they actually want one. This reluctance by nursing staff to accept a student and subsequently act as a mentor for the student is supported in the literature. A qualitative study reported by Earnshaw (1995) found that the trained staff were reluctant to take on the role of mentor. Participants in this current study indicated that they had witnessed staff being randomly assigned to a student at the shift handover. This approach to student allocation is supported in the literature by Pearcey and Elliott (2004).

This reluctance by the experienced staff member to accept a student could be as a result of the staff feeling uncomfortable mentoring a student, even for just one shift. There was evidence in the data that the staff felt they were under scrutiny by the students and in the event that they made an error, this would have a negative impact on their own image as a competent staff member. This discomfort was also reported in the literature by Pearcey and Elliott (2004) in that staff felt threatened by students asking questions and continuing to probe with questions. Participants in this study perceived that the staff felt threatened when a student had an inquiring mind. This

was identified among the different levels of staff in the off-campus clinical setting and also across various facilities where the participants were placed. It is apparent in the data that there is little or no difference in this phenomena between public or private health care providers.

Another reason for staff not being willing to accept a nursing student in the off-campus clinical setting relates to the already heavy workload that the staff already have without having a student added to the mix. Comments from the staff in the clinical setting which were recounted by participants in this study indicated that the staff felt that having a student increased their workload, despite them already having a full patient load. Participants felt that there was no allowance made, in a workload allocation model, for the staff who were also supervising students. Participants clearly indicated that they felt that a nurse's workload should be reduced so as to allow the nurse the opportunity to teach the students effectively. In a study of 35 students and 15 mentors, Watson (1999) found that some staff did not want to take on the extra workload of having to mentor a student. The findings of Watson's (1999) study are replicated by the findings of this study in that the nursing students reported that a number of the staff in the off-campus clinical setting would not accept a student because they were already too busy. Participant C perceived that asking a staff member to explain something or to demonstrate a skill, a second time, would validate the staff member's decision not to accept further students in the future.

A number of the participants were sensitive to the reluctance of the staff to accept them. Participants developed their own means of coping with this reluctance on the part of the staff to mentor a student, or in the event that they viewed a registered

nurse as a bad mentor. These strategies essentially had the effect of relieving the staff of their unwanted responsibilities. Effectively the registered nurse got what they wanted - no student. These strategies varied depending on the individuals involved. One participant explicated engineering the clinical setting so that they would be placed with a staff member who would be accepting of a student. Other participants attempted to build a working relationship with the nursing staff in an effort to be accepted by the staffing the clinical setting. Literature supports the use of these strategies to overcome the negative acceptance of students by some staff (Pearcey & Elliott 2004; Tang, Chou & Chiang 2004). Registered nurses view the teaching of students and nursing as 'different work' in that teaching is not viewed as being nursing work.

The issue of nurses teaching nursing students raised the issue in the nursing student context of the teaching abilities of experienced nurses. Many of the nurses expected to teach nursing students were in fact not 'educators'. Whilst the individual nurse can competently practice the skills of their chosen profession, relaying this knowledge and skill to a beginning practitioner can be a challenge that the experienced nurse feels unable to meet. There was an expectation on the part of the nursing students that the staff who were in an education role, were able to teach nursing students effectively and pass their knowledge and experience on to the students in a professional manner.

Teaching ability, whilst being an issue of concern for the nursing students, appears to be a low scale issue in the larger scheme of being in the off-campus clinical setting and developing a professional identity. Whilst a number of participants indicated that

the best educators in the clinical facility, from a learning management perspective, were the nursing staff who were currently teaching in the vocational education sector, data proposed that the participants felt that it was the treatment that they received from the nursing staff and the attitude of the nursing staff that had the greatest impact on the participant's ability to learn. Tang, Chou and Chiang (2005), in a study (n=214) investigating students' perceptions of effective and ineffective clinical instructors, found that the crucial difference between an effective and an ineffective clinical teacher was the individual's attitude towards students, more so than their actual teaching ability per se.

Participants reported that the nursing educational level of the individual staff also appeared to contribute to their acceptance of nursing students. Auxiliary nursing staff, staff employed at the assistant in nursing and enrolled nurse level, are trained in the vocational education sector and as such are trained to either a Certificate or Diploma level respectively, with the qualification being dependent on the course of study undertaken. Staff at the assistant in nursing level generally complete Certificate level four courses and the staff employed at enrolled nurse level are trained to the Diploma level in the vocational sector. Participants perceived that the behaviours of the assistants in nursing and enrolled nurses were related to the perception that the students may 'steal' the jobs which the auxiliary staff fulfilled. This was evident in the following statement by Participant G:

> *You know they weren't, as I say they weren't treating us as RNs they were treating us as, you know somebody they suspect might steal their job.*

Participant B proposed that the auxiliary staff were protective of their jobs because they were in regional areas and the availability of employment was limited due to a finite number of employment opportunities in their local communities.

This study identified the staff that were most likely to cause the participants to experience internal conflict in the off-campus clinical setting were the lower qualified staff at the level of assistant in nursing or enrolled nurse. This finding does not appear to be apparent in the literature to date. Participants in this study identified a number of reasons they perceived the lower qualified staff felt threatened by students, ranging from an inability to gain employment in another field due to the limited employment prospects in regional centres through to issues associated with the hierarchy of nursing.

When nursing students are placed in the off-campus clinical setting they are faced with the prospect of trying to find their position in the structural organisation of the clinical setting and the profession overall. The student wants to be seen as a professional and as such they are looking up to the staff as a role model, however it appears to be not uncommon in the perception of the student for the nursing and auxiliary staff to disrespect the student. This is another aspect of the meso-level of the conceptual framework that was described by Farrell (2001). Being viewed as 'just a student' is also incorporated in the macro-level of the conceptual framework described by Farrell (2001) as this condition is relevant to the nursing students' position in relation to powerful others and incorporates the marginalisation and disempowerment that results. There is a distinct hierarchy in the nursing profession and this results in exclusion of nursing students from the group. Nursing students are

in the position of being a beginning practitioner placed in a clinical setting for experience and as such they have no real place in the organisational hierarchy of the facility where they are placed.

It became apparent in the analysis of the data that there were two aspects to the condition of staff identifying participants as being viewed as 'just a student'. The first aspect related to the context that they had no skills and subsequently had no scope of practice. The second aspect of this condition related to the perception of the students that the staff felt they were simply there as an extra set of unpaid hands that could be utilised to complete the tasks that the staff did not wish to undertake. This was particularly apparent in the aged care setting; however it also appeared in the data related to the acute care setting.

The student's perception that they were in the off-campus clinical setting as a set of extra hands was utilised by the staff to ensure that the nursing students remained aware of their place in the hierarchy and in a number of cases the participants were reminded that they were 'just a student' and that they were at the very bottom of the hierarchy. Nursing students perceived that although they felt they had a greater level of education than the assistants in nursing in the facilities, they were still viewed as being at the bottom of the hierarchy. The perception by nursing students that they are considered to be at the bottom of the hierarchy is supported by Farrell's (2001) meso-level perspective of the framework as the organisational structure is evident. Data analysis revealed that there was potential for a long serving staff member at the assistant in nursing or enrolled nurse level to be perceived as being at the top of the

hierarchy, with registered nurses and other staff taking a place that was perceived to be subordinate.

Nursing students are often assigned the menial tasks in the clinical setting which are traditionally completed by the assistants in nursing; this creates an air of tension between the students and the assistants in nursing as the assistants in nursing view the students as taking their jobs. Participant G perceived the auxiliary nursing staff as viewing the students coming into the off-campus clinical setting and completing the tasks which were usually completed by the assistants in nursing and the enrolled nurses. Whilst the nursing students believed that the staff should be happy that their workload was being reduced by the students, they felt that the staff believed they were taking work away from the staff. Nursing students would prefer the opportunity to undertake the tasks associated with becoming a registered nurse; however it is the registered nurse who delegates the tasks with the students compelled to accept what the registered nurse gives them, all the while undertaking tasks the assistants in nursing would normally do; thus potentially upsetting the hierarchical balance through complying with directions from the registered nurse.

The exclusion of the nursing students from patient-based decisions, even under the direction of a staff member, was evidenced in the study. Participants also indicated that they were segregated in the handover process and in many instances were not actively included in the handover process. This insulation of the nursing students from the everyday team work and decision making at ward level is supported in a study by Howe (2001) which found that newly graduated nurses were not involved in patient-based decisions and none of the participants in the Howe (2001) study

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were included in the ward meetings, with some not advised that the meetings were occurring.

The findings of Howe (2001) concur with the findings of this current study in relation to the failure of nursing staff to encourage nursing students to be a collaborative team member. Howe (2001) argues that it is important that the 'junior' staff members who are new to the clinical area are included in the day to day activities of the team. This results, in the view of Howe (2001), in a more positive nurturing environment in which all members of the team feel worthy and recognised for their input into the dynamics of the workplace. Brammer (2008) identifies the monitoring and supervision of nursing students by the registered nurse as a 'gate keeping' function in which the registered nurse is responsible for ensuring that the nursing student is undertaking tasks in a safe and competent manner.

Students are placed into clinical facilities in a supernumerary capacity to allow them the opportunity to develop within a supportive learning environment nurtured by experienced members of the nursing staff (McGowan & McCormack 2003). Patton and Cook (1994) indicate that supernumerary status is predicated on the assumption that a one-to-one relationship facilitates learning and socialisation into the role of nursing. The volume of literature dealing with the concept of supernumerary status is limited and the literature dealing with how students experience this concept is even more limited.

According to Watson and Norrie (1997), supernumerary status has never been straightforward to define, understand or implement. Watson and Norrie (1997) point

to a fundamental bifurcation in the interpretation of supernumerary status with the English General Nursing Council and the Royal College of Nursing adopting conflicting views which echo an underlying struggle between academia and service. A similar situation appears to occur in Australia. Universities expect that the nursing students will be placed in the clinical facilities as supernumeraries; however because of the critical shortage of nurses and auxiliary staff the supernumerary status of students is often questionable as they sometimes undertake the duties of paid staff members.

Issues associated with supernumerary status were experienced by a number of the participants in this study as described in Chapter Four and this is echoed by the findings of White (1993). White (1993) found that the qualified staff in the clinical facilities understood what supernumerary status meant; however it was not adhered to when the staffing levels fell. This was further underlined in a study by Endacott *et al.* (2003) who argued that despite the supernumerary status being implemented to ensure that the student's learning needs were of paramount importance, managers did not necessarily subscribe to this approach and they would consistently suppress learning requirements in favour of service needs.

Essentially the purpose of students being supernumerary was to facilitate the role of being a learner with proponents of supernumerary status envisaging that the workload that was left behind could be picked up by the auxiliary staff and care assistants (Ormerod & Murphy 1994). There are however negatives to this approach and McGowan (2006) identifies the issue of students being made supernumerary to ensure that they are not used as extra hands leading to a situation where they miss

out on fundamental nursing experience and run the risk of being excluded from the nursing team. McGowan (2006) unambiguously supports Downes (2001) in a declaration that supernumerary status is one of the key elements that contributes to the student nurse's perceived and actual lack of clinical skills.

Downes (2001) further argues that the nursing staff are acutely aware of their responsibility for the actions of a student, indicating that nursing staff may have been responsible for curtailing students' practice due to a misplaced fear of being accused of irresponsibility or demonstrating their inability to judge a student's capabilities prior to delegating or allowing a task to be completed. In a profession such as nursing where overt judgement skills are viewed as a core characteristic, this fear of irresponsibility and the fear of not meeting the expectations of the student in relation to their own skills are of particular relevance. In the current study, participants discussed the issues associated with nursing staff either delegating menial tasks or deliberately completing tasks in the absence of the student when the staff were aware that the skill was required as a component of the placement.

Effective supernumerary status in conjunction with an effective mentor program was however seen to have a positive impact on the student experience of nursing (Spouse 2000). This was evident from the discussions in this study whereby students related positive outcomes for them as a result of being supernumerary and positively supported by staff. Following the implementation of an effective supernumerary status in Ireland, Hyde and Barry (2002) identified animosity arising between the staff and the students due to the supernumerary students upsetting the ambient social structure that normally operated in the clinical setting. Animosity arose as the staff

were unable to 'pigeon hole' the 'new' students. There was evidence of staff pigeon holing students as being 'just students' in the current study. As described above this notion is apparent in the literature. The students perceived they were viewed as having limited scope of practice and in a number of instances the presence of a supernumerary student upset the balance of the workplace. Castledine (2001:626) effectively summarised the issue of supernumerary students when he stated:

> … whatever new strategies are used one thing should be made clear: student nurses' supernumerary status means that students must still get involved in practice so that they can realise not only their own needs but also their professional responsibilities.

The participants indicated that they were involved in the practice of nursing; it was just that the involvement was often as an extra set of hands undertaking the work of the auxiliary nursing staff. This does not allow the nursing students the opportunity to realise their own needs and subsequently develop their professional abilities.

In the analysis of the data it became apparent that the participants were familiar with the role of being a supernumerary member of the nursing team. There appeared to be a degree of confusion about what it meant to be 'a student' in the clinical setting. As the nursing student tries to determine where they fit within the structure of the placement they experienced a degree of internal conflict which increases the level of anxiety the student experiences and impacts upon their clinical experience. This is apparent through the participants indicating that they are either just observers or misinterpreting what being involved in the workload meant. This confusion in respect of what it meant to be involved in the workload is based on the construction of meaning in accordance with how the students, as individuals or as a group, interpret the symbolic interactions between themselves and the staff.

In the current study, whilst the students were fairly cognisant of the requirements, the participants perceived that the staff were often unsure of what the students' role as a supernumerary member of the nursing team involved. An explanation of what supernumerary status involves and the scope of practice of nursing students would alleviate a considerable amount of the tension that is felt by staff, thus reducing the anxiety experienced by students.

The reality for the nursing students is that they are not there to make up the numbers; however in a number of instances they are included in them. This has far reaching effects both for the nursing students themselves and the staff that are working in the facilities. It became apparent that the staff in a number of clinical settings 'pigeon hole' nursing students in an effort to control the nursing student's position in the hierarchy. An inability by the staff to effectively 'pigeon hole' the students results in a degree of animosity between the staff and the students with both sides unclear of the expectations of the other. Whilst the students are aware of what they are allowed to do, the staff are unsure of what the scope of practice for a student is; add to this the issue of supernumerary status and the staff become increasingly confused as to what role the student plays in the clinical setting. The reality is that the nursing students need to be able to access clinically relevant skills, and because of confusion between staff and students this is not occurring in all settings.

McKenna *et.al.* (2003) in a study of the experiences of newly registered nurses, found that they reported being undervalued by their peers. Whilst the nursing students are beginning professionals, it is necessary to recognise that despite this

fact, the nursing students are able to bring something to the clinical setting; it just may not be at the same level as an experienced staff member.

Student performance

Nursing students perceive that they are viewed as being 'different' by the nursing and auxiliary nursing staff. Whilst it is possible that the nursing and auxiliary staff may feel that the nursing student should be performing at a higher level because of the nursing students' training; there is an element of control on the part of the staff which ensures that the nursing students are 'controlled' and undertake limited tasks. This disparity between the levels of education tends to lead to conflict between the nursing students and the auxiliary nursing staff as well as the nursing staff trained under the traditional education model.

Participants perceived that there were issues surrounding the fact that they were studying towards a Bachelor's Degree in Nursing. There was a perception on the students' part that there was a level of bias directed towards them from the assistants in nursing and enrolled nurses and to a certain extent also from the registered nurses who were perceived by the participants as being university trained. It became apparent that there was a certain stigma attached to getting the Bachelor of Nursing degree and this was especially prevalent in the cases where the participants were already employed as an enrolled nurse in a clinical facility. Data revealed that the nursing staff at the enrolled nurse level felt threatened by the fact that a peer was obtaining a higher educational qualification and there were comments made to the participants about not coming back to the facility thinking that they could then tell

the enrolled nurses what to do once they had attained the Bachelor of Nursing degree. Participant X perceived that the enrolled nurses in the facility where the participant worked were of the opinion that the participant had crossed the line and gone to the other side.

Analysis also revealed that the staff were not keen to assist students to attain the required skills as there was perceived to be a belief amongst the staff that if a student is undertaking the BN, then they already have the knowledge and therefore they don't need to be shown anything else. This behaviour was demonstrated by both the traditional (hospital) and the university trained registered nurse; however it was also demonstrated by the auxiliary staff. Nursing requires the integration of both the theoretical and the practical components and this can only be achieved in a supportive learning environment.

An interesting discovery from the data was that the nursing students became defensive about the level of education that they are receiving through undertaking the Bachelor of Nursing degree. This defensiveness led to the generation of further internal conflict as the participants justified their educational experience. It became apparent from the analysis that the assistants in nursing, and to an extent the enrolled nurses, in the clinical settings were threatened by the level of education that the students had by the time they were placed in the facilities and this served to increase the perceived conflict between the staff and the nursing students.

A number of the participants indicated that the hospital trained registered nurses were envious of the educational level and the theoretical exposure that the students

received through the completion of the Bachelor of Nursing program. Participants perceived that the registered nurses who were hospital trained felt that the educational level of the university trained students was an advantage to the profession and many indicated that they wished they had the same level of training in the theoretical aspects as the current Bachelor of Nursing students. Hospital trained nursing staff are able to empower nursing students with their years of valuable clinical nursing experience and this creates a positive learning experience for the nursing students. A number of the participants perceived that they could learn more from a nurse with 30 years experience in a clinical setting than they could from a university trained nurse with five years experience. Similarly, a number of participants indicated that they perceived that an enrolled nurse or an assistant in nursing with extensive work experience had more to offer than a university trained nurse with limited clinical experience post graduation.

Whilst the nursing students were defensive of the university level training that they were receiving, the students' felt that the staff who were perceived as being hospital trained were better at mentoring students as they had possibly undertaken the role of mentoring junior nursing staff in the hospital based apprenticeship model. As no data was collected from the staff who were mentoring the participants in this study, any reference to hospital trained staff is reliant on the perceptions of the participants and in some instances direct evidence in the data through the students being able to confirm that the staff were hospital trained during their conversations with the staff. As has been alluded to previously, the hospital trained nurses were envious of the level of education received by the nursing students and in some instances the staff indicated that they wished that they had have had the same opportunities. This would

indicate that the hospital trained nursing staff felt that the current tertiary model of nursing training is superior to the traditional training model.

Nursing education is delivered within the context of a university curriculum and includes study in three major strands: nursing practice (theory and practical), professional nursing development (behavioural sciences, law and ethics) and sciences (anatomy, physiology, microbiology and epidemiology) (Sengstock, Moxham & Dwyer 2006). University education equips the students with a holistic approach to the care of patients including the social and psychological aspects of care. Nursing students are encouraged to incorporate this into their everyday care (Howe 2001). There is scope in some university nursing curriculums for students to study alternative forms of health care such as non-western medical and nursing practices (Howe 2001). Rather than the nurse developing as a practitioner[11] focused on practical task oriented work, the nurse is developed as an individual practitioner and the 'profession' of nursing is developed. Hospital trained staff on the other hand received a far more vocationally oriented training program which led to a more task focussed environment in which tasks were done with limited understanding of the theoretical aspects. The different learning approaches between the vocational and university training approaches leads to conflict in the off-campus clinical setting and subsequently impacts on the development of professional identity.

Duffy (1995) discusses the issue of conflict arising in the clinical facilities between staff who have had a different focus in their learning compared with students who

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[11] 'Practitioner' in the context used here is as a person who 'practices' nursing. It is not to be taken in the context of the clinical designation of Nurse Practitioner in which the individual nurse has undertaken postgraduate study and gained advanced skills to attain the standing of Nurse Practitioner in the structure of the profession.

are now learning in a very different model of nurse education. In one model there are the nurses that practice task focused work whilst in the other model there are nurses graduating from university with a very different approach to their nursing practice. It is, according to Duffy (1995), this difference in nursing ethos that leads to a degree of animosity between the staff and students. Interestingly in this study the data indicated that it was not the hospital trained registered nurses who were responsible for the internal conflict experienced by the nursing students, rather it was the university trained nursing staff and the auxiliary nursing staff. The degree of animosity described by Duffy (1995) between the hospital trained staff and the university trained nursing students was not apparent in this study. This is interesting and warrants further study.

The task oriented practice of the auxiliary nursing staff could be perceived as being the reason for the animosity between the auxiliary nursing staff and nursing students in that the nursing students are encouraged through the university curriculum to develop as independent learners who are encouraged to practice in a relaxed team environment with increasing independence and a reduced hierarchical structure. Duffy (1995:12) saw the:

> … continuation of traditional beliefs in nursing practice as defining for participants the reality of daily practice. While some participants professed to be non-traditional in their practice, it became evident that they were actually operating within a traditional framework, one which has mystified the reality of power relations in nursing.

Duffy saw this mystification of reality as creating contradictions and problems in the participant's daily practice. This study identified that the auxiliary nursing staff are practicing in accordance with the traditional task-oriented model of nursing. There

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were some participants in this study who initially tried to reject the traditional approach that was utilised by the auxiliary nursing staff; however in a similar situation to the participants in Duffy's (1995) study they were forced to 'submit' to traditional practices.

A small number of the participants in this current study have current experience and employment as enrolled nurses and data revealed an interesting issue in relation to this experience. The issue of disclosure of this was a carefully considered aspect amongst the participants with this experience. The decision to disclose was a conscious one based on the participant's individual perception of the environment and the staff with whom they were working. A number of the participants chose not to disclose their experience, thus 'acting dumb' in an effort to gain exposure to the requisite skills and knowledge.

In the event that the participant did disclose their previous employment they indicated that they were expected to undertake a greater load than the participants without the same experience and this load was increasingly unsupervised. Participant A related an incident where the staff realised that the participant had experience as an enrolled nurse and the subsequent response was "Great, you're already a nurse; there are ten showers that need doing, and off you go'. This leads to the participants with the existing nursing knowledge not gaining adequate exposure to skills that they require as a registered nurse. This is an area of concern for students as they are supposed to be training as registered nurses and yet if they disclosed their existing nursing knowledge they were not exposed to or given the opportunity to practice the

necessary skills. This, in the eyes of the participants, could jeopardise the outcome of their placement in terms of their grade.

Time management in nursing

Nursing students experience time related issues in two forms. The first is the perceived lack of time that nursing staff have to teach nursing students and the subsequent expectation by the nursing staff that the nursing students should be able to perform at the same level as experienced staff members. Nursing students perceive an air of impatience from the nursing staff in this situation. The second element is the pressure that students experience related to having to complete a full-time university workload whilst also undertaking the requisite clinical placements resulting in a perception of having to race against the clock to complete the assessment items. The specific behaviours associated with the time/task imperative are acknowledged in the conceptual framework developed by Farrell (2001) at the meso-level perspective of that conceptual framework.

Nursing students perceived that being pressured to perform at the same level as a qualified staff member, whether that was an assistant in nursing, enrolled nurse or registered nurse was inappropriate in that the nursing students were still learning and were not able to complete the tasks as quickly as the staff who were experienced in the clinical setting. Participants related incidents where staff had instructed them in completing a task and they were told they were not completing the task fast enough. Interestingly a number of the participants indicated that the registered nurses would tell the nursing students, generally through the use of non-verbal communication, to

hurry up; however they would throw in a couple of extra questions along the way in an effort to see if the student was able to answer the question and complete the task at hand. Whilst the participants perceived this as a negative, in reality this approach may well be a positive in that the nursing staff are ensuring that the nursing student is able to undertake the administration of medications in a safe and competent manner.

Students are placed in the learning environment to integrate theory into practice and they need to understand the rationale for the completion of the procedure. Through feeling rushed by the nursing staff the students felt as though they were losing valuable learning opportunities and this impacted on their overall ability to meet the learning objectives of the placement. The participants in this study perceived this approach to be inappropriate as they felt they should be learning the skills and when the skills were achieved the time management skills will follow. This is reflected by the findings of Delez (2003) in a study of horizontal violence in the American nursing education setting. This study found that the time constraints appeared to be more apparent in the aged care setting with the participants being forced to meet time imperatives which were based on the time it took experienced staff to complete the same tasks.

Farrell (2001) identified a task-time imperative in the nursing profession. Farrell (2001) argues that this imperative is evident in that the staff are required to undertake and complete specific tasks at dedicated times throughout the shift. Whilst the administration of medications and certain procedures is critical to accurate timing, there are tasks such as showering which are not time critical; however the staff view

these tasks as having to be completed within a set time-frame and failure to complete these tasks within the time frame creates conflict. Therefore, there are two approaches to the task-time imperative which Farrell (2001) identifies. The first is the dedicated time where a task needs to be undertaken at a specified time, whilst the second is the length of time taken to complete a task. Similar conflicts were reported by Duffy (1991) in a study of horizontal violence in nursing workplaces.

As has been indicated previously, nursing students will not be able to perform at the same level of proficiency or speed as the paid staff and as such the nursing student may take longer to complete the task, thus resulting in a degree of frustration on the part of the nursing staff toward the student. It is also possible that the nursing staff are under pressure due to the task-time imperative and this places the nursing staff under pressure to perform tasks in a set time. Evidence in this study of this task-time imperative impacting on nursing staff is evident through the reporting by participants of the nursing staff telling students to go away because they do not have 'time' to answer their questions. In this instance the staff are not necessarily feeling frustrated by the questioning of the nursing student, rather they are demonstrating their own frustration with the time frames in which they are required to operate.

The time constraints which are placed on the students made the students feel unwanted and in the way of the staff. Essentially the staff made the students feel as though they were a burden. The time constraints that the students experience create a perception in the eyes of the nursing student that they are unable to meet the learning outcomes to the best of their ability. It is part of the learning experience that the nursing students develop the organisational ability to complete competing tasks

within set time parameters. Nursing students who are stressed because of the situation in which they find themselves may not be able to achieve optimal levels of learning and this then has a compounding impact on the nurse-student relationship.

Whilst participants identified time constraints in the off-campus clinical setting, they also identified a concern with managing clinical commitments with ongoing study and personal commitments. The time constraints that nursing students perceive in not being able to juggle clinical commitments with the university and work commitments that individual students have, impacts on the students' ability to meet the requirements of the program. Therefore the issues associated with time management in the clinical setting and outside of the clinical setting can create a negative experience for the students and can impact negatively on the nurse-student interactions.

Participants entered the off-campus clinical setting with the expectation that they would be able to address the stated learning outcomes for the placement. Participants in the study identified a number of reasons that they felt the expectation of achieving the learning outcomes was not possible. This inability to achieve the learning outcomes that the nursing students expected to complete is related to the macro-level of the framework in which the dominant group inflicts such acts of violence as denial of power, control and access to rewards (Farrell 2001).

This reference to dominance is related to medicine and the organisational administration which generally demonstrate a degree of dominance over nursing. It is feasible however that the nursing and auxiliary nursing staff feel that they have a

degree of dominance over the nursing students and as such they demonstrate the hierarchy that exists in nursing. Dominance over nursing students is demonstrated through the staff and the administration regulating what the nursing students can and cannot do in the clinical setting. This demonstration of power over nursing students also extends to the University and the Queensland Nursing Council (QNC) as both these organisations place restrictions on what nursing students can and cannot do in the off-campus clinical setting. The dominance exerted by the universities and the nursing registration boards is for different reasons, including curriculum and compliance with statutory requirements.

The placement of restrictions on the activities of beginning professionals is not limited to the nursing profession as other professions demonstrate similar controls. The legal profession, through the various law societies and the *Legal Practice Act 2004* which operate in the different jurisdictions, restricts the activities of beginning practitioners as does the medical profession through the Medical Registration Boards. This indicates that the nursing students are not the only ones in the professions who are having their access to learning opportunities restricted. This is significant in that not only does the literature support the findings of this study, but it also indicates that the access to learning opportunities is being blocked even after the nursing students gain employment. Blocking of access to promotion and learning opportunities has an impact on the development of a professional identity through forcing the students to comply with the requirements of the registering bodies in order to gain professional recognition. Jackson (1970) indicates that the norms of practice enforced by the profession are more stringent that the legal controls which are applied. When professionalization of an occupation occurs, certain aspects

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become more pronounced, for instance the existence of a professional subculture with an explicit or implicit code of conduct.

Professional identity

It was suggested by Wilkes and Wallis (1993) that the caring attributes of nursing students develop over the three years of their program. This was supported further by Wilkes and Wallis's (1993:21) assumption that "it may be speculated that these caring attributes are best learned through experience". This development of a caring and compassionate nature throughout the nursing program is an aspect of professional identity development. Napthine (1996) concurred with this and cited the Australian National Nurse Education (1994) review in which the quality of nurse education is described as being dependent on the quality of a student's clinical experience.

The current study was reflective of this in that the experiences of the students varied between the clinical settings and also within the clinical facility. Whereas nursing students may have been accepted as a part of the nursing team on one ward within a facility, another ward may isolate the students and make the nursing students feel unwelcome. This scenario was evident in the discussions throughout the study in that while participants had positive experiences in some clinical settings, this was subject to change both between and within the clinical facilities.

The culture of the facility or the specific unit of the facility where nursing students are placed can have a marked impact upon the nursing student's developing identity

as a nurse, due to the negative workplace environment. The unwillingness of the staff in some facilities to accept students is a cultural issue that impacts severely on the student's ability to develop the skills required as a registered nurse. The attitudes of the staff in the facilities where the students are placed were an issue that cannot be underestimated in the development of professional identity. Where participants were placed with an enthusiastic mentor in the clinical setting, the impact was considerable and positive. The participants experienced a 'breath of fresh air' when placed with a registered nurse who wanted to mentor a student. In this instance the nursing students perceived that their opportunity to learn had increased dramatically. The opposite was however the case when the registered nurses do not want a student in the clinical setting.

Participants indicated that in the event that the registered nurses were either unwilling or unable to accept students due to the staffing levels in the facility, participants were not supported by other staff such as other registered nurses. Rather, they were left to complete the unfinished work normally undertaken by auxiliary nursing staff, or these tasks were delegated to the nursing students from the outset. Lloyd-Jones, Walters and Akehurst (2001) found in their study that those students who did not work with a mentor were usually not supported by any other registered nurses, thus resulting in the student being delegated auxiliary nursing tasks. This study reflects Lloyd Jones *et. al.* (2001) in that the researchers in that study found that the delegation of auxiliary nursing tasks due to a lack of mentors significantly impacted on the learning outcomes of the students and thus had a direct impact on the development of identity in nursing students.

In the current study it was identified that the participants were being used as 'extra hands' in the event that the facility experienced staffing difficulties. This experience is reflective of the experiences of students in a study by Napthine (1996) which reported instances of staff being removed from the roster in the periods of time when nursing students were placed in the facility. Whilst this study did not seek evidence of staff being deliberately removed from the roster, nursing students perceived that they were used as unpaid extra hands. Thus the nursing student felt that they did not have the opportunity to gain the experiences that were required to meet the learning outcomes required for the program.

The categories of *'tradition bearing'*, *'staff'* and *'student performance'* intersect to create *'place'*. The concept of *'place'* is related to the interactions of the categories in that the students are required to follow the traditions of nursing and these are enforced, both overtly and covertly, by the staff in the facilities who have taken on the tradition bearer role. *'Tradition bearing'* has an impact on the '*staff*' and '*student performance*' in the clinical setting as the staff attempt to stay within the traditional bounds of the culture and the students as they attempt to determine the boundaries of the traditions. This interaction between the three categories clearly impacts upon the position that the student holds within the clinical setting and the broader profession. As a consequence of the anxiety that the nursing students experienced they made a concerted effort to determine where they fit within the hierarchy. Students' experienced varying degrees of anxiety and these levels of anxiety are more likely to be related to their interactions with the nursing staff than the students workloads and the patient care that they are delivering.

Basic Social Process

The basic social process that the participants experienced was '*anxiety*' and to manage the impact of the conditions affecting the basic social problem a strategy of 'not ruffling feathers' was utilised. This aspect is important as it is the means by which the participants in this study attempted to control and minimise the effects that the negative workplace behaviours had on their ability to learn and develop the requisite skills required of a beginning RN. This required the participants to realise that there was a problem and then identify the consequences of the problem. It was then necessary to identify a way of addressing the problem and this utilised both explicit and implicit strategies.

'Not ruffling feathers' meant that the participants went into the clinical setting, followed the directions given and did not attempt to effect cultural change within the context of the clinical setting. Participants found it was important to accept the culture as it was, as any attempt to effect change, or any attempt to step outside of the accepted norms of the setting resulted in negative consequences for the participants. It was apparent in the data analysis that the consequences could be both immediate and delayed.

Whilst there were consequences for stepping outside the traditionally accepted boundaries, it was evident that the nursing students were responding to the stressors to which they were exposed in the off-campus clinical setting in an effort to avoid the sanctions imposed by staff. The stressors to which the nursing students are responding to are not physical stressors, rather they are psychological stressors which impact on the development of a cultural identity. These psychological

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stressors are the anxiety and internal conflict which result from the participant's interactions with the staff and with the off-campus clinical setting itself. This manifests in varying forms depending on the individual participant. Whilst some participants questioned their decision to become a nurse, others experienced stress related health issues which led them to question the purpose of studying to become a nurse. In an effort to address the stressors associated with developing a professional identity in the off-campus clinical setting the nursing students in this study tended to adhere to the unwritten rules which formed the implicit code of conduct. This meant following the accepted practices in the facility in an effort to meet the requirements of the clinical placement.

The findings of this study indicate that the maintenance of the status quo is necessary for the students to gain at least some experience in the clinical setting. Participants who did 'ruffle feathers' soon realised that doing so resulted in sanctions and these sanctions were vigorously imposed by the nursing and auxiliary nursing staff. One participant indicated that because they asked questions they perceived that they had received lower grades than the other students in the group who maintained the status quo. Participant B perceived:

> *I asked questions endlessly for the learning experience. I got passes ... I received the lowest sort of grade out of all my peers.*

Participants indicated that the sanctions that were imposed by the staff in the facilities had long lasting effects on their future study and employment opportunities. Participants experienced a degree of internal conflict as they attempted to determine where they fitted within the hierarchy, both at the facility and the professional level. This internal conflict was related to as:

I figured if I am at that level, and I had seen my peers at work, then I have really misjudged what it is to be a nurse. (Participant B)

The nursing students just want to become registered nurses who are equipped both practically and theoretically to deliver optimal nursing care to the patients.

It is possible to draw similarities between the experiences of nursing students in the off-campus clinical setting with the experiences of part-time professional employees in other professions. Essentially the nursing students in the off-campus clinical setting are transient in nature, as are part-time professional employees in many organisations. Lawrence and Corwin (2003) proposed a theory of professional part-time employment and suggested that part-time professionals had two choices if they did not wish to be marginalised in the workforce. These choices were "compliance with existing rituals, and the innovation of new rituals" (Lawrence & Corwin 2003:936). Compliance equates to 'not ruffling feathers' and as the nursing students were not in a position of innovation to implement new rituals to any great extent, compliance is the safer option if they are to succeed and graduate.

Whilst the participants indicated that they were not prepared to 'ruffle feathers', a number of participants indicated that they were subtly attempting to change the existing rituals which were *in situ*, but participants were well aware that the innovation of these new rituals would be a slow process. It was suggested by Lawrence and Corwin (2003:936) that:

> … part-time professionals will be more likely to engage in compliance strategies when (a) they have little access to organizational resources or power, and (b) they view their part-time status as short term.

This is especially relevant in the case of the nursing students as they have very limited access to organisational resources or power and their part-time status is at least in the initial stages, short term. The work of Lawrence and Corwin (2003) in relation to part-time professionals is reflected in the findings of this study. The majority of the participants adopted compliance strategies to cope with the issues that they faced in the off-campus clinical setting in the face of negative workplace behaviours. As the nursing students are also situated at the very bottom of, and outside, the nursing hierarchy, it is unlikely that they would have the access or the ability to effect new rituals. Lawrence and Corwin (2003) indicate that it is usually the full-time staff in the higher positions in the organisation who have access to the power and resources necessary to effect change. Without the resources and the power to effect change the nursing students in the current study are left at the bottom of the hierarchy to creatively idealise about potential innovative strategies to address the inequalities that currently exist in nursing practice.

The strategies utilised by the nursing students in an effort to cope with the basic social problem of trying to determine where it is that they fit in the hierarchy is essentially an individual process that is traversed by each individual student throughout the process of becoming a registered nurse. Whilst the process was an individual one, it was also a joint process, as the nursing students discussed their experiences with each other. There was however an apparent lack of awareness, even amongst the students themselves, regarding what they were actually doing in response to the internal conflict that they were experiencing. The anxiety is experienced as they transitioned from being a 'non-nurse' to a registered nurse at the end of the three years (or equivalent) time period that is necessary to meet the

requirements for registration. Literature also indicates that the levels of anxiety continue into the nurse's graduate year in employment (Mooney 2007).

The greatest cause of anxiety was negative workplace behaviours and the students' interactions with the staff in the off-campus clinical setting. This anxiety was exacerbated by uncertainty in relation to competence and accountability on the part of the nursing student in the off-campus clinical setting. Mooney (2007) proposed that the anxiety experienced by nurses as they continued into their graduate year of employment was centred on uncertainty relating to clinical competence and accountability.

Individual nursing students were using a strategy of 'not ruffling feathers' to overcome and adjust to the challenges that they encountered in the off-campus clinical setting. Rather than working collaboratively, individuals were using reactive strategies rather than a proactive approach to solving or limiting the overarching problem of internal conflict. Individuals in the healthcare and university sector at the macro-/meso-levels had not developed interventions at either the organisation or facility level to be systematically applied to address the issues experienced by nursing students as these issues were unknown and the purpose of this study was to address this dearth of knowledge. This may be due to an unawareness at the micro-level that a problem actually exists and this then results in the concerns of the nursing students not being fed up to the macro- and meso-levels of the healthcare and educational institutions.

Nursing students are needed in increased numbers to meet the ever increasing demand for registered nurses due to the critical shortage that is currently being experienced on a global scale (Oulton 2006). Nursing students are 'accommodated' rather than 'accepted' in many of the off-campus clinical settings where they were placed and some participants had considered leaving the profession as a direct result of the treatment they received from the staff whilst on clinical placement, and the internal conflict that they experienced as a result of their interactions with staff. Whilst the comments of O'Brien-Pallas, Duffield and Alksnis (2004) were related to the retention of nurses nearing retirement in New South Wales, their comments are pertinent to the workforce planners of today in an effort to retain nursing students after they graduate. O'Brien-Pallas *et al.* (2004:299) proposed that "… workforce planning and policy development based solely on 'head counts' and financial concerns are unlikely to be effective or sustainable."

This study can assist the workforce planners and educational facilities to develop proactive approaches in an effort to minimise the negative impact that is currently experienced in the off-campus clinical setting. It is necessary for the current strategies utilised by nursing students, in an effort to overcome the internal conflict and anxiety they experience in the off-campus clinical setting, to be extended beyond reactivity to the psychological stressors which trigger this reaction. Further research would assist in supporting the development of new rituals which are more appropriate to the contemporary practice of nursing and which are more in accordance with contemporary human resources management practices.

The identification of the condition, '*anxiety*' as the basic social process that nursing students experience as a result of the challenges associated with negative workplace behaviours that they faced in the off-campus clinical setting represents new knowledge in the field of nursing education. Increased levels of anxiety and internal conflict is resultant from the student's interactions with the nursing staff and the off-campus clinical setting as a result of the interaction of '*tradition bearing*', '*staff*' and '*student performance*'. In positive and supportive learning environments it was apparent that the interaction of the conditions, as the students attempted to manage their clinical experience, was minimal in comparison to less supportive clinical settings. Participants who found themselves in challenging situations due to unfavourable interactions with staff had difficulty in identifying where they fitted within the facility and the profession as a whole. As a means of dealing with the levels of anxiety and internal conflict which they experienced, students adopted an approach which involved 'not ruffling feathers' if at all possible. The discovery of this new knowledge is an important contribution which enhances the current level of knowledge and provides a valuable guide for future research in the experiences of undergraduate nursing students in the off-campus clinical setting.

Conclusion

This chapter has discussed findings and integrated the findings of existing literature. Literature has been used to substantiate study findings and in instances where findings of the current study are not supported by the existing literature, argument is presented to justify them. This study has highlighted the theory that nurses behave

badly towards each other, and to nursing students, as a result of their being an oppressed group and has considered the impact that this may have on professional identity development. The immediate impact of the negative workplace behaviours is anxiety and decreased learning opportunities in the off-campus clinical setting. Previous gaps in the existing knowledge were identified and the discussion draws attention to how the current study's findings provide a significant contribution to knowledge. This chapter further developed the central tenets of the argument which founded the developed theory and advanced this theory. Chapter Six emphasises the implications for nursing practice, nursing education, organisational knowledge, theory and research. Chapter Six also provides an evaluation of the grounded theory study that forms the basis of this thesis.

Chapter Six – Conclusion and Recommendations

Introduction

Chapter Five provided a discussion of the substantive theory of nursing students' experiences in the off-campus clinical setting. Existing theories and the literature that was available in relation to the study topic was utilised to contextualise the study. In this chapter the achievement of the study's aims is demonstrated, with the substantive theory being evaluated using the criteria proposed by Charmaz (2006). Following this evaluation the methodological approach utilised in this study is used to position the use of Constructivist grounded theory as it was applied in this study. Conclusions are then presented by drawing together the major aspects of the previous chapter. These conclusions emphasise and identify the implications of this study's findings for nursing practice, nursing recruitment and retention, nursing education, organisational knowledge, theory and research. The study limitations are acknowledged and the recommendations from the study are presented in the final section of the chapter. The chapter concludes with some final remarks about the study findings.

Achievement of the study's aims and objectives

In Chapter One it was discussed that the aim of this study was to identify and contextualise the experiences of second year undergraduate nursing students in the off-campus clinical setting and to develop a substantive theory that explains how the

nursing students experience the off-campus clinical setting. In Chapter Four the basic social problem was identified and the conditions that led to, and explained, this problem were explicated. The contextual conditions were described and through the discussion of these it was possible to explain why nursing students faced challenges in determining where they fitted within the hierarchy of nursing as a profession and also within the facilities where they are placed. The basic social process, '*anxiety*', was also presented in Chapter Four and this provided an explanation of how the nursing students in the study responded to the basic social problem. The latter stages of Chapter Four presented and described the substantive theory that was developed. The objectives and the aims of this study have therefore been achieved through the discovery and description of the problem, conditions and responses that led to the discovery of theory.

Evaluation of the Grounded Theory

The following evaluation considers the position of the author through the course of this study in relation to what has been gained through a reflection into the journey, and through looking forward to imagining how the endpoint appears to the reader. Charmaz (2006) argues that the endpoint of the research makes sense to the researcher as they have been immersed in the process; however, for the reader the lines between process and product can become blurred. Charmaz (2006) indicates that other scholars are liable to judge the grounded theory process as an integral part of the final product and as such proposes that researchers need to consider their audience. Whether that audience is nurses, nurse educators or academic colleagues, ultimately they will be the ones that will judge the usefulness of the methods

employed through the quality of the final product. In an effort to ensure that the criteria for grounded theory have been met, a review of the credibility, originality, resonance and usefulness of the study reported in this thesis is presented in the following text.

Credibility

This study's credibility is demonstrated in that the research achieved intimate familiarity with the research topic through immersion in the data. Whilst the source of the data was a single university School of Nursing, data were collected from a number of sites and from participants with diverse experiences both within the nursing profession and from previous employment experiences outside of the nursing profession. This facilitated credibility as the participants with experience in other professions and employment provided an opportunity to make systematic comparisons between their experiences and the experiences of the participants with previous nursing experience. Such comparisons formed an important component of data analysis.

This thesis provides links between the data that were gathered and the final theory that was developed. The links between the data and the theory are demonstrated by the provision of excerpts from the interviews and the development of the categories which provided an insight into the data that informed the development of each of the categories. These excerpts and the associated discussion are provided to allow the reader the opportunity to develop an independent assessment of the study.

Originality

The categories that were presented in this report are original and offer new insights into the topic of how undergraduate nursing students experience the off-campus clinical setting in relation to negative workplace experiences. Prior to the commencement of this study there was limited knowledge and understanding of the experiences of negative workplace behaviours by nursing student in the off-campus clinical setting in a regional setting. The analysis of the data has provided a conceptual rendering of the experiences of the nursing students and explained the realities associated with the development of a cultural identity and being a nursing student in the off-campus clinical setting in a regional context. This is an original approach to studying the experiences of nursing students in the off-campus clinical setting as the majority of the studies which are undertaken primarily focus on the experiences of staff in the larger centres. This study has focused on the experiences of students outside the metropolitan area. Originality is further enhanced as there are limited studies investigating the development of professional identity in nursing students.

There are both social and theoretical implications from the study. The theoretical implications are that for the first time there is a theory of the effects of negative workplace experiences on nursing students in the off-campus clinical setting and this can be used to explain some of the experiences of being a nursing student. Furthermore there are societal and professional implications as the issue of workplace aggression between peers is highlighted and the costs to the nursing student in the terms of developing their identity as a nurse are highlighted. Through

achieving a greater awareness of workplace conflict and the impact that it has on the development of cultural identity in nursing students, it is possible to address the issues that may be contributing to a reduced number of staff remaining in the profession.

Resonance

The resonance of this study is demonstrated through the categories of '*tradition bearing*', '*staff*' and '*student performance*' and the concepts associated with these categories portraying the fullness of the experience of negative workplace behaviours by nursing students in the off-campus clinical setting. The study has revealed meanings that are taken-for-granted and exist in the nursing profession through the experiences of the nursing students as they experience these processes. Further to this, the study has drawn links between the larger collectivities such as registered nurses, enrolled nurses and auxiliary nursing staff associated with the nursing profession, highlighting that whilst the profession is on the one hand the largest collective of health professionals in the medical and allied health arena, on the other hand it is a profession that is divided.

The substantive theory that was developed provides the reader with a deeper understanding of the circumstances that the nursing students are faced with in the management of their experiences of negative workplace behaviours whilst in the off-campus clinical setting. This insight is achieved through the theory explicating the concepts which impact upon this development.

Usefulness

The analysis presents a substantive theory that offers interpretations that the nursing profession, and academia, can use in an effort to improve the experiences of nursing students whilst in the off-campus clinical setting. The interpretation that is offered in this study allows for the integration of theory into practice, both within the nursing profession and into the educational facilities that provide nursing courses at the undergraduate level.

The analytic categories which were developed in this study proposed generic processes were operating across all of the facilities in which the nursing students were placed. It became apparent that there were individuals in the facilities that set the expectations for 'fitting in' within the facility and within the professional hierarchy as a whole. There were a number of tacit implications inherent in the generic processes and these were examined in the analysis of the data and were subsequently described in the findings and discussion.

This study contributes to the existing knowledge base of nursing education. This will provide an insight into the issues associated with the seemingly entrenched traditions of the nursing profession and provides some insight into the need to change the hierarchical culture if nursing is to fully embrace the new generation of nurses in their development of a professional identity. Recommendations are provided later in this chapter in relation to the contribution of this study to enhancing the experiences of the undergraduate nursing students in the off-campus clinical setting.

Value of Grounded Theory method

The structure for the research activities reported in Chapter Three was provided by the use of the grounded theory approach and methods. The theoretical perspective of Symbolic Interactionism allowed for the discovery of the patterned behaviours that were evident in the data. This was an important aspect as the research aimed to explain how participants experienced the off-campus clinical setting and explain the meanings that they assigned to their experiences in terms of responding to the negative workplace behaviours they experienced.

Studies reporting the experiences of nurses in the clinical setting in relation to workplace violence are increasing; however, few of these studies consider the issue of negative workplace behaviours on nursing students when undertaking pre-registration off campus clinical experience. Many of these studies focus solely on the nursing staff after they have completed their undergraduate nursing education and consider the issues associated with horizontal violence solely from an oppression perspective. Through the use of a grounded theory approach it was possible to discover new findings that contributed significantly to the existing literature and knowledge in the field. This approach allowed for the development of a substantive theory.

Study conclusions

Implications for nursing practice

Nursing and auxiliary staff often work with nursing students in both formal and informal arrangements in the off-campus clinical setting. The formal arrangements appear to be restricted to the Preceptor and facilitator positions with the other staff being placed in an informal agreement and accepting (or in some instances refusing to accept) students on an ad hoc basis. Registered nurses are involved in the education of nursing students in both direct and indirect ways. Staff are directly involved through the preceptorship, facilitation or mentoring of nursing students, and indirectly through their involvement with nursing students whilst they are undertaking a clinical placement. Auxiliary nursing and nursing staff still interact with nursing students in the off-campus clinical setting even if they are not assigned a nursing student for a particular shift. Regardless of how the interactions between nursing staff and nursing students occur, the nursing staff need to be aware of the behaviours which constitute horizontal violence, not only for the sake of the students, but for themselves as these behaviours impact on the development of an identity as a nurse and the retention rates which directly impact on the workloads of the registered nurses.

Limitations

This study was designed to identify and contextualise the experiences of the second year undergraduate nursing students as they experienced the off-campus clinical setting. The second aim of the study was to develop a substantive theory which

would explain the experiences that the participants had in the off-campus clinical setting in regional Queensland. Consistent with the grounded theory method the developed substantive theory is specific to the study sample from which it was developed. In an effort to enhance the theory, a wide demographic of participants was included in the study. This was a deliberate sampling strategy that ensured variation in the developed theory. There is however, no assumption of generalisability of the theory to other contexts and the theory is presented here for further development in other contexts that may allow for transferability and further refinement and further enhancement.

As with all research, there were limitations as the researcher is a part of the study. No researcher is completely objective (Charmaz 2005). The researcher is also a health care professional. The rationale for this approach was presented in Chapter Three. Constant comparative analysis of the data was utilised along with self awareness, journaling and discussions with supervisors to minimise the methodological limitations in this study.

Recommendations

The major recommendation from this study is that the experiences of the nursing students be taken into account in the formulation of the nursing curriculum and the nursing students receive training in dealing with the inappropriate behaviours and professional identity development issues associated with undertaking a clinical placement.

Other recommendations include:

Regulatory authorities[12] need to develop position statements and a scope of practice for undergraduate nursing students. Once developed this position statement and scope of practice then needs to be clearly communicated to staff in the off-campus clinical setting. This will result in an increased understanding of the scope of practice of nursing students when they are in the off-campus clinical setting. This could be achieved through the implementation of a strategy that clearly indicates the scope of practice of a nursing student at a given level of education. This information needs to be prominently displayed in a key area of the facility for staff to raise their awareness of the nursing student's scope of practice. As the curriculum in each of the universities offering nursing is slightly different, it would be necessary to involve each of the universities in developing student scope of practice guidelines for their own students and then require dissemination of this information to the respective facilities.

Consideration needs to be given to the creation of a position within the nursing professional hierarchy that specifically identifies the position of nursing students within the profession. Such a position in the hierarchy would provide the nursing students with a sense of belonging to the profession whilst minimising the impact that the current high levels of anxiety have on students when they are unable to determine their fit in the facility and the profession.

Nursing staff in the off-campus clinical settings need to be made aware of how to optimise their use of a nursing student. Rather than having the nursing student tailing

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[12] It is acknowledged that the Tasmanian Nursing Board has developed principles of delegation in relation to nursing students.

along behind, staff need to consider what tasks the student can undertake and optimise these abilities. Nursing staff at all levels need to understand the scope of practice for students and adhere to this.

Facilities need to consider implementing cultural change strategies to ensure that the culture of inappropriate behaviours and isolation of nursing students is not perpetuated. To this end the staff in the facilities need to be made aware of behaviours and how such behaviours, especially the negative ones, have an influence on students. There needs to be a cultural shift in the off-campus clinical setting to facilitate this change in culture.

It is imperative that the facilities attempt to move the nursing staff away from the perception that 'teaching' is not nursing work to a position where the nursing staff view teaching nursing students, and indeed colleagues, as an inherent aspect of nursing work.

Researchers need to be encouraged to focus on the impact that cultural aspects of the nursing profession have on the experiences of the nursing students and how this affects their decisions to seek employment, not only in nursing but in specific fields of nursing. The limited research knowledge that currently exists in relation to the experiences of nursing students in the off-campus clinical setting has resulted in a dearth of literature in this aspect.

The theory of the experience of undergraduate nursing students in the off-campus clinical setting needs to be further tested in other contexts in an effort to increase the

transferability of the theory and to determine the explanatory capacity of the substantive theory presented in this thesis.

Conclusion

The study found the interrelations between and within '*tradition bearing*', '*staff*', and '*student performance*' form contextual conditions that led to challenges in developing a professional identity. These conditions also impacted on the student's determination of where nursing students 'fit' within the profession. This resulted in internal conflict and anxiety whilst in the off-campus clinical setting. Students respond to these challenges through a process of 'not ruffling feathers'. This theory is dynamic in nature and accounts for the variations in experience, conditions and responses that participants utilise in an effort to limit the impact that the problem poses for them. The theory provides some explanation of a very complex ingrained culture that is evident in a profession that has a significant hierarchical history. The recommendations presented provide a guide for action, for Schools of Nursing, clinical placement facilities and the staff that work within these facilities.

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Appendices

Appendix A – Ethics Clearance

MEMORANDUM
From the Office of Research

Secretary, Human Research Ethics Committee
     Ph: 07 4923 2603
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26 August 2005

Mr Brian Sengstock
Faculty of Arts, Health and Science
Building 6, Central Queensland University
Rockhampton QLD 4702

Dear Mr Sengstock,

HUMAN RESEARCH ETHICS COMMITTEE
ETHICAL APPROVAL
PROJECT: H05/07-83, CONTEXTUALISING NEGATIVE EXPERIENCES OF UNDERGRADUATE
NURSING STUDENTS IN THE OFF CAMPUS CLINICAL SETTING.

The Human Research Ethics Committee is an approved institutional ethics committee constituted
in accord with guidelines formulated by the National Health and Medical Research Council
(NHMRC) and governed by policies and procedures consistent with principles as contained in
publications such as the joint Australian Vice-Chancellors' Committee and NHMRC *Statement
and Guidelines on Research Practice.*

On 26 August 2005 the Human Research Ethics Committee of Central Queensland University
acknowledged your compliance to the conditions placed on your ethics approval for the research
project *Contextualising negative experiences of undergraduate nursing students in the Off
Campus Clinical Setting.*

The period of ethics approval is 15 August 2005 to 30 June 2006. The approval number is
H05/07-83, please quote this number in all dealings with the Committee.

The standard conditions of approval for this research project are that:

you conduct the research project strictly in accordance with the proposal submitted and granted ethics
approval, including any amendments required to be made to the proposal by the Human Research Ethics
Committee;

(b)   you report immediately anything which may warrant review of ethics approval of the
project, including:
serious or unexpected adverse effects on participants;
proposed changes in the protocol;
unforeseen events that might affect continued ethical acceptability of the project;

(A written report detailing the adverse occurrence or unforeseen event must be submitted to the Committee Chair within one working day after the event.)

you provide the Human Research Ethics Committee with a written "Annual Report" by no later than 28 February each calendar year and "Final Report" by no later than one month after the approval expiry date;

(A copy of the reporting pro formas may be obtained from the Human Research Ethics Committee Secretary, Nicole Turner please contact at the telephone or email given on the first page.)

if the research project is discontinued, advise the Committee in writing within five (5) working days of the discontinuation;

you make submission to the Human Research Ethics Committee for approval of any proposed variations or modifications to the approved project before making any such changes;

you comply with each and all of the above conditions of approval and any additional conditions or any modification of conditions which may be made subsequently by the Human Research Ethics Committee;

you advise the Human Research Ethics Committee (email: ethics@cqu.edu.au) immediately if any complaints are made, or expressions of concern are raised, in relation to the project.

Please note that failure to comply with the conditions of approval and the *National Statement on Ethical Conduct in Research Involving Humans* may result in withdrawal of approval for the project.

You are required to advise the Secretary in writing within five (5) working days if this project does not proceed for any reason. In the event that you require an extension of ethics approval for this project, please make written application in advance of the end-date of this approval. The research cannot continue beyond the end date of approval unless the Committee has granted an extension of ethics approval. Extensions of approval cannot be granted retrospectively. Should you need an extension but not apply for this before the end-date of the approval then a full new application for approval must be submitted to the Secretary for the Committee to consider.

If you have any queries in relation to this approval or if you need any further information please contact the Secretary, Nicole Turner or myself.
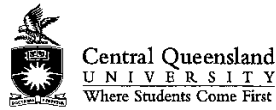
Yours sincerely,

Associate Professor Ken Purnell
Chair, Human Research Ethics Committee

Cc: Project File
                                 Dr Lorna Moxham, Dr Trudy Dwyer (Supervisors)
Application Category: A

Appendix B – Information Letter and Consent

Investigator:	Brian Sengstock
Address:	School of Nursing and Health Studies
	Central Queensland University
	Rockhampton. 4702.

Telephone:	07 49309817
Email:	b.sengstock@cqu.edu.au

Project Title:
Contextualising negative experiences of undergraduate nursing students in the off-campus clinical setting.

Dear <<Address Block>>

I am undertaking a PhD research study to identify and explore the experiences that second year undergraduate nursing students may view as being negative when in the off-campus clinical setting.The experiences of undergraduate nursing students in the off-campus clinical setting is an area that warrants further investigation. It is anticipated that through undertaking this research a clearer understanding will be gained as to what students actually experience when participating in the off-campus clinical setting. This information may then be useful for educators in both the tertiary sector and clinical organisations in the development of policies and curriculum for undergraduate nursing students.

As you are a second year student enrolled in the undergraduate Nursing Program, I would like to invite you to participate in this study by consenting to be interviewed. Interviews will be conducted in a group setting with groups consisting of between 5 and 12 individuals. The interviews will be recorded on audiotapes and transcribed at a later date. The recording of the interview will ensure that all points identified in the discussion receive full attention and data is not reliant upon memory. This will allow clear understanding of the issues raised. The interview will take approximately one and a half to two and a half hours of your time. However, you may be required to participate in a second interview taking no more than one hour of your time. The second interview will be an individual interview to clarify a specific point/s that were made in the initial interview.

I realise that information gained from the interviews may be of a sensitive and potentially confronting nature for some participants. For this reason counselling is available through the University's Careers, Counselling and Health Service. Whilst anonymity of participants will not be possible in the focus group setting, confidentiality will be maintained by the researcher and it will be reiterated with all participants that confidentiality of the information disclosed is to be maintained. Please be assured that your privacy will be protected as personal identification will not be disclosed in the writing up f the research. Data will be securely stored in accordance with

Central Queensland University Policy for 5 years. Under no circumstances will your name or identifying details appear in publications associated with this research.

Should any of the results in publications include direct quotes, pseudonyms will be used. A five-page summary of the results, without the identification of individuals involved in the project, will be offered to all students who participate in the interview and indicate they would like to receive the summary by ticking the appropriate box on the consent form.

Participation in the research project is completely voluntary and you will be free to withdraw from the study at anytime without prejudice. Non participation will not affect your academic standing. If you are willing to participate in the project would you please sign the consent form below, complete the demographic questionnaire and return it to me in the reply paid envelope. Upon receipt of the consent form further correspondence will be sent to you regarding the location and time of the focus group interviews.

If you have any questions regarding the research process please contact:

Brian Sengstock
Building 18
School of Nursing and Health Studies
Central Queensland University
Bruce Hwy
North Rockhampton, Qld 4702.

Phone: 4930 9817
Email: b.sengstock@cqu.edu.au

Alternatively you may contact my supervisor Dr Lorna Moxham.

Dr Lorna Moxham
Head, School of Nursing and Health Studies
Building 18
Central Queensland University
Bruce Hwy
North Rockhampton, Qld 4702.

Phone: 4930 9894
Email: l.moxham@cqu.edu.au

If you have any concerns about the way in which this research is to be conducted please contact Research Services Office at Central Queensland University, phone 07 49232607.

Thank you for your time and potential interest in the project.

Yours sincerely

Brian Sengstock
PhD Candidate
School of Nursing and Health Studies
Central Queensland University

Central Queensland
U N I V E R S I T Y
Where Students Come First

CONSENT FORM

Investigator: Brian Sengstock

Address: School of Nursing and Health Studies
                       Central Queensland University
                       Rockhampton. 4702.

Telephone: 07 49309817

Project Title: **Contextualising negative experiences of undergraduate nursing students in the off-campus clinical setting.**

I, ... of …………………………………………

………………………………………………….. (Address*) hereby agree to participate in a research study explained to me by the researcher. I understand that I am to participate in a focus group interview and possibly an individual interview, in which I will share my experiences in the off-campus clinical setting as a second year undergraduate student. I acknowledge that my privacy will be protected and that I am free to withdraw from the study at anytime.*

I understand that:
Any information that I provide will not be made public in any form that could reveal my identity to an outside party i.e. I remain anonymous to individuals not involved in the focus group that I participate in.
I am free to withdraw my consent at any time during the study without penalty or prejudice.
I have had the opportunity to discuss this study and I am satisfied with the answers I have been given.
I know who to contact if I have any questions about the study.

If you have any concerns about the way in which this research has been conducted please contact Research Services Office at Central Queensland University, phone 07 4930 9777.

Date: ....
                                                          Signature of participant.

………………………………………………………………………………………………
Please indicate if you would like to receive a plain English summary of results when the study concludes.
                                                    Yes   No
                                                    ☐   ☐
    Should you require this summary, please ensure that your contact details remain up to date
    with the University.

Appendix C – Demographic Questionnaire

Central Queensland
U N I V E R S I T Y
Where Students Come First

Demographic Questionnaire

If you agree to participate in the study, please complete the following questionnaire and return it with the consent form in the reply paid envelope. Please do not record any identifying details on this form such as your name or address or the names of any organisation that you work.

Please tick the relevant boxes.

Age	18-20	☐
	21-25	☐
	26-30	☐
	31-34	☐
	35-40	☐
	41 and above	☐
Gender	Male	☐
	Female	☐

Prior Nursing Experience

	EN	☐
	EEN	☐
	AIN	☐
	OTHER	☐

Please specify ....

Current type of employment ....

Type of employment in past 5 years ....

....

....

....

....

....

Years in Nursing Program	Two	☐
	Three	☐
	Four	☐
	Greater than 5	☐
Highest level of school	Ten	☐
	Eleven	☐
	Twelve	☐
	Other	☐

Please specify ....

Is English your first language   YES   ☐
                                            NO   ☐

Clinical Placements for second year practicum.

            Aged care facility   ☐
            Community setting   ☐
            Rural/ Remote setting   ☐
            Public Acute Care
                  Medical   ☐
                  Surgical   ☐
                  Paediatrics   ☐
                  Emergency   ☐
                  Operating Rooms ☐
                  Other   ☐

            Private Acute care organisation
                  Medical   ☐
                  Surgical   ☐
                  Paediatrics   ☐
                  Emergency   ☐
                  Operating Rooms ☐
                  Other   ☐

Appendix D – Example of Open Coding

Participant:	Ok, well by and large most people seem quite happy to have students **[willingness to accept students]**, um there's been very few people who haven't wanted to have a student **[willingness to accept students]** um but, I find that um people who have, who have been nurses for quite some time **[length of service]** sometimes they might query how you are working something out because I still choose to put pen to paper to do the nursing calculations **[querying student ability]**. Ahh, they say how did you get that like I might put 20% you know where they might put 1/5. it is the same thing its just written differently if that makes sense **[questioning student ability]**.
	Laughs
	Yea little things like that, I suppose that is not really a negative, just that there are different ways of doing things **[different ways of doing things]**, you know everyone has got their way of doing things **[individual approach]** but they, I sort of found that the people that have just sort of newly graduated **[length of service]**, because I have been mentored with a lady who has been a nurse for 13 years and another who has been a nurse for three years **[allocation to RN]**. And both of them have been really good in letting me do things in the scope of my practice **[scope of practice]** and following Tomlinson and those peoples recommendation or Johanna Briggs for how procedures are done, they have gone no, no it's done this way sort of thing **[individual approach]**.
Interviewer:	Is that more coming from the one who has been out for thirteen years than the one who has been out for three?
Participant:	Um the one that, well those two have been really good **[supportive staff]** but the ones who were hospital trained **[education level]**, gees this is terrible, people, it seems to be those people, you know people who have between 20 and 30 years sort of thing **[length of service]**, they seem to have their way **[individual approach]** of doing the calculations and sometimes I feel like their, its sort of their voice **[tone of voice]** when they see me doing the paper, like even with Clexane if we've only got 100 mL syringes of Clexane and the Doctor wants 80, you know I'll even put that on paper so that the whole process is gone through **[process]** and you can show them that this is what he wants and this is what I have to discard and dada dada **[keeping on side]**. Sort of thing, maybe I am, maybe I am you know overdoing it **[keeping on side]**, but just so that it is constantly relating it to the maths to the formulas of why this is so **[rote learning]**. Um because I think that is my major thing of not wanting to hurt anybody by giving them the wrong medication, the wrong dosage **[do no harm]**.
Interviewer:	And their sort of like its easy, just do it.

Participant: Yea that's right, that is basically what I am saying yea.

Interviewer: When did you first, if at all, experience or notice negative behaviours in the off-campus clinical setting?

Participant: Well, ….., um well in the community nursing situation not so much as in the acute care setting **[placement settings]** and um when I sort of um have thought about this and after going back and speaking to these ladies since **[reflective approach]**, probably because some people, some other nurses think that if you work in the community setting you are, the vibe is that you are less of a nurse **[lower quality nurse]**, that you job is less important **[importance of role]**. But really in actuality empowering people to be able to stay at home, you know in their own environment, I mean that is very, very positive **[importance of role]** um so but they feel that they are less of a nurse **[less of a nurse]** so they seem to be more accepting of the students **[acceptance of students]** and how they do things because each and every one of them of the nurses I was with in the community setting, they do things slightly different **[individual approach]** but they are still doing the job **[same outcome]** and nobody says oh that's not the right way of doing a dressing or you shouldn't have admitted that person to CAPS or they are not appropriate for that or, you know everyone is sort of, it is more of a team environment **[team environment]**, um whereas it seemed to be less of a team environment **[team environment]** in the acute care setting because everyone has got their own people, their own you know case load and they sort of just want to do things with theirs **[workloads]**, with their people and not so much worry about other people **[team work]**. But they seem to have time to say oh that should have been done or the doctors should have been contacted sooner **[time]**, that sort of thing it seems like the interstaff relationship **[inter-staff relations]** is probably a little less, um not as therapeutic to each other, nurse to nurse sort of thing.

Interviewer: So they tend to demonstrate some degree of hostility towards their own?

Participant: Yes. Sort of thing whereas in the community setting maybe because it is um, even though each one has their own set thing when they come together to do their conferences on how they are going to approach things it is more of a everybody put their input in and help each other out **[teamwork]**. Um, like if one person was really good at and had experience with, lots of experience doing Dopplers so therefore they sort of traded people, like I'll go and see xyz and do the Doppler, or I'll come and show you how to use it, they are really good like that and another lady had no experience with a CAD pump and basically you know another nurse was happy to go out there and help her **[teamwork]** with it so it is really good like that whereas um if I was in an acute care setting and I as a student wasn't sure of you know a catheter or wasn't sure how to do a blood pressure, there were some people that you wouldn't want to ask **[avoidance]** because they would be like "Oh my God, you should know this" or that sort of thing **[knowledge base]**. That's the vibe **[that's the vibe]**.

Appendix E – Conditional Matrix

Explanation of the Conditional Matrix:

The Conditional Matrix provided on the following pages is an excerpt from the matrix used in this study to assist in the axial coding process. The matrix provides a good example of the what, when, how, why and consequences of the category which became known as a '*Tradition Bearing*'.

Participant	What	When	Where	Why	How	Consequence
C		At the end of the shift	In most professions it is the younger staff that go home first, in nursing it is the older ones	Younger staff stay back to finish the paperwork rather than just had the patients over	Here's the patients and I haven't done this and that	Good nursing notes are completed by younger nurses
E	The majority of the people with the negative attitude have been around forever in the facilities	Staff member has been in the facility for long time	Staying in the facility allows the staff to develop a comfort zone	Staff tend to feel safe in their comfort zone	Use of power and domination over students	The longer the staff are in the facility the worse the attitude
G		Placed in the aged care setting with staff that have been there for extended times AIN has been in the facility for extended time When the hospital staff have been out for a long time Student makes an observation on patients condition	The longer the length of service the greater the attitude Some of the older staff in the hospitals are supportive Older staff can be difficult to deal with as they get set in their ways	They have the attitude they own the place They view the student as a temporary inconvenience Appear to have trouble managing their time These staff see the students as the future of the profession	Treating students as someone who might steal their job Not accepting students as a member of the team AIN not completing tasks but expects student to help Willing to help student and teach Older RNs are more aggressive	Not willing to give outsiders a go Staff with longer service tend to be rougher Older RNs in the hospital appear more willing to teach Older RNs may be less accepting The longer they are in a facility the less they know about a patient as a person

				AINs have been in the facility for ages and think they know it all Student commented on a wound Young students have no life experience and older students viewed as having too much	Hierarchy constructed on perceived knowledge not age	Uni students are all sort of equal
H	Facilities with low staff turnover have a higher incidence of negative treatment of students	RN makes an error of judgement When there is a low staff turnover AINs have been in the facility extended times Individual is qualified as an EN When the student is younger but is perceived as being older When placed in a group of older students	AINs believe that the students have it easy Increased incidences in facility with low turnover of staff	RN told student to administer the wrong drug to a patient Compared with some areas the ward has low turnover rates AINs have historical issues and believe the students have it easy ENs appear younger and haven't been in nursing as long Younger students lack life experience	Power and control issues Majority of the staff are non graduates Verbal communication More open mined approach Holding things against the student when they realise her age Older students judge younger on perceived life experience	I have been doing this for however many years You have it easy compared to us AINs tend to be older ladies who aren't afraid to use colourful language Well what would you know

K		Student is young and straight out of school When the EN has been in the facility too long When the nurses on the medical ward are more senior	In their assumption that all younger students lack life experience	Student had a level of immaturity EN may have left it too late to move on The ward has minimal staff turnover	Student potentially saying something wrong at the wrong time Treating herself as an RN and carrying herself as such Staying of the ward longer when they get there Nurses having been out for extended times (>10 yrs)	They were all picking on her because of her age Well its too late to move on and become an RN
L		AIN been in the facility a long time When the AIN has longer service in the facility than the RNs	AINs tend to be more mature aged women	Lack of staff turnover at the AIN level They tend to stay as AIN and not progress RNs tend to be mobile	Staff staying in the facility for extended times AINs are generally older than the RNs AINs respecting the RNs as staff	AINs have a lot of respect for the RNs
N		When staff have worked in the facility for extended time		Staff are limited in their understanding and education They get enjoyment out of this aspect	Limited employment opportunities elsewhere Staff stay for longer times	They were sort of stuck in a rut Didn't get much enjoyment out of being there

					Developing their own way of doing things	
P		There are staff who have developed a niche in the facility Student comes in and has a different way of doing the same task When a staff member in the facility is happy at their present level The student is either too young or too old	Staff develop a niche in the facility and want to stay put indefinitely	Because the staff have an established power base in the facility Staff feel threatened by change They are comfortable in the role that they are in Staff member has been there the longest and therefore should know the most Older students have life experience and the younger ones don't	Refusal to accept that there may be better ways to do things Resisting change Not wanting to progress and become an RN Staff assuming that if you are old you have too much life experience and too young not enough	You can't just walk in from uni and tell us to change They have no intention of ever becoming an RN We're trying to stop that approach Why are you doing it at 50?
Q		When the student assumes that the RN has been out for a while based on age		Because the nurse is older the student assumes they have been out a while	RN has an understanding of what it is like to be a student	She had only been out a couple of years

| R | | When the student realises that a lot of the staff are older

Grad RNs who have been out for a couple of years

AINs are older and have been in for 30 years

When the students are in a facility and challenge the way things are done | There are some younger ones but most of them are older | Nursing seems to attract older women

There are some great RNs that have been out for a short time

Facilities don't seem to turn the AINs over like they do the RNs

They have been there that long they feel they can give orders

Some of the younger students want to challenge the staff | A lot of RNs are in their 40's

Their being up with knowledge and skills

Older AINs feel threatened in the facility when students are there

AINs are set in their ways

Questioning why things are being done in a certain way

RNs can be set in their ways

Just moving patient to patient and not taking a holistic view | Maybe they find it difficult to work with me as an older person

Its all about keeping the peace

Student role is short term

Maybe we should be challenging more often

RN become quite task oriented |
|---|---|---|---|---|---|---|
| T | | When a student has been nursing for a number of years prior to coming into the BN

When a young student is placed with an experienced older RN | | Student has a considerable amount of experience as an EN

The RN has graduated years ago and now has a young student | Student assimilates the norms of nursing through practice

It is a chore to teach as they have no life experience | That's the way it works

The uni screens ALC's |

| V | | Staff member has only been in the facility a short time | | The staff member is fairly new and has been assigned a student | Use of body language and doing own thing | Student was too much stress for her |
| Y | | When the student is an older student member of the group | | Student is older than many of the other students | The younger students see you as a mother figure | Some just treat me as another student |