Approved Educational Institutions' role in supporting pre-registration students in the practice learning environment.

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“You cannot hope to build a better world without improving the individuals. To that end, each of us must work for our own improvement”-

Marie Curie.

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List of Abbreviations

ADKAR - Awareness, Desire, Knowledge, Ability, and Reinforcement.

A&E - Accident and Emergency

AEI(s) - Approved Educational Institutions

BCU- Birmingham City University

BNF- British National Formulary

CLiP - Collaborative Learning in Practice

Cons. GT - Constructivist Grounded Theory.

COVID - Abbreviation commonly used to discuss Coronavirus or the Pandemic. It May relate to “Long COVID’ which is characterised as prolonged COVID symptoms passed the ten-day isolation period.

CPAL - Coaching peer-assisted learning

CPD - Continuing Professional Development

GMC - General Medical Council

HCPC - Health and Care Professions Council

HEE – Health Education England

INTERDISCIPLINARY - Multi-Disciplinary Team

LeDeR - Learning from lives and deaths- People with a learning disability and autistic people

MYEPAD - Midlands, Yorkshire, and East Practice Assessment Document NICE - National Institute for Health and Care Excellence.

NHS - National Health Service

NMC - Nursing and Midwifery Council – May also be referred to as ‘The Regulator.’

PAL - Peer Assisted Learning

PICs - Participant Information Centre(s)

PLPs - Practice Learning Partners

RCN - Royal College of Nursing

SLAiP - Supporting Learning and Assessment in Practice

SPAGG - Specialist Palliative Audit and Guideline Group

SSSA (NMC, 2018) - The Standards for Student Supervision and Assessment

Glossary of terms

Future Nurse **standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d)** – Generic Terms used to reference all documents that make up the standards listed under the Standards for Nurses on the NMC website. These standard documents referred to within the thesis under this term include:

- The Standards of Proficiency for Registered Nurses (NMC,2018a)
- Part 1: Standards framework for nursing and midwifery education (NMC,2018c)
- Part 2: Standards for student supervision and assessment (NMC,2018)
- Part 3: Standards for pre-registration nursing programmes (NMC,2018d)

The "Code" - is a widespread term used to discuss The Code: Professional standards of practice and behaviour for Nurses, Midwives, and Nursing Associates (NMC,2018b).

Practice Learning Partners – A term used to represent organisations that work with AEIs to provide placement opportunities for healthcare students. This may be in a post-graduate or preregistration student capacity and applies to all fields and disciplines.

Practice Learning Environment – Any non-AEI environment that a pre-registration student or post-graduate student may access as part of their training to gain practical exposure and learning opportunities.

Preface

This study was constructed using a set brief created by Birmingham City University in 2017 under the Project Title "Universities' Role in Supporting Learning in Practice."

Birmingham City University's School of Nursing and Midwifery has a track record in leading on assessment in practice research. We are seeking proposals for a PhD study that will explore existing provisions and devise a new model for supporting practice learning, which will be fit for student nurses, nursing assistants and Higher Apprenticeships.

Background

Nursing is a practice-based profession. Therefore, clinical education is an essential part of the undergraduate nursing curriculum. The quality of nurse education depends largely on the quality of the clinical experience (Elliot, 2002; Napthine, 1996). Students require effective clinical placements to allow the application of theory to practice (Elliot, 2002). These experiences are central to the student's preparation for entering the workforce as a competent and independent practitioner (Penman and White, 2005; Papp et al., 2003).

The School offers a Nursing and Midwifery Council (NMC) -approved programme for mentors, 'Supporting Learning and Assessment in Practice' (SLAiP), which clinical staff are required to complete successfully.

The programme allows mentors to assess and 'sign off' student nurses so they can register with the NMC. While there is a clear process for clinical practice, there is very limited guidance for universities regarding the support of students and their learning in practice.

Our School has two models for supporting students. Placement Support and Development involves academic staff working with practice to support mentors in failing students, carrying out educational audits in clinical areas and supporting students who are having difficulty. The second model is for Placement Support Staff - academic staff who are mainly university based but may visit practice half a day a week or less to support placement. No one really knows which model is best for students, mentors, and academic staff. The rapidly changing context of nurse education, including the introduction of student fees, withdrawal of placement tariffs for practice settings and the growth of related undergraduate programmes, which also require placement support, make this a very timely question.

Elliot M (2002) Clinical education: a challenging component of undergraduate nursing education. Contemporary Nurse 12: 69-77.

Napthine, R. 1996. Clinical Education: A system under a pressure. Australian Nursing Journal, 3(9): 2024.

Papp, I., Markkanen, M. & von Bonsdorff, M. (2003) Clinical environment as a learning environment: student nurses' perceptions concerning clinical learning experiences. Nurse Education Today, 23 (4): 262–268.

Penman, J., & White, F. (2006) Peer- Mentoring Programme 'Pop-Up' Model for Regional Nursing Students'. Journal of University Teaching and Learning Practice, 3 (2): 6

Abstract

Changes to pre-registration nurse education occurred in 2018 when the Nursing and Midwifery Council (NMC) published the results of consultation efforts, with their subsequent results shaping the 'Future Nurse'. By extension, changes to the professional image and expectations of nurses stand to affect the content of pre-registration nurse education. As key stakeholders, a key question raised in view of these changes includes how Approved Educational Institutions (AEIs) actively look to work with Practice Learning Partners (PLPs) as they prepare pre-registration nurses for registration.

Using an adapted, constructivist grounded theory approach, eleven individual, semi-structured interviews were conducted with participants from seven different Participant Information Centres (PICs) across the West Midlands. This led to the formation of four distinct participant groups: Registered Nurses who work directly with pre-registration student nurses in the practice learning environment, Practice Placement Managers or Clinical Educators, a Head Nurse, and Representatives of the NMC. The subsequent analysis of these interviews led to the construction of two analytical categories which were:

1. Training, awareness and understanding of the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d).
2. Looking back to pay it forward.

Amongst others, the most significant findings of this study include:

- A recognition of limited research in the public domain, which discusses the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d),
- A lack of awareness and incomplete implementation of the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d),
- Little justification for the breath of change and the sustainability of this working model exists in light of the 'NHS staffing crisis' and the "toxic" learning culture acknowledged by the NMC.

From these main findings, some of the key recommendations from the study focus on increasing awareness and understanding of the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) to improve the learning culture. However,

there is a recognised need for further research to explore the lived experience of newly qualified nurses who were the first to be trained using the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d). This is needed so that previous successes can be continued or replicated, but also so that the needs of pre-registration nursing students can be better met by using the current educational standards.

As these standards are in their relative infancy, and to compare and contrast the preceding and current ways of educating and preparing student nurses, it has been necessary for the thesis to consider older references and actively use them within discussions or to highlight differing schools of thought in the literature. From a nursing literature perspective, this is particularly relevant to the aspects of the thesis which form the background literature of the study, as well as pre-existing models of pre-registration supervision and assessment. In several parts, this includes seminal texts or references to the Supporting Learning and Assessment in Practice (SLAiP) standards (NMC,2008; RCN,2015) and literature which relates to the use of a 'mentor' and sign-off mentor' which features in the 2010 educational standards (NMC,2010).

To situate this within this study further, as established within the abstract, the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c NMC,2018d) replaced the 2010 and their supporting roles of 'mentor' and 'sign-off mentor' and appropriated terminology and roles which include that of a Practice Supervisor and Practice Assessor. A conscious choice has, therefore, been made to keep older literature and not support them with a more contemporary source. The rationale behind this is to be able to clearly distinguish between time frames that align with the preceding or current models of pre-registration supervision and/or assessment. It is also argued that not updating older literature with current sources more clearly reflects the research/opinions/insights and interpretations that were 'true' of the time that they were written about or in.

In alternative instances, older literature was also drawn upon because the references reflect seminal perspectives or lenses present at the time or because specific ideas/philosophies have not changed and are still relative to more contemporary applications. This will be particularly relevant in Chapter 3, which considers research methodology and applied research methods.

With this in mind, to ensure the research aim and objectives are considered in light of the changes and more contemporary expectations of pre-registration nurse education, as set by the regulator (NMC), an initial examination of the degree of change instigated by the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMc,2018d) implementation will now be presented by introducing the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) and comparing them to the previous standards of pre-registration nurse education.

1.1 Introduction: The *Future Nurse* Standards.

There are a variety of reasons why the preceding Supporting Learning and Assessment in Practice (SLAiP) standards (NMC,2008; Royal College of Nursing (RCN),2015) were replaced as part of the regulator's new vision for nursing care and pre-registration nursing education standards (Anon, 2018).

Amongst them, a documented expansion of pre-registration pathways and the need to allocate appropriate learning opportunities for more students than ever before (Jones-Berry, 2017) appears to be a primary driver for change (see preface). The initial benefit of such an expansion is an increase in the number of people available to join a professional register. It also directly links to efforts made by all stakeholders to decrease currently unsustainable demands on the National Health Service (NHS). Increasing the number of pathways and the theoretical number of people who may be eligible to join a professional register, in time, could lead to more sustainable staffing levels and subsequently address lesser access to critical resources that form part of the NHS, which is recognised as being in "crisis" (Horton,2017; Kendall-Raynor,2017; Waters, 2022). This perception of "crisis" is emphasised in statistics captured in a survey conducted in part by the RCN in 2022. This survey demonstrated that in over 20,000 responses taken, 83% of registrants reported insufficient staffing to meet patient needs (Devereux, 2022). This is not only a rise from the 73% recorded in 2020 (Devereux, 2022) but poses a challenge for those supervising preregistration students and supporting safe, effective learning opportunities within the practice learning environment.

These findings, assimilated previously, resulted in an RCN survey in 2021, which suggested that the *"Intention to leave appears to be far strongest among nursing staff working in NHS hospital settings, with 60% of respondents stating they are considering or planning to leave"* (RCN,2021).

This is somewhat corroborated by the regulator's own figures that were drawn upon by Mitchell (2022) and showed that:

- *As well as 25,219 nurses, the Nursing and Midwifery Council register also lost 1,474 midwives, 306 dual registered nurses and midwives, and 134 nursing associates over the year.*

- *The total of 27,133 people leaving the register is an increase of 13% from 2020-21 and starts to reverse a downward trend in leavers seen since 2016-17.*

When additional comparisons were made between the preceding educational standards (NMC,2010) and the Standards for Student Supervision and Assessment (*SSSA*) (NMC,2018), some of the key stakeholder's initial responses to these changing times were particularly focused on the inclusion of formerly labelled "advanced skills" (Peate, 2018; Leigh and Roberts,2017). This is important to consider as these "advanced skills" now act as part of the re envisaged baseline for pre-registration nursing students, which they should be able to demonstrate at the point of registration and are formally documented in the Standards of Proficiency for Registered Nurses (NMC,2018a).

The combination of factors that have led to a longstanding "crisis" in the NHS as well as attempting to implement the *Future Nurse standards* (NMC, 2018; NMC,2018a; NMC, 2018c; NMC,2018d) therefore poses a new set of challenges that Approved Educational Institutions (AEIs), and Practice Learning Partners (PLPs) continue to address and together. As all change requires a degree of transition from older to current or new ways of working, consideration of the longstanding/historical issues alongside more current, impacting factors, such as the further decline of prospective students studying and later joining a professional register (Ford,2022) also stand to alter how the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) can be implemented. This extends to how services recover from actions taken during the pandemic, such as the redeployment of the staff to other points of care, redistribution of limited resources, restrictions or closure of specific services or wards, as this alters areas that pre-registration students would have gained access to and therefore have the potential to influence essential training opportunities (Al-Jabir et al.,2020; Lancaster et al.,2020; Legido-Quigley et al.,2020; Xiang Tay et al.,2020).

With considerations so far in the thesis in mind, the justification of a detailed comparison and breakdown of key similarities and differences can be based on two significant factors. The first is that, as a pre-existing challenge, a common interpretation of the preceding SLAiP standards relied on a named mentor taking overall responsibility for a pre-registration student (NMC,2008; RCN,2015). This led to

a pre-registration student being allocated to a single trained mentor and a separate sign-off mentor. For AEIs and PLPs to adhere to this aspect within the SLAiP standards, arrangements commonly encouraged pre-registration students to spend at least 40% of their time in the practice learning environment with their named mentor and sign-off mentor (NMC,2008; Pearce,2019; RCN,2015). In addition, these named staff would supervise, support and assess the pre-registration students. Assessments would also occur when pre-registration students were taking part in a block placement that would result in a pass or refer decision at the end of each placement.

To become a named mentor and undertake the aligning responsibilities in a recognised way, a registered nurse had to complete a suitable theoretical course and pass. This was usually offered by AEIs and allowed attendees to gain formal recognition and/or learning certification, which aligned to accredited modules. However, recently, being available to attend a course and gain certification has been made problematic due to working conditions, such as short staffing. However, another factor to consider is the lack of funding available for Continuing Professional Development (CPD) to be provided (The Flamelily,2018; RCN,2018; NMC,2021).

In addition, becoming a named mentor or sign-off mentor did not form a compulsory element of a registered nurse's role and may have added to poor attendance or uptake of the SLAiP course or suitable equivalent. By proxy, this would have contributed to fewer mentors accessible in practice learning environments. This, therefore, restricted the number of registered nurses available to support, supervise and assess pre-registration students formally (Dirks,2021). As a further implication, this could potentially negatively impact how many pre-registration students may be placed in any one area. The lack of uptake amongst registered staff was also notable in the number of sign-off mentors active in the practice learning environment, as this required an additional, mandatory course to be passed (NMC,2008; RCN,2015). In practical terms, this led to an even greater shortage of staff who could sign pre-registration students off at the end of their practice learning exposure. From a transference perspective, if the roles are treated "like-for-like", despite the fact that it is everyone's responsibility to support pre-registration nurse education in some capacity, we may have a shortage of appropriately prepared or experienced Practice Assessors.

From these explanations, some understanding can be formed as to why removing the SLAiP standards has formed an initial, comparable change but was necessary, as they highlight the impossibility of sustaining a 1:1 ratio. This is summatively and initially, due to the chronic nature of nursing staff shortages, pressures created by a global pandemic and a potential to increase but replace existing workforce members with a relatively inexperienced workforce to meet an arguably greater service user demand.

The second reason for a more detailed comparison is also rooted in suggestions that the current approach toward pre-registration supervision and assessment has prompted significant change between AEI and PLP communications and the process it entails. This is primarily due to the removal of specified time for practice supervisors to work with pre-registration students under the *SSSA* (NMC,2018) and that pre-registration students should be “practice supervisor read” at the point of registration. In addition to role changes that have been discussed under the guise of “advanced skills”, the regulator has actively encouraged and separated the roles of practice supervisors and practice assessors. To expand this consideration, in line with the *SSSA* (NMC,2018), the practice assessor's role is to make decisions through partial “information that I have received through sought feedback from the students' Practice Supervisors” (Feeney and Everett,2020:18). The role of the practice assessor also requires them to undertake sporadic, assessed episodes of care that occur in each part of the pre-registration nurses’ training. This has removed the need for a sign-off mentor, which was utilised in the SLAiP standards (NMC,2010). Instead, the intention is that this would ultimately ensure that a preregistration student can meet or achieve the proficiencies aligned to their part (Feeney and Everett,2020; NMC,2019). It also differs from the pre-existing educational standards for nursing education, as the sign-off, which took place at the end of each placement, is now intended to be demonstrative of progressive development and can last over twelve months. Changes in this area extend further, as the ability to pass a part also now relies on some form of consensus between the practice assessor and academic assessor. This is because both parties must recognise and document that the pre-registration student has met all the criteria to progress within their programme (Feeney and Everett, 2020; Hodgetts, 2023; NMC,2018).

This, therefore, lends itself to an alternative approach advocated for by the regulator whereby an interdisciplinary or “team approach” to pre-registration student supervision and assessment formally occurs. In real-time, this has the benefit of adapting to daily changes in the practice learning environment and removes the need to have a dedicated person working with any preregistration student at any given time. Theoretically, it, therefore, increases access to registered staff who should be able to supervise or assess pre-registration students and increase physical placement capacity.

Theoretically, this links to other areas that influence the pre-registration student experience, such as levels of impartiality or objectivity that result in a pass or refer decision (Feeney and Everett,2020; Lidster and Wakefield,2022). Having a “team approach” or forming a consensus to pass or refer a student’s progress and changes the onus of an individual decision. This is due to the current approach being reliant on offering feedback from a wider body of clinicians who can contribute to the overall assessment of a pre-registration student through supervisory reports. This contribution is typically captured in dedicated sections within feedback given in assessment documents, such as the MYEPAD document (PAN Midlands, Yorkshire, and East Practice Learning Group (PMYESLG),2020).

From these initial comparisons, it may be suggested that there are now significantly greater expectations placed on what they can do at the point of registration (Pearce,2019), which would enable pre-registration students to be “practice supervisor ready”, is immediately problematic to achieve. It is also noticeable that, despite the standardised expansion of a nurse's role and the removal of modular content to inform pre-registration supervision and assessment, there is no specific period to consolidate between the practice supervisor and practice assessor. In the face of current constraints and the potential change to the amount of experience accessible to preregistration students in the practice learning environment, it is challenging to justify the inclusion of these “advanced skills” aforementioned alongside the ability to study for non-medical prescribing once registered. However, in line with the Standards of Proficiency for Registered Nurses (NMC,2018a), this includes more niche skills as described in Annexes A (NMC,2018a:2731) and B (NMC,2018a:31-37) of the document. This challenges the ability to fully anticipate how achievement of skills and

nursing procedures in Annexes A and B will be consistently supported in all practice learning environments despite using a “team approach”, particularly when a large proportion of the existing nursing workforce may not be able to demonstrate and teach a skill or nursing procedure themselves.

To illustrate this, *Annexe A: Communication and Relationship Management Skills* (NMC,2018a:27-31) *and Annexe B: Nursing Procedures* (NMC,2018a:31-37) are presented in Table One below, which gives a brief overview of the main changes between the educational standards discussed so far:

Table 1-Annexe title, a brief outline of their focus, and examples of what these have included compared to 2010 standards and what was expected of new registrants.

Title of Annexe	**A brief outline of the Annexe focuses and an example of the content.**
Annexe A: Communication and relationship management skills (NMC,2018a: 27-31).	Communication and relationship management skills: Communication techniques and therapies that complement the needs of the patient in a variety of placement learning environments. These include identifying and applying specific techniques and therapies that may have originally been signposted to a healthcare professional with field-specific expertise, such as Cognitive Behavioural Therapy (CBT).
Annexe B: Nursing Procedures (NMC, 2018a: 31-37).	**Annexe B:** Nursing Procedures: Outline of procedures that newly registered nurses must be able to demonstrate as they deliver compassionate, evidence based, person-centred care (NMC, 2018a). However, consideration of Annexe B and the realignment of nursing procedures also prompt recognition that some nursing procedures newly qualified registrants are expected to demonstrate were previously classified as advanced duties that required additional training and assessments to confirm proficiency (Brown,2017; Peate,2018; Welyczko,2020) such as performance of chest auscultation, interpretation of ECG readings, and the ability to perform Per Rectal (PR) examinations when appropriate (Feeney and Everett,2020; Lidster and Wakefield,2022; NMC,2018a).
2010 standards (NMC,2010)	The newly qualified graduate nurse should demonstrate the following skills and behaviours. They should be used to develop learning outcomes for each progression point and for outcomes to be achieved before entering the register: Safely manages drug administration and monitors effects; Safely and effectively administers and, where necessary, prepares medicines via routes and methods commonly used and maintains accurate records;

	Monitors and assesses people receiving intravenous fluids; Safely maintains and uses nasogastric, PEG and other feeding devices.

From this, Annexe B (NMC,2018a), procedures that fit the formerly “advanced skills” profile may call into question the suitability of a person able to supervise and assess the achievement of skills, especially if the nursing procedure or skill is not something practised by the Practice Assessor. The question of realigned skills that shape pre-registration education also draws from Gopee’s work (2023). This was because it was one of the first publications available in the public domain to discuss the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) as an entire set of documents. Gopee (2023) highlights that, before the pandemic, there was little to no specific mention or discussion about changes to the nursing curriculum or the role of a nurse in the public domain. There was even less that went beyond the description of the practice supervisor and practice assessor roles or suggestions for how the existing workforce may be systematically or consistently updated to meet the newly aligned levels of proficiency.

As such, the levels of expertise within a practice learning environment may challenge the ability of all registrants to meet the reimagined vision of a nurse outlined as a whole from a procedural or skill perspective despite it now forming a professional requirement. Instead, it could lead to the realigned baseline of skill and procedural knowledge being aspirational indefinitely. This suggestion is based on the premise that a potential lack of experience, with an improperly applied leadership model, may lead to pre-registration students being supported by individuals who cannot demonstrate a skill or proficiency that newly registered nurses are now expected to demonstrate from the point of registration. As this, then, has the potential to create divides between existing workforce members and new registrants, this could contribute to historically suboptimal working cultures and counteract points that are usually the driving forces for change, as the Messenger (2022) report suggests, and as did the Francis Report (2013) before it. This is perhaps even more likely, as a preceptorship survey, partly funded by The Nightingale Foundation and drawn upon by Mitchell (2022a), indicated that:

84% of nurses and 80% of students thought the transition to practice as a newly registered nurse (NRN) had become more challenging in the last two years. As well as COVID-19, respondents reported workplace pressures and staff shortages as major barriers to NRNs accessing preceptorship" (Mitchell,2022a).

Alongside these deliberations, it is also unclear at this time if all the formerly classified "advanced skills" are reflexive and meet current patient needs, particularly in a post-pandemic climate where more people are presenting with symptoms associated with 'Long Covid' (The Lancet,2020). Additionally, in the wake of the pandemic, some staff have also developed Post Traumatic Stress Disorders (PTSD) as a consequence of their work throughout the pandemic waves (Guo et al.,2020; Kang et al.,2020; Nelson and Lee-Wing,2020), and this has potentially exacerbated ongoing attrition rates (Falatah,2021) or left some workers and patients who survived COVID with long-standing health and wellbeing issues (Department of Health,2020; Pappa et al.,2020). This indicates that although all registrants should look to support others in line with their professional "Code" (NMC,2018b), not everyone has the emotional capacity or is willing to do this in the wake of the pandemic.

To get a sense of the standard documents that make up the Controlling standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) framework before further discussion of *The Future Nurse: Standards of Proficiency for Registered Nurses* (NMC,2018a) and *Part 2: The Standards for Student Supervision and Assessment* (NMC,2018) ensues, an overview of the main documents has also been compiled and can be seen in Table Two below:

Table 2- NMC standard document name and a brief description of the document and its content.

Document Name	**Brief Description of this document's content**
Future Nurse: Standards of Proficiency for Registered Nurses (NMC,2018a)	This document holds a set of proficiencies that highlight specific "knowledge and skills that registered nurses must demonstrate when caring for people of all ages and across all care settings" (NMC,2018a:3). These proficiencies correspond with seven different platforms and include Skills Annexe A (NMC,2018a:27-31) and a separate Annexe for relevant nursing Procedures (NMC,2018a:31-37).
Part 1: Standards Framework for Nursing and Midwifery Education (NMC,2018c)	Consist of five headings to focus on and suggest ways in which AEIs and Practice Learning Partners may work together to enable a flexible way of creating, developing, and delivering "innovative approaches to all education for nurses, midwives, and nursing associates' education while being accountable for the local delivery and management of approved programmes in line with our standards." (NMC, 2018c:3)
Part 2: Standards for Student Supervision and Assessment (*SSSA*) (NMC,2018)	Outline the roles of the practice supervisor and practice assessor and suggest ways in which students are assessed for theory and practice learning during their practice placements. This includes the stipulation that pre-registration students may be supervised by any nurse, midwife, nursing associate, and registered health and social care professionals who form part of the multi-disciplinary team (NMC,2018).
Part 3: Standards for Preregistration Nursing Practices (NMC,2018d)	Discuss the curriculum standards which follow the student journey from the "selection, admission and progression" process through to the qualification that is to be awarded to the student.

From this, a consideration of the wider impact of changes made to pre-registration nurse education and the role of a nurse in patient care in acute settings will be explored and inform the next section of the thesis.

1.1.2 Wider Impact: Where does the patient fit into future registrant investment and the implementation of the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d)

It is often recognised that the need to develop pre-registration students so they are "practice ready" (Brown,2017) at the point of registration has always formed the basis of evolving the profession (Leigh et al.,2019; Loveday,2019). However, in line with current, increased demands on the primary care sector (Gillespie, 2020; Molodynsky et al.,2020) and NMC Strategy 20202025 (NMC,2019a; NMC,2020), the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) repeatedly alludes to the benefit of registrants being able to care for patients/service users at any point during their lifespan; as in from birth to palliative care and loss. It also emphasises the need to "critically apply knowledge and skills and provide expert, evidence-based, direct nursing care" (NMC,2018a:3) within all four fields of nursing practice and across all care settings (Gillespie,2020; NMC,2018a:3; NMC,2020).

Consideration of the NHS England's Long Term Plan (NHS,2019) and NMC Strategy 2020-2025 (NMC,2020) in congruence with the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d), in part, also imply that alongside an ever-growing demand and the potential movement towards generically educated practitioners, longevity of patients/service users is increasing. In addition to these factors, there is also a greater proportion of patients who require access to healthcare for either combined needs or support for multimorbidity in the wake of increasing social and health inequality (Boehmer et al.,2018; NMC,2020; The institute of health equity,2020). In some ways, this, too, promoted the need for changes to the baseline requirements of a registered nurse, their role, and daily responsibilities. It also highlights the potential suggestion that for registrants to appropriately assess, diagnose, care, and treat patients/service users effectively, the focus of practice learning and educational content needs to be embedded within their local arrangements.

A long-term benefit of advocating for an "all care settings" approach (NMC,2018a:3), therefore, may contraindicate the use of pathway-specific courses and help to prevent

premature preferences to pathways or specialities in practice learning environments, i.e., medical and surgical and community, which includes assistance from a mental health or learning disability perspective. Generic education could also allow pre-registration students to recognise the need for transferable qualities and knowledge that benefit generic nursing care. It also recognises the opportunity for pre-registration students to promote innovative ways in which care is accessed, in addition to conventional care pathways, and therefore promotes holistic approaches. “Telemedicine is a primary example of this, as a range of aged people can use it in an appropriate and preferably private space. One benefit of Telemedicine is the immediate availability to access advice and having to travel to services. However, limitation concerns could include access and knowing how to use dedicated technology or know it’s there in the first place (Asiri et al., 2019; Castle-Clarke, 2018). In time, this transferable knowledge could help pre-registration students, would-be registrants, and members of the existing workforce to more cohesively meet a larger proportion of generic patient needs and expectations. It also helps to avoid over-reliance on signposting and creating extreme points of pressure as individuals access care services either by accessing primary and/or secondary sectors throughout any given year (Jivraj et al.,2020; Nabizadeh-Ghourhozar et al.,2021).

However, despite highlighting some overarching benefits and consideration of how to foster a “people of all ages and across all settings” (NMC,2018a:3) approach to care provision, there is room for additional critique. This partly stems from tentative suggestions that although a review of management and communication skills (NMC,2018) and nursing procedures (NMC, 2018) may have been entirely necessary at the point that the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) were implemented until they are fully embedded and have been evaluated, it is difficult to say if the context in both annexes is truly representative of the changing patient/service user needs, particularly post COVID Pandemic. This may also be attributed to timing, as implementing the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) occurred when a global pandemic ensued to an unanticipated scale and impact. This extends to the condition’s associated pathophysiology, the number of people that would live with “Long Covid” indefinitely, and the amount of holistic support needed as part of the recovery movement during

and post waves of the Coronavirus (Department of Health,2020; Godlee,2020; Thornton,2020).

It was also not entirely known when this study was initially conducted if including specific skills and nursing procedures was feasible and safe in all placement learning environments. An example of this may include aspects of Annexe A (NMC,2018a: 27:-31) which allude to newly qualified registrants demonstrating their ability to identify and use best practice communication skills and approaches for providing therapeutic interventions (NMC,2018a:29). This may be initially problematic as communication "is central to the provision of safe and compassionate, person-centred care" (NMC,2018a:27), incorrect application and use of therapy could exacerbate an existing condition or be inappropriate for specific patient use. As such, the selection and application require greater expertise that may only be consistently reached through specific training and experiences. It also seemingly does not consider that without regular use or exposure to a range of patients/service users, the skill or nursing procedure cannot be adapted to suit potentially complex patients. This extends to a new or existing registrant who may have recently been deemed proficient to practice a specific skill or nursing procedure. However, due to time lapse, they may not retain enough information to use it within their care repertoire to a sufficient standard and, therefore, maintain it (Peate,2018). While there is a caveat in the *Standards of Proficiency for Registered Nurses* (NMC,2018a:27), which states that "Registered nurses must be able to demonstrate these skills to an appropriate level for their intended field(s) of practice", it remains possible for new registrants to overestimate their ability based on superficial achievement of proficiency and has in some cases proven to create significant differences between what can be recognised as strength or weakness in a practice learning environment (Baxter and Norman,2011).

The mismatch between general nurse education and generic nurses working in a speciality setting has, to some degree, already been demonstrated in real life, as the need for specialist knowledge and expertise has been demonstrated in Australia (Wilson et al.,2018). In this example, Australian general nurses who worked within specialist areas suggested that despite having "ad-hoc" sessions and gaining some knowledge and awareness, numerous individuals who contributed to the study felt insufficiently prepared and "out of their depth and found it difficult to navigate the

differing roles" (Wilson et al.,2018:814) before their exposure and caring for patients with specific needs (Wilson et al.,2018). Anecdotal evidence collated in this example also suggested that attendance at training sessions became more generalised and did not alter or improve staff perceptions. Instead, recommendations formed in this study indicated that specific needs should be embedded throughout a curriculum (Wilson et al., 2018).

To a degree, this also does not significantly indicate that lessons have been learnt or sustainably achieved in comparison to findings initially highlighted in the Treat Me Right! the Report, issued by MENCAP. In part, this report suggested that failing to create specific roles for learning disability nursing led to "…. many healthcare professionals having little understanding of learning disability" (MENCAP,2004) and that general nursing did not provide a sufficient solution. This not only correlates with more recent findings in Wilson's (2018) work but was noted much earlier in MENCAP's follow-up report, *Death by In Difference* (MENCAP,2007), which flagged that despite a broad overview of knowledge, the training and knowledge base was insufficient for supporting individuals. In addition, findings in the report indicated that due to inequalities in the healthcare institution, a lack of awareness and understanding of additional learning needs or learning disabilities not only existed but led to preventable deaths in acute settings. In comparison to the current nursing climate, the 2022 report from Learning from *Lives and Deaths People with a Learning Disability and autistic people* (LeDeR) indicates that although COVID-19 was the leading cause of death for individuals who had a learning disability, in 2021, the death rate for this year was 21.5% in comparison to 10.4% within the wider population (Clews,2022). The LeDeR report also indicates that:

> *"A total of 3,304 deaths were reported to the LeDeR team in 2021, including 208 children".*
>
> *Is behind the report, published by King's College London, said 49% of deaths were deemed to be "avoidable," compared to 22% for the wider general population".*
>
> (Clews,2022).

Further evidence was presented publication in 2022 entitled "*More than Words: Supporting Effective Communication with Autistic People in the Healthcare Setting*" (Economic and Social Research Council,2022) but is emotively reflected upon in an open letter in 2023 published in the Nursing Times as part of an unnamed editorial. This open letter highlights concerns put forward by Mental Health Academics UK (MHNAUK) as part of the consultation for the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) before their implementation in 2018. More specifically, these state that "the NMC standards are inherently responsible for the atrophy of mental health nursing education across all four nations, resulting in a violation of our first principle: to protect the public" (MHNAUK in Anon,2023). Additional criticism extended to the following points:

- *"prescribing a generic nurse education syllabus, which is antecedent to the dilution of mental health nursing identity;*
- *A failure to govern the standards in earnest, as they are translated and validated by the AEIs and NMC;*
- *A failure to foresee the derivation of a procedural, task-orientated and adult-centric nurse education programme across the UK has precipitated a generation of mental health nurses with a redundant skill set.*

(MHNAUK in Anon,2023).

Another pertinent example of discord between the old and new practice standard would be the inclusion of non-medical prescribing and ambitions from the regulator, which suggest that at the point of joining the professional register, pre-registration students *"will already be equipped to progress to the completion of a prescribing qualification"* (NMC,2018a:6). In comparison to the preceding standards, however, more substantive experience and advanced skills were required to complete a prescribing course (Duncan and Johnstone,2018; Prydderch,2019). This was seen to be necessary due to the gravitas and, therefore, significance the prescription of medications has on patient care and safety. Without prior experience, the individual undertaking a course may also have not been exposed to enough nuances influencing prescribing medications. Some of these include the use of medications based on

unlicensed usage or to promote a therapeutic effect. For example, Hyoscine Butylbromide (BUSCOPAN) is used in imminent, end-of-life care for the management of respiratory secretions (Specialist Palliative Audit and Guideline Group (SPAGG),2016) as opposed to being typically used as an antispasmodic in gastro-intestinal or genito-urinary disorders (National Institute for Health and Care Excellence (NICE), 2022).

However, as with many situations, without sufficient knowledge, there are significant side effects to consider. From a drug-specific perspective, this may include side effects of an intervention that could complicate an existing condition or lead to polypharmacy and medication errors. Another example within the UK was incorporating formerly advanced skills and nursing procedures into their curriculums (Perkins,2019), such as pharmacology and non-medical prescribing. Despite there being several key benefits to nurses obtaining prescribing ability (Prydderch,2019), which include: *"acceptance for nurse prescribing amongst patients, with many reporting a significant improvement in the care received"* (Prydderch,2019:1). This extends to the promotion of greater autonomy; and access within the community, there is recognition that practitioners needed two- or three years qualified experience before being able to prescribe (Prydderch,2019).

Under the preceding SLAiP standards (NMC,2010), there was also an additional need to gain at least one year's experience within the specific practice area that practitioners specialise in before prescribing (Prydderch,2019). This could mean that existing registrants before the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) may not be able to fully support the decision to prescribe or offer specific advice about medications. The exceptions to this are nurses who have developed the appropriate skills and knowledge to fulfil advanced roles and as prescribers, which again are limited compared to other professions (Prydderch,2019). It may also be suggested that the complexity of non-medical prescribing is further complicated when the consideration of medications being given for non-licensed reasons is factored into the prescription and dispensation of medications. This is not dissimilar from another example whereby Farokhzadian et al. (2018:1) identified that some *"modern advances and the complexity of healthcare have led to serious deficiencies in the quality of care and patient safety"* when sizeable changes have been initiated.

To link this back to current changes, the NMC *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) and separation of parts and documentation within the regional MYEPAD document (PMYEPLG,2020) do allow for a number of these elements to be woven into pre-registration education within all parts. However, further discussion is needed in line with thoughts already expressed in Peate's (2018) work. This includes suggesting ways that professionals on the register can consistently maintain an achieved procedure or skill to a sufficient standard once they establish themselves in a speciality and may only have limited exposure to a nuanced or realigned skill or proficiency.

In addition, due to the ever-changing nature of some practice learning environments, keeping up to date in an irregularly accessed area could mean that *"a lot of staff aren't properly trained to look after these people who are so vulnerable… it's scary… the care isn't a good standard"* (Wilson et al., 2018: 818). Considering this is expected from the first year at an undergraduate level, Ion et al.'s (2020) suggestion that this is beyond reasonable expectations at the point of entry to the professional register arguably presents another real potential.

To summarise, consideration of these impacting factors, which are long-term and new, has been somewhat amplified by publishing the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d). In the initial period following their implementation, some initial but very tentative suggestions can be formed. The first is that before greater data generation occurs, the ability to fully meet the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) in their relative infancy underlines their aspirational nature. Despite their potential for the long-term healthcare landscape, the short-term appears littered with issues. The second tentative suggestion is that, without significant investment into the existing workforce, a disparity between experienced workforce members and newly qualified registrants might, and to some degree, already have started to occur. This is evidenced through acknowledgements of the regulator that there is an existing need to address *"limited access to professional development"* (NMC,2020:28) despite realigning skills in 2018. This lack extends to maintaining a skill when a pre-registration student joins the register and works with counterparts who do not possess the newer skills outlined in the annexes (NMC,2018a). In some ways, this, too, poses both questions and gives

weight to the idea that without sufficient CPD, it will be challenging for registrants already in post to achieve and meet the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d). In extension, obtaining sufficient skills, proficiencies and underpinning knowledge to support pre-registration students is essential (Swift et al.,2020; Tuomikoski et al.,2020). Without reviewing these to ensure that the more recent shift towards supervisor and assessor roles may also be problematic in perpetuity.

The next section will highlight how the abstract and introduction content have stemmed from the primary research question and helped to sculpt the research question into a singular aim and three objectives.

1.1.3 Research Question, Aim, and Objectives.

The preface of this thesis (see p.14) demonstrates that I was initially asked to consider if any additional or alternative models could be used to enhance an AEI role in supporting preregistration students by optimising the use of the current educational standards. However, a draft of the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) was released in the same year and went for consultation with the nursing profession. This draft consultation influenced the first iteration of the research question. This was captured in How Might Registered Nurses Adapt Their Practice in relation to student nurse supervision and assessment to Meet the New Standards for Proficiency and Standards for Student Supervision and Assessment in Nursing? However, there were no concrete considerations in the public domain as the final version of the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) had not yet been published. This led to the study using former language, terminology, and roles at the start. This is demonstrated in the starting objectives, which drew from an aim to explore ways that may be provided to students while they are on placement and included:

1. To explore how “mentors and sign-off mentors” currently use clinical supervision and mentorship with their mentees in the clinical area.
2. To investigate “mentors and sign-off mentors” understanding of the new NMC *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d).
3. To examine any potential barriers that may impact the ability of “mentors and sign-off mentors” to deliver the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d).

These research objectives were also used to guide initial literature search strategies based on the vast nursing literature available that may be considered. Composing a dedicated set of objectives ultimately provided structure to the search for robust nursing literature and ensured that all were relevant and represented a balanced discussion. However, until early 2019, registrants were primarily related to preceding nursing education models and roles associated with the SLAiP standards (NMC,2008; RCN,2015). This meant that a lot of literature considered the role of the mentor and sign-off mentors and their accrued experience to support preregistration students in

practice. Considering this relevant knowledge, therefore, was not only beneficial and built the common ground for the study to start from but allowed for direct comparison between SLAiP (NMC.2008; RCN,2015) and the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d). Again, this was also important, as a complete publication of the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) in May 2018 led to the discontinued use of mentorship and the associated SLAiP standards (NMC,2008; RCN,2015). This meant that the set brief and, parts of the content, and the structured objectives became obsolete early in the study. Furthermore, the removal of the preceding roles, such as the 'mentor' and 'sign-off mentor' and the implementation of the Practice Supervisor, Practice Assessor, and the new role of Academic Assessor created a new role that AEIs fulfil (Drayton and Edmonds,2020).

This led to a revision of the thesis title, which became: Approved Educational Institutions' Role in supporting pre-registration students in the practice learning environment. It also prompted a refinement of the aim and objectives for the study, which became:

Research Aim:

To identify if there was a significantly better way of supporting pre-registration students in clinical practice that could be utilised by the university using the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d).

Research Objectives:

1. To explore the current understanding and awareness that existing registrants have developed in relation to the Standards of Proficiency for Registered Nurses (NMC,2018a) and *SSSA* (NMC,2018).
2. To identify how existing registrants are meeting the more recent requirements of the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d).
3. To examine any potential barriers affecting an existing registrant's ability to implement the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) with preregistration students.

From these objectives, understanding the theoretical differences between the SLAiP (NMC, 2008; RCN,2015) and the *SSSA* (NMC,2018) not only has the potential to inform exploration but also allows the study to systematically consider a body of evidence that supports or argues against the need for change, or the degree of change made to the nursing profession. However, as these are significant and have considered a breadth of literature, separate objectives were created and have been broken down into subheadings so that the plethora of evidence available may be appraised. These will now be introduced.

1.1.4 Literary Objective 1 - To highlight and appraise key similarities and differences between Supervision and Mentorship so they can inform new ways of supporting preregistration nursing students.

A critical exploration of these literary objectives has been broken down into several subheadings that separate discussions surrounding the key similarities and differences between SLAiP Standards (NMC,2008, RCN,2015) and the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d). The first examines defining roles and responsibilities that influence pre-registration support in practice learning environments.

Subheading One – Similarity and Difference: Defining the role of a practice supervisor or practice assessor in comparison to a Mentor or Sign-off Mentor.

Despite a well-documented lack of consensus amongst individual practitioners which surrounds how the roles of a supervisor or former mentor may be fulfilled on a daily basis and individual circumstances (Henderson and Eaton,2013; Gopee,2023; RCN,2015), the definition on which the *Future Nurse: Standards of proficiency for registered nurses* (NMC,2018a) and Part 2: The *SSSA* (NMC,2018), are based, indicates that a supervisor can be any registered nurse or midwife who assumes a role model position and will "*Contribute to the ongoing observation, training and assessment of students"* (Feeney and Everett,2020:7). The separate role of a registrant, who acts as a Practice Assessor, is then encouraged to utilise feedback and documented support offered by *"NMC registered nurses and midwives, and other*

registered health and social care professionals" (Duffy and Gillies,2018; NMC,2018:6; Pearson and Wallymahmed,2020) within the Regional MYEPAD document to contribute to the students' assessment and progression of a pre-registration students' progress (PAN Midlands, Yorkshire, and East Practice Learning Group (MYEPLG,2020). The rationale for separating the roles is so that a multi-professional and "team" approach (Duffy and Gillies,2018) to the supervision of a pre-registration student forms a continual and real-time reflection of their development and associated progress. This, therefore, creates a sense of evidenced-based robustness and objectivity in any progress decisions (Feeney and Everett, 2020; Lidster and Wakefield,2022; NMC,2018:8).

In some ways, the definition of supervision provided by the NMC in the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) and practice guides (NMC,2018e) demonstrates a secondary, close mirroring of sentiments that underpinned the theoretical and practical actions required under the SLAiP standards (NMC,2008; RCN,2015). This is due to a perceived similarity and focus between SLAiP standards and the *SSSA*(NMC,2018), which emphasise the need for registrants to be change agents or role models to support, supervise and assess pre-registration students in such a way that they are prepared for registration (NMC,2010; RCN,2015). In light of this similarity, it may be suggested that despite issuing a specific definition, a degree of overlap between models is largely unavoidable as the preparation of a preregistration student relies on consistency achieved within practice learning environments. This can only be set by individuals and their practice and, therefore, transcend specific terminology or language use, as it does not change the fundamental ethos and distinct qualities that registrants and preregistration nursing students embody. This leads to secondary considerations, which include similarities between the SLAiP standards (NMC,2008; RCN,2015) and the *SSSA* (NMC,2018) in the context of individual practice and being able to adapt support based on specific needs of the pre-registration student.

1.1.5 Subheading Two: Similarity – Adapting the standards and guidance to suit the preregistration student's needs.

Another key similarity between the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) and SLAiP standards (NMC,2008; RCN,2015) is that to ensure that pre-registration students have the best opportunity to meet core values, that most recently have been encapsulated in the seven platforms listed within the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d), registrants should maximise their ability to adapt theoretical and practical opportunities to an individual's personal learning or development needs (NMC,2018; NMC, 2018c; RCN,2015). This could imply that a degree of flexibility, in some cases, discretion, and the ability to adapt to pre-registration students' needs are achieved through the registrants exercising personal judgment and using accrued anecdotal experience to support preregistration students (Feeney and Everett,2020; NMC,2018; NMC,2018c). This is so that within the remits of the practice supervisor and practice assessor role, pre-registration students are provided with balanced assessments and feedback which is purely based on individual merits or achievements and is worded in such a way that pre-registration students can access it, apply it, and consolidate the learning experience to improve existing practices.

The use of constructive feedback from an interdisciplinary perspective can also be used to highlight and target areas that require more support in methods that suit the pre-registration student if they are underperforming. Both aspects of adapting to the pre-registration students' needs and exposing them to different formats that feedback may take could help to prepare preregistration students who will also be expected to become Practice Supervisors at the point of registration. However, with only optional practice guides (NMC,2018e) and a staff update, there may be a degree of inclination to draw on their own experiences and what they have witnessed from more experienced registrants.

This extends, as well, to how to construct feedback (Fitzgerald et al. 2010), with ramifications for the pre-registration student if this flexible approach, used within supervision, becomes too loosely or poorly defined amongst registrants; blending roles and their responsibilities may occur if not be more likely, on the basis that any Practice Assessor can also work as a Supervisor for other students they are not assessing (Feeney and Everett, 2020; Gopee, 2023; NMC, 2018). In addition to these factors, before reverting back to the separation of roles, there may also be room for confusion

amongst registrants, owing to the NMC issuing a statement advising AEIs and practice partners that in the initial response to the Coronavirus pandemic. In this statement, aspects of *"Supervision and Assessment have been amended to allow the same person to fulfil the role of Practice Supervisor and Practice Assessor for the period that this emergency standard is in place"* (NMC,2020a) until the Current recovery programme standards (NMC,2021a) replaced them.

Given all of these considered factors, there may be an increased likelihood of registrants falling back into previous and well-engrained habits, and it has the potential to undo the sense of objectivity that defining separate roles as part of a "team approach" is intended to create. There is also scope to tentatively consider that, as a registrant, supervising and providing constructive feedback to pre-registration students is not only an art form, but all registrants now, and to some degree, have always assessed and evaluated a student nurse based on Professional Values, their rapport with peers, patients or service users, and any form of care or intervention that they either observe or witness the provision of. As such, it may be questioned if all registrants should instead become Practice Assessors, and this process is overseen by a Practice Supervisor who conducts the necessary interviews, reviews the feedback provided in the MYEPAD, and conducts an assessment based on an episode of care that they choose from an objective position. This is a significantly different approach between SLAiP standards and the *Future Nurse* Standards, as recognised in the third subheading based on the "team approach" and its implications for feedback received by the pre-registration student.

Subheading Three- Difference: The formalised use of a "team approach" to pre-registration supervision and assessment and its implications on student feedback.

A Practice Assessor's current role is based on their ability to assess using a team approach and having multiple perspectives to consider as part of a continual assessment of the part they are studying. This is accompanied by episodic assessments. In the short-term addresses preexisting issues of greater student numbers to trained mentors and sign-off mentors in practice learning environments (Lobo et al.,2014). However, utilising not only a team-based approach but an interdisciplinary approach and relying on written feedback may lead to an unhelpful

and inconsistent amount of subjective decision-making. A part of this may be due to individual professional bodies such as the General Medical Council (GMC) and Health and Care Professions Council (HCPC) embracing different professional standards and focusing on different areas of healthcare within their education processes. As such, differing standards of practice, flexible guidance to the point of being vague, and assessment decisions that rely on the feedback shared in the MYEPAD document (but may not include the rationale for decisions) may lead to or create variations in the detail and quality of feedback provided to a peer or preregistration student. The quality of feedback may also be affected by the experience accrued by the individual constructing feedback, their own use of terminology or language, and how aware they are of what a pre-registration student is expected to know or demonstrate within each part of their education (Feeney and Everett,2020; Gopee,2023; Sundler et al., 2019). Elements of this, however, may be unavoidable, as different practitioners hold different ideologies and have different perceptions of a singular professional identity. However, the use of interdisciplinary working provides students with a great opportunity to observe and experience different approaches to supervision and assessment. This extends to how their practice assessors interpret the collection of information to support their decisions and appraise the pre-registration students' progress. This may increase the opportunity to create a broad range of experience and skills for developing rapport with individual student nurses to *"facilitate student learning through independent participation; raise and respond to proficiency and conduct concerns; supervise, support and provide feedback to students"* (Leigh et al., 2019a:1125).

This highlights the importance of creating a sense of continuity and understanding amongst all healthcare professionals; this is not only shown in how healthcare professionals outside of a role interpret or come to understand them but is typically shown in how they prioritise aspects of healthcare daily and is somewhat reflexive of the standards and codes of professional practice they adhere to, and therefore create natural differences between them and a Nurse, Midwife, Nursing Associate or those that contribute to supervision of a student but are not regulated (Feeney and Everett, 2020; Godsey et al.,2020). In time, consistent understanding and, therefore, clarity of what is expected may prove to be a point that AEIs can assist with, as they may be able to work with the practice to inform common benchmarks that pre-registration

students should be working at in relation to their ‘part’ of the training but does not necessarily limit their exposure if they want to develop or gain exposure in advance. In extension to this, AEIs may offer a broader perspective and guidance that can inform supervision and assessment practices based on their NMC-approved curriculums to complement the existing provision made by Trusts. Otherwise, a lack of clarity could build on pre-existing issues that relate to levels of subjectivity in the decision-making process due to personal interpretation, experience, and preparedness for the role of mentor and now Practice Supervisor or Practice Assessor, as highlighted in subheading four.

1.1.6 Subheading Four – Similarity: Subjectivity in decision-making, preparedness for a supervising or assessing role, and experience as a Practitioner.

Providing feedback and acquiring non-technical skills, such as showing compassion, listening to others when delivered, and empowering others to adapt supervision styles when addressing or escalating concerns. However, using these non-technical skills could also complement taught theory and how registrants can support others to attain required practical skills, denoted in the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d), such as venepuncture and cannulation (NMC, 2018a; Welyczko,2020). A greater concurrency between professionals who assist with the supervision of pre-registration students may also help preregistration students feel more prepared for supervision and assessment of others as they progress towards registration. As alluded to earlier, any aspect of practice learning environments which requires practitioner judgement acknowledges that a degree of subjectivity will always exist and influence how supervision and assessment are conducted, which can challenge how new methods are embedded or adapted to suit the individual learner's needs (Cantanese and Shoamanesh,2017; Underwood et al.,2019). This is partly because supervision and assessment of others are shaped or influenced by the registrants’ level of self-awareness and how they interpret their interactions with pre-registration students (Mikkonen et al., 2020). It is also demonstrated through the practitioner’s ability to meet the standards of practice and personal style they develop as their exposure to supervision and assessment increases (Botma et al.,2013; Mikkonen et al., 2020; Por et al., 2011; Tuomikoski et

al., 2018). From a student's perspective, White (2017), Rooke (2014) and Benner et al. (2010) all suggest that a more experienced registrant led to higher levels of agreement with the Practice Supervisor and former mentor, a greater ability to plan and organise additional learning, and increased overall satisfaction with the placement experience (Benner et al.,2010; Rooke,2014; White,2017) *"It also counteracted feelings that despite theory modules teaching leadership skills, students remain concerned about undertaking mentoring responsibilities one year after qualification"* (Davis and Richardson,2017:1187).

Additional subjectivity levels associated with the provision of pre-registration supervision refer to how pre-registration students are supported in practice placements. For example, the supervision model recognised in the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) and the SLAiP standards (NMC,2008; RCN;2015) suggest that pre-registration students linked the quality of their placement experience with how prepared a registrant was for a responsible role. Furthermore, pre-registration students state that this was just as important as the registrant's attitude to creating a positive learning culture, learning, and professional relationship that they established with a student nurse (Cantanese and Shoamanesh,2017; Underwood et al.,2019; Vinales,2015). The identification of suboptimal learning culture is, therefore, one of the key priorities for would-be Practice Supervisors and Practice Assessors to address, as it helps to prevent an otherwise "toxic" learning culture that pre-registration students may be exposed to (Feeney and Everett,2020:43). Some of these included students feeling unsupported to learn and not classed as part of a team (Birks et al.,2017; Feeney and Everett, 2020:43; Freeling and Parker, 2015). As such, another potential strategy to support students in practice is for AEIs and Practice Learning Partners to adopt a collaborative focus on empowering these supervisors to identify potential challenges to the learning environment and develop the necessary non-technical skills that are required to do this to meet the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) and adhere to the current iteration of *The Code: Professional standards of practices and Behaviours for Nurses, Midwives and Nursing Associates* (NMC,2018b).

Given the similarities and differences established so far, several factors have been highlighted, which include the combined impact of subjective and vague supervision, as well as innumerable amounts of practice supervisors. To some degree, these have the potential to form differing perspectives and could make it difficult to assess a pre-registration student without a personal assessment of performance and conduct. This may then challenge the integrity and base of a Practice Assessor's decision. In turn, this could lead to documentation being poorly kept or lacking the necessary detail or depth. Consideration of the factors so far also highlights that the appropriate actions, understanding, and interpretation of feedback and making an objective decision that carries significant weight ultimately relies on how informed, experienced, and able the registrant is to make a judgment (Mikkonen et al.,2020) which can then be rationalised. Without evaluating the supervision and assessment process, it is challenging to state with certainty if any set combination of supervision and assessment practices outweighs the benefits of a flexible approach to supervising and assessing pre-registration students. On the other hand, it may lessen the strain on the limited number of registrants with experience who formerly acted as mentors and sign-off mentors (Lobo et al.,2014), which somewhat addresses concerns.

Another consideration from this may be that too many sources of supervision could also affect a student negatively. Some of the ways this may be observed include poor attention to supervision actually taking place, in the sense that one person may take for granted that another suitable person is providing supervision when, in fact, no one is. This could then lead to a failure to supervise and ensure patient safety, as well as ensure that feedback is meaningful and is focused enough to either demonstrate that a proficiency has been achieved or where there are aspects of development to consider in the next part of their training (Feeney and Everett,2020; Gopee,2023). As such, too many variables or too many different styles of supervision introduced, particularly in the short term, could lead to confusion or a disjointed record of the student's progress being produced, which, therefore, complicates the decision-making process enacted by the Practice Assessor and the pass or fail decision itself. This is particularly the case when the Practice Assessor is discouraged from supervising or working directly with the pre-registration student they are personally assessing or when they do not fully understand the new processes that underpin the *Future Nurse*

standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) and its differences from SLAiP (NMC,2008; RCN,2015). This leads to the consideration of Subheading Five: Understanding and being aware of standard requirements and maintaining role boundaries to influence learning culture.

1.1.7 Subheading Five– Similarity: Understanding and being aware of Standard requirements and maintaining role boundaries to influence learning culture.

Ensuring that all healthcare professionals understand the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) and the *SSSA*, in particular, could help clarify the role expectations and make it less challenging when guidance is broadly worded to encourage adaptability and registrant discretion. This is based on evidence that suggests that despite there being a prerequisite course, such as the English National Board (ENB) 998 (Crotty and Bignell,1988) and, more recently, the Supporting Learning and Assessment in Practice (SLAiP) course (NMC,2008; RCN,2015) for supporting pre-registration students, registrants still did not fully understand their roles (Meeuwissen et al.,2019). Reasons for this have included the interchangeable use of terms or language used to describe the roles in practice learning environments and the degree of overlapping roles, definitions, and responsibilities (Gopee,2023; Zhang et al.,2016) that sat alongside flexible guidance that Practice Learning Partners interpreted (Horsfall et al.,2012; Gopee,2023; Melon and Murdoch-Eaton,2015) and then adapted, by individual registrants, to suit the learner.

When continuing to compare the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) *and the RCN Mentorship project: From Today's Support in Practice to Tomorrow's Vision for Excellence* (2015), efforts to address this aspect of practice learning environments were found in how newly qualified registrants are prepared to challenge these "toxic" learning cultures in practice learning environments (Feeney and Everett,2020:43). In the past, a desire to avoid creating a "toxic" or negative learning experience had led to mentors providing a student with an overgenerous mark or even passing pre-registration students when this was otherwise contraindicated (Helminen et al.,2016).

A potential way to improve learning culture was initially identified in recommendations that called for *"Stronger Co-ordination between Education and Practice Agencies, Strategic sponsorship of mentoring programmes and secure funding for mentorship"* (RCN,2015:12). Part of these recommendations was met by registrants and the requirement to attend the SLAiP (NMC,2008; RCN,2015) or similar courses, which offered some formalised clarity for registrants to act as mentors and sign-off mentors. When these roles were rescinded, this removed the need to gain accreditation, fulfil the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d), and work as a Practice Supervisor (Rosser,2017). As such, AEIs are no longer obligated to provide a theoretical standard or underpinning (NMC,2018) that, in turn, shapes how registrants fulfil their influential role (Feeney and Everett,2020; Gopee,2023). Arguably, this has broken a link between the AEIs and placement providers, which encouraged registrants to develop their methods of supporting pre-registration students and their colleagues in a clinical setting, which somewhat contributes to a learning culture in practice areas (Mikkonen et al.,2020).

Instead, registrants are now offered NMC-approved, online but optional practice guides (NMC,2018e) on how they may become informed about their roles and act as competent supervisors (Rosser, 2017). The notion of an option resource contrasts with evidence offered in a systematic review, which suggests that the use of a mentoring course was an asset for newly registered nurses (Chen and Lou,2014). Amongst many reasons recognised within the review, the main benefits were that *"The implementation of mentorship programs reduced turnover rates, employer turnover costs, and medical negligence rates. Job satisfaction and professional identity were improved"* (Chen and Lou,2014:433). It also enabled former "mentors" to seek clarity and discuss processes involved with their roles or prompted them to seek guidance and a second opinion earlier if required (Zhang et al.,2016).

Despite some registrants finding a pre-requisite course useful, removing processes that clarify the expectations of the role can also create a decline in formal rigour applied to supervising and assessing pre-registration students. The loss of rigorous process could include the ability to consistently sense check the suitability of any registrant, which is concerning, as *"not every nurse will have the required aptitude and ability to ensure that learning outcomes conducive to the education of a student nurse have*

been met" (RCN,2015:4). However, it still can influence the pre-registration students' level of satisfaction and quality they associate with the placement (Gale et al.,2016) and is still expected to supervise practice.

It may also be suggested that removing a prerequisite standard used to assess the future Practice Supervisors and Practice Assessors inadvertently removes a safeguarding process for the public. This is based on the potential concept that a registrant can typically pass a nursing degree, having only achieved a pass mark of 40% for academic assignments between levels 4 to 6 to qualify (Rushforth,2007), which does not take into consideration the new skills and complexity of the new curriculum and skills required (Perkins,2019). Newly qualified registrants are also three times more likely to make mistakes due to a skill deficit than more experienced colleagues (Saintsing et al.,2011). This includes *"medication errors, the inability to follow physician orders correctly or in a timely fashion, and improperly supervising patients, resulting in incidents such as patient falls"* (Saintsing et al.,2011). It is therefore concerning that the accumulation of all the preceding challenges, removal of academic rigour, and non-obligation to sense check the quality of post-graduate knowledge allows people to work in positions that have been recognised throughout decades as influential (Ball,2017; Devlin and Duggan,2020; Helminen et al.,2017) and can perpetuate schools of thought or knowledge amongst the future workforces. From these points, it may be tentatively put forward that every registrant will now have different foundation points. This makes it more challenging to offer supervision and impacts an AEI's ability to consistently offer strategic advice, support, and guidance for specific preregistration students in the practice learning environment. This may then lead to generically offered solutions that may not suit individual learners despite their academic position and associated benefits.

Concerns have also been identified that newly qualified registrants may struggle now that courses such as SLAiP (NMC,2008; RCN,2015) have been rescinded. These concerns stem from practitioners recognising that even with its use, mentors often felt that when they qualified, they had little or no experience to offer pre-registration students and, therefore, did not see themselves as mentors and act accordingly (Carey et al.,2016). Without a pre-requisite and a baseline body of experience to fulfil

the role, there is an increased likelihood that newly qualified registrants may feel *"overwhelmed by the responsibility, especially if they are newly qualified, trying to get to grips with competence in relation to their practice"* (Andrews et al.,2010:252; Devlin and Duggan,2020) and generally feeling ill-prepared to act as a mentor or supervisor to others (Casey and Clarke,2011; Ingvarsson et al.,2019; Wilson,2014). At the point of registration, a newly qualified practitioner may also have not developed the appropriate non-technical skills and may be insufficiently prepared to support, supervise, or assess others (Bennett et al.,2017; Christensen et al.,2016; McKenna and French,2011; Mikkonen et al.,2020). In some cases, due to poor experience in pre-registration training, feelings of being ill-prepared extended to not being ready for the point of registration and for the autonomy a nurse holds (Thomson et al.,2017).

This links to further evidence that suggests that the amount of clinical experience gained as a registrant is directly linked with how successful they feel they are at delivering in their role as mentor or supervisor (Jokelainen et al.,2011; Meng Chong et al.,2016; Nettleton and Bray, 2008). A part of this self-perception and readiness to supervise or mentor others was also linked with the registrant's existing level of proficiency, levels of intuitiveness, and ability to recognise what other people needed (Mellon and Murdoch-Eaton,2015; RCN,2015). Available literature suggests that mentors further develop themselves by using their lived experience to develop their teaching style or demonstrating skills to more junior people as part of the mentoring process (Tuomikoski et al.,2018). They also piece together aspects of what they learn from others, suggesting no singular point of reference exists. Pre-registration students felt the combination of these factors helped them generate a more rounded and informed perception of their duties as future registrants (Merga et al.,2020) and improve their performance once qualified. This helped them give feedback, use reflection to adapt their practices and develop management skills that govern pre-registration supervision and assessment.

Therefore, the combined lack of training standardisation for Practice Supervisors and Assessors, clarity of the role, and ability to ensure a baseline for supervision practices beyond an optional resource could inhibit the registrants' ability to meet the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) and ensure *"that all nurses, midwives and nursing associates in any practice learning environment*

should be able to undertake a Practice Supervisor role" (NMC,2018f). It could also limit their time to consolidate their understanding of the role as a registrant and its expectations if they do not utilise the optional resources before undertaking a position which allows them to supervise and/or assess others. Evidence suggests that newly qualified registrants also need time to adjust to their remit as qualified staff and develop their sense of priorities and ultimate responsibility for their workload (Ingvarsson et al.,2019; Haddad et al.,2017; Sparacino,2015). Depending on the experience of the student nurse will depend on how independent they have become throughout their programme. As such, a new registrant could experience varying degrees of *"Transitional Shock"* (Kramer,1974; Ingvarsson et al.,2019; Haddad et al.,2017; Sparacino,2015) which could then exacerbate existing feelings of being overwhelmed or ill-prepared (Bennett et al.,2017; Devlin and Duggan,2020; McKenna and French,2011) to undertake the role of a Practice Supervisor or Practice Assessor.

An additional contributor without a theoretical baseline to more solidly refer to and develop rapport with AEIs is that the true perceptions of a supervisor's role may become distorted by the new registrant's desire to be accepted or taken seriously in their professional working environment. This may extend to how pre-registration students identify and set to overcome forms of "Transitional Shock" that people may experience instead of focusing on building relationships with colleagues (Halpin et al.,2017) and pre-registration students. The latter is particularly important, as the desire to be liked or accepted by peers could influence how much a new or more junior practitioner will question or challenge others. This could then lead to hesitancy in upholding the desired attributes of a Practice Supervisor and duties within their role, and could instead, lead them to perpetuate outdated practices (Bickhoff et al.,2016) disseminating them, as well as perpetuate a theory to practice deficit (Monaghan,2015). A lack of understanding and missing a formalised introduction to concepts within the *SSSA* (NMC,2018) and its expectations may also lead to newly qualified registrants experiencing difficulty when taking part in difficult decisions or managing confrontation. For example, if pre-registration students' feedback is poorly received. As such, they could then struggle to enforce optimal practices, discourage suboptimal learning cultures, or fail to fail pre-registration students (Black et al.,2014; Duffy,2013; Hunt,2014), as well as change their more senior colleagues if necessary.

This then has the potential to affect professional relationships, and the roles of the Practice Supervisor and Practice Assessor roles should also be considered and inform discussions that follow in Subheading Six.

1.1.8 Subheading Six Difference – Explicit discussion of pastoral care and professional relationships in line with *SSSA* role definitions and role expectations.

The pastoral element of mentorship that is not as explicitly captured in the *SSSA* (NMC,2018) roles was valued by the students in a variety of ways. This seems to be most attributable to the formation of positive and dedicated relationships established between pre-registration students, mentors, and sign-off mentors (Barr and Dowding,2019; Gopee,2023; Merga et al., 2020). The benefits within the literature associated with this role found that students felt more accepted and that positive relationships led to promoted independence in their practice and encouraged the pre-registration student to demonstrate a higher level of responsibility and engagement in their placement areas (Crombie et al.,2013; McCallum et al.,2016; Stenberg and Carlson,2015). In the past, these benefits led to common practices in nursing whereby registrants who chose to act as a mentor looked to establish a balance between competing priorities in their role. This may include developing and ensuring individual proficiency while meeting the needs of an individual by responding to well-documented pastoral needs, such as anxiety and self-doubt during placements (Al-Niarat and Abumoghli, 2019; Stenberg and Carlson,2015; Thomson et al.,2017). However, the balance of pastoral support and giving objective assessment is not simple and is also a substantially subjective process, as it forms another practitioner-led initiative in practice.

Extended benefits reported through the use of a balanced mentorship role also include greater consistency in terms of delivering and meeting the expectations of the role as people understood it,, but also offers an evaluated increase in student satisfaction and their sense of belonging (Bishop, 2007; Gopee,2023; McCallum et al.,2016). Therefore, effective supervision and former mentorship of pre-registration students in whatever capacity is not only pivotal in terms of developing the characteristics required of all NMC registrants, as listed within their *Code of Professional Standards and*

Behaviour (NMC,2018b) but is also shown to increase a preregistration student's confidence when disseminating evidence amongst their peers and retaining students through to registration and uptake of proficiency (Al-Niarat and Abinoghli, 2019, Crombie et al.,2013; Thomson et al.,2017). This may then influence how they explore options to support pre-registration students and what resources are used when they act as a registrant in the future. This could include the greater usage of peer support models in parallel with supervision conducted by registrants (Budgen and Gamroth,2007; Davis and Richardson,2017; Gopee, 2023; White,2017).

However, having dedicated mentors could have the opposite effects and highlight the dangers of strong personalities or negative experiences for both parties (Hunt et al.,2012; Hunt et al.,2016; Webb and Shakespeare,2008) within the mentor and student relationship. Some of the well-known consequences include discourse and personal bias in favour of specific students and communication breakdown between the parties involved (Black et al.,2014; Duffy,2013; Hunt et al.,2016; Peiser et al.,2018). It may be argued that the separation of the supervisor and practice assessing duties is also one of the most significant changes the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) proposed but is one of the only points with explicit guidance being available, in the sense that there are clear boundaries that each role should maintain (Feeney and Everett,2020; Gopee,2023; Lidster and Wakefield,2022). However, a benefit that separating the roles holds for the student in comparison to the mentorship model is that greater consistency from an individual assessment point of view can be reached through the team approach to supervision, and it can generate more objective and, in some cases, more resilient and emotionally intuitive perspectives that can support the pre-registration student's development; as *"The Code"* stipulates (NMC, 2018b; Webb,2018).

1.1.8 Summary of Subheadings and Literary Objective One.

To summarise Literary Objective One, the combination of factors highlighted within subheadings and the thesis so far suggest and allude to several benefits and limitations when initially implementing the *SSSA* (NMC,2018). Although there are more

similarities than differences when core elements of the Practice Supervisor and Practice Assessor roles are compared, the differences are significant and could impact the quality of pre-registration supervision and assessment if AEIs are not working collaboratively with PLPs to help with consistent interpretation and helping all healthcare professionals to understand the relevant parts they contribute to.

There is also the potential for existing registrants not to have already attained what is expected of newly qualified registrants and pre-registration students at the point of registration; the potential gap may also create role inequality and, in their infancy, an ability for all registrants to meet the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d). As a short and long-term impact, if a collective effort is not made to support existing registrants to meet the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) as a whole, there may be ineffective support for pre-registration students who will soon to be newly registered and lead to a perceived increase in pressure on staff. This pressure may be formed based on several of the identified factors, such as the pre-registration students' ability to be proficient in ways that their supervisors may not have been or are currently working at. Another form of pressure is to become familiar with the role of a newly registered nurse and adjust to being a registrant while establishing themselves as Practice Supervisors with little formalised experience.

Literature also suggests this may lead to registrants devaluing and doubting their ability to make decisions and assess others despite their experience as former mentors and sign-off mentors (Leigh and Roberts,2017). From a wider impact, a perceived lack of accreditation that supports a role and alterations to the baseline level of skill and procedural knowledge without upskilling the existing workforce could fundamentally detract from creating a sustainable workforce. Furthermore, it also has potential to undermine the NMC's intention to improve on existing learning cultures that otherwise have been found to contribute to registrants feeling ill-prepared and *"dropping people in at the deep end"* (Feeney and Everett, 2020:43), which is built on historical but still relevant precedents and contributions towards high attrition rate, as well as burnout and compassion fatigue in newly qualified registrants (Duffield and O'Brien-Pallas,2003; Elin et al., 2019; Health Education England (HEE),2014).

As a final consideration for Research Objective One, the individually considered factors have the potential to create significant disparity in the pre-registration student's experience. This can lead to inconsistent and unmet expectations placed on PLPs, AEIs or the individual pre-registration student. It may also be summatively noted that where the provision of supervision can be fulfilled by any healthcare professional within a practice learning environment, there may be difficulty in distinguishing who is taking overall accountability for a pre-registration student's experiences at any one time.

In addition, the subjective and lived experiences that shape the work of registrants and the preregistration student's journey towards registration are an embedded part of being an autonomous practitioner and growth towards registering as a nurse. Based on the degree of subjectivity that affects decision-making processes and what individuals feel is important to disseminate within their influential positions (Brooke,2017; Rylance et al.,2017), it would be challenging to standardise or consistently quantify what constitutes optimal student support completely. This includes what this support should be or look like and could be detrimental to the learner. This is suggested as advocating for any particular method or model for supporting preregistration students and arguably creates a greater risk than promoting a standardised way of working. This is because a standard approach may only suit some learners, all registrants, or individual practice environments, which could impact patient safety and the ability to provide person-centred or holistic care. This could further impact the registrant's ability to contribute to the choices offered as part of active learning, the patient care process, and the overall effectiveness of practice supervision and assessment. However, this should be weighed against the benefits of having greater freedom or flexibility that the *SSSA* permits. To some degree, having too much choice to accommodate more significant student numbers and ensure they pass may not be entirely beneficial. While it is suggested that this may not be fully realised until the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) have been fully embedded and evaluated, consideration of different models that could complement the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) has been explored in more detail in Research Objective Two.

1.2 Literary Objective Two - To critique and identify how, or if, a singular model may aid AEI efforts to support pre-registration nursing and significantly complement the *SSSA*.

As a precursor to the introduction, information in the set brief for the study identified that there were already two methods in which AEIs support pre-registration students in practice. In line with the detail in the preface, it states that:

> *"Placement Support and Development involves academic staff working with practice to support mentors in failing students, carrying out educational audits in clinical areas and supporting students who are having difficulty. The second model is for Placement Support Staff - academic staff who are mainly university-based but may visit practice half a day a week or less to support placement" (see preface)*

However, in the practice learning environment, there are several different ways that existing registrants offer support to pre-registration students outside of these provisions. As one or two are widely used, it is important to consider how these complement the *SSSA* (NMC,2018). particularly as pre-Coronavirus pandemic, there was "a small range of alternative approaches to one-to-one mentoring to seek support, supervise and assess nursing students while engaging in practice learning within clinical placements" (Wareing et al.,2018). This is problematic, as more staff are leaving the nursing profession post-pandemic despite larger pre-registration student cohorts being created and taught by AEIs. In addition, considering complementary ways of training pre-registration students could enhance ways that interdisciplinary working occurs, and placement capacity suits a multitude of healthcare-based professions that share the same practice learning environments (Sevenhuysen et al.,2013; Williamson et al.,2020).

Based on a literature search, the two models appeared to be the most widely discussed and have been considered for their individual strengths and weaknesses as well as their compatibility with the *SSSA*. These are Peer Assisted Learning (PAL) or

Coaching and Peer Assisted Learning (CPAL) as well as the Collaborative Learning in Practice (CLiP) model, which will now be presented under their relevant subheadings.

1.2.1 Peer-Assisted Learning (PAL) or Coaching and Peer-Assisted Learning (CPAL)

One of the ways that practice initially adapted in light of the challenges previously discussed was to utilise "buddy systems," "Peer Assisted Learning" (PAL), or "Coaching and peer-assisted learning" (CPAL) (Wareing et al.,2018) beyond the classroom settings, but these are based on pedagogical strategies (Ignacio and Chen,2020) and social learning theory (Sevenhuysen et al.,2017). More recently, this has also included the "synergy" model to enhance support in specific clinical areas and encourage peer teaching and learning across all parts of preregistration training (Leigh et al.,2019). Over decades, PAL and similar models have blended with other influences from non-healthcare professions. These include the police and prison service, as the use of a PAL-adapted system allowed more experienced staff "to show people the ropes" as they gain critical workforce experience and develop proficiency (Carey et al.,2016; Glynn et al.,2006; White and Hesop,2012). As there is already acknowledgement that there is timely need to develop pre-registration students and recognise that nursing is a practice-based profession (see preface), greater development of PAL-related strategies has the potential to do the same, but so far, it has reported mixed successes due to the variable attitudes of registrants, their use and understanding of the model and limited transferability amongst a host of placement areas (Carey et al.,2016; Hirdle et al.,2020).

Limited Transferability amongst areas that utilise a PAL-based system for student support is not aided by the evidence, which suggests that, up until now, PAL has largely been trialled in settings that focus on smaller numbers and has yet to be evaluated in larger settings. Having said that, the evidence does suggest that in one case, *"Implementing the PAL placement model at just two sites increased placement capacity by 12 students, a 1.3-fold increase across London"* (Reidlinger et al.,2017:339) alongside positive working experience and suitable workload allocation

(Reidlinger et al.,2017). The same study reported that registrants assuming a role directly involved with student supervision took less time to fulfil their duties (Reidlinger et al. 2017), which shows it has definite potential. It also allows pre-registration students to teach from a peer-to-peer vantage point and empower students (Sevenhuysen et al.,2017). When combined with the noted benefits in the literature, similar success could be replicated in other settings, but further exploration and evaluation are emphasised in this study. The dangers of skipping this step may also be detrimental to patient safety, as is the removal of a theoretical standard due to the potential impact this may have on the quality of supervision. It could also lead to too many students being placed into an area and does not work well with the ratio of registrants available, despite a robust model being put in place. In that case, there is potential for it to lead to superficial assessment and investment in learning (Sevenhuysen et al.,2013). It also relies on the registrants being suitably trained and competent (Gopee,2023), which links back to earlier suggestions supporting AEI input in upskilling the future workforce in partnership with PLPs and using pre-established ways of working.

Further implementation of PAL-based support is not made easier by the limited available resources to implement these more extensive work systems. In addition, in the current financial climate, investors may be reluctant to invest in a PAL-styled model that does not suit a more significant proportion of placements within any Trust. This is further supported by evidence suggesting that PAL may only be a viable option in the acute sectors due to the level of autonomy required for lone working, or similar, in other settings such as the community where lone working often occurs.

Given these new and existing factors highlighted in Research Objective One, the challenge to implement significant change as advocated for in the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) and increase placement capacity cannot be underestimated. This is due to the need to find solutions that help to grow the future healthcare workforce but offer them experiences that maintain the quality of placement exposure offered to pre-registration students

(HEE,2017; Reidlinger et al.,2017). It is also unlikely to arrive at a suitable outcome unless a consensus can be reached and all registrants are upskilled and exposed to different ways of working, which may require expenditure. Additional challenges in Research Objective One also highlight that there are difficulties when attempting to embed a PAL or similar system in practice environments. These are partially caused by the flexible discretion that is encouraged between registrants' exposure to healthcare and their pre-registrant training. The challenge of implementing a PAL or similar system is that it relies on a suitably prepared facilitator who has sufficient knowledge and confidence to adapt or trial different educational approaches which suit any pre-registration student need (Carey et al.,2016; Davis and Richardson,2017; Underwood et al.,2019).

The primary objective of a PAL or similar model is to encourage peers to develop skills and support each other in the workplace setting (Carey et al.,2016; Reidlinger et al.,2017; Sevenhuysen et al.,2013). The ability to develop amongst or alongside peers is one of the most significant benefits pre-registration students offer in the literature about PAL or similar models. This perspective suggests that PAL or similar models promote a learner's confidence (Davis and Richardson,2017). It also naturally fits the common desire to learn collaboratively with others with similar experiences and skill levels. This is because pre-registration students associate this with creating a safe space that enables them to discuss and debate concepts that consolidate key areas required to be a prepared registrant (Carey et al.,2016; White,2017). These may include performing non-technical skills, interprofessional learning, networking, and consolidating their experience to have a more realistic perspective of a registrant's role and responsibilities (Carey et al.,2016; Davis and Richardson,2017; Reidlinger et al.,2017). However, PAL or similar models heavily rely on being pre-registrant-led and individuals actively engaging in the process. This could lead to pre-registration students who are naturally more confident, have a greater problem-solving ability (Hmelo-Silver and Barrows,2008; Hmelo-Silver and Eberbach,2012), or are inclined to lead. In contrast, this may lead to others being happy to assist but not actively given the opportunity to develop the leadership and management skills required of a registrant's role until it is formally raised as a point for development. In either

circumstance, if not appropriately facilitated or overseen, there is a danger that knowledge shared amongst a near-peer group may not be entirely accurate or be built on and explore underpinning rationale (Carey et al.,2016) and undermines the overall effectiveness of a PAL or Problem-Based Learning approach to student development (Al-Kloub et al.,2014; Hmelo-Silver and Barrows,2008).

Although PAL and similar models encourage pre-registration students to work in partnership with their peers, this approach needs to address long-standing issues of negative learning cultures and existing reluctance to act or invest in mentoring pre-registration students. If anything, it highlights an opportunity for pre-registration students to bypass a degree of negativity that could be present in their placement exposure that is attributed to the surrounding registrants being unsupportive and, in some ways, embodying characteristics that are associated with more negative placement experiences (McKenna and Williams,2017; Benner et al.,2010). In addition, PAL or similar models would only remain an effective measure against negative learning cultures if more experienced students continued to be responsive and welcoming of evaluation from registrants or more junior peers. This is so that feedback remains constructive and mutually offered and ensures that more confident pre-registration students do not overstep their realms of practice through the support offered to others and can maintain professional boundaries (Brunero and Stein-Parbury,2009; Davis and Richardson,2017; Lakeman and Glasgow,2009) and behaviours as a role model and registrant (NMC,2018b).

Pre-registration students also report that the use of PAL models gives them additional time and opportunity to consolidate skills needed as a registrant informally, as well as improves their confidence to construct and provide feedback, observe skills performed by peers, build rationale, and link underpinning theories to practice learning environments (Davis, and Richardson,2017; Harvey and Uren,2019; Underwood et al.,2019). As such, PAL or similar peer-led models do not rely on a formalised arrangement by an external party (Carey et al., 2016; Harvey and Uren,2019) and are relatively inexpensive to adopt if this format is chosen. However, this aspect of PAL

and similar models is also partially flawed when adapted to suit pre-registrant training. This is because PAL typically refers to peers or near peers actively assisting and learning from each other as equals (Carey et al.,2016; Davis and Richardson, 2017; Irvine et al.,2017). Use of PAL or similar models, therefore, still requires some form of registrant facilitation and registrant input, which can lead to difficulties in tracking who is acting as a practice supervisor at any one time for preregistration students who are using a PAL model (Underwood et al.,2019). There is also limited evidence as to whether more practitioners in the area significantly contribute to benefits to patient outcomes (Nickson et al., 2013), but in some ways, it links back to challenges highlighted in Research Objectives One and Two, which highlight some of the challenges associated with multi professionals assessment of pre-registration students, their understanding of their roles' involvement and how communication amongst practice supervisors is documented (Underwood et al.,2019). Although a counterargument could be offered whereby a multiprofessional approach to supervision does enable more regulated professionals to be available at any one time for PAL to be adequately supervised, this does not remove the potential for registrants to assume other registrants are in the vicinity and that they will observe and document what is observed or have the same perspective on an episode of care (Harvey and Uren,2019). Overall, PAL also has greater transferability than other and less known models, as it is already used by physiotherapists, occupational therapists, social workers, and medical counterparts (Carey et al.,2016). It, therefore, carries precedence, which can be transferred to nursing. Depending on the clinical area, some registrants may have already been exposed to its use and can try the methods they have observed; they can choose to include this approach when they act as practice supervisors if they deem it appropriate.

In some ways, the *SSSA* lends itself to a structured use of PAL or similar models because preregistration students will naturally be exposed to many practitioners in the "part" of training that they are in, and it encourages peer learning to a greater degree than previous models (Williamson et al.,2020). As such, pre-registration students become naturally exposed to different hubs and spokes within practice learning environments and are encouraged to work with other professionals and nursing

students who may be more senior or junior to themselves. In addition, the benefits already discussed indicate that this also allows the student to develop or gain constructive awareness about areas they may need to develop (McKenna and Williams,2017).

1.2.2 Collaborative Learning in Practice (CliP).

Similar benefits relating to student satisfaction, an increase in confidence, and dissemination of knowledge were noted when the CLiP model (Harvey and Uren,2019; Williamson et al., 2020) was suggested as an alternative means to increase placement capacity (Hirdle et al., 2020). Although it has been used in smaller settings, it is directly comparable with PAL and CPAL models. However, CliP increased placement capacity by offering a 2:1 ratio of preregistration students to one practice supervisor. A similar lack of evidence also evaluates its use (HEE,2014; Stenberg and Carlson,2015; Williamson et al.,2020). However, from the evidence that does exist, it is suggested that the CliP model did indicate that this was an advantage to its use as real-time feedback could be achieved (Williamson et al.,2020). The practical application of CliP draws influence from Dedicated Education Units (DEU) and the Amsterdam Model (Williamson et al. 2020), which emulated CPAL and PAL schemes. Similar benefits between all models included time management, leadership characteristics, organising shift patterns, and looking to develop themselves in peer groups (Carey et al.,2016; Sevenhuysen et al.,2013; Underwood et al.,2019; Williamson et al.,2020). However, pre-registration students exposed to the CliP model stated that a significant benefit of its use was the ability to gain real-time feedback on their performance (Williamson et al.,2020). Feedback also showed that a peer coaching approach or learning model benefited pre-registration students with healthcare experience more than those who were entirely new to the environment. Feedback surrounding the CliP model found that this particular group of students required greater support or structure input from practice supervisors in their clinical exposures (Underwood et al.,2019).

However, a CLiP model's disadvantages may outweigh its implementation's benefits in large settings. Some of these include the ability to recognise the level of pre-

registration students, difficulty in ensuring they maintain their supernumerary status, and both parties understanding the model and its intricacies to be effective (Hirdle et al.,2020; Williamson et al., 2020). The use of a CliP-based model also does not address the primary concern for larger areas that are considering employing a multi-student-to-registrant approach, as there has been a lack of formal mentors for some time. In light of additional factors such as high attrition rates and experienced practitioners retiring, although there could be more supervisors to hand in line with the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d), the model may be too restrictive and not actively encourage pre-registration students to work with a multitude of registrants or be consistently achievable across Acute Trusts that offer a range of hub and spoke placements. With this in mind, both registrants and pre-registration students have expressed concerns about working with many different staff. This was shown in pre-registration feedback, which stated:

> *"One of the biggest differences I found is the relationship between your Mentor...we felt like we hadn't worked with our Mentor that much, and I know that some of the staff were unhappy having to sign off some of their students that they'd only worked one shift with. Normally, you made such a good relationship with your Mentor [but] with CLIP, we're working with so many different nurses, it gets passed down the chain about how you are, and it feels like maybe they haven't got the full picture of you".*
>
> (Williamson et al.,2020:4).

It is interesting to note that in the same study, registrants also developed reticence about the use of a multiple supervisor approach in combination with the CliP model and disclosed in a focus group within the same study that:

"Students also couldn't understand how a Ward Manager would know what they were doing 'cos they hadn't worked alongside them...we knew what every student was doing at any given point, but, because they didn't have that scrutiny, they couldn't see how we knew they were improving..."trust me, we know what you're doing well–you will be graded appropriately."

(Williamson et al.,2020:4).

However, despite initial reticence and concern over the adjustments, staff did report greater trust in the pre-registration students in the vicinity, although it remains unclear if this led to feedback being delivered and if this was a more positive or negative experience than that experienced in mentorship (Clynes and Rafferty,2008).

Additional ambiguity may be caused in some instances where the use of a CliP or similar model has amalgamated the mentor and supervisor roles to establish a *"coach-mentor role. However, the purpose of additional training was to ensure mentors understood that the coach is there to help someone learn, instead of just teaching them"* (Harvey and Uren,2019:39), which may, in turn, confuse the intention to move away from preceding roles and establish clear roles with aligning expectations. Therefore, it is argued that to meet the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d), a combination of nursing models underpinned by the pragmatic use of nursing theory and overseen by a competent supervisor could provide the basis for future student support tools (Lakeman and Glasgow,2009). An example of this is particularly evident in a three-function interactive model of supervision, as recognising the combined importance and balance of normative, formative, and restorative strands of clinical supervision (Bowles and Young,1999; Brunero and Stein-Parbury,2009), which could be generated through a structured form of PAL, CPAL or similar. To achieve this, joint decision-making, design, and planning must occur between AEIs and Practice Learning Partners.

An additional benefit to applying a structured PAL model with significant AEI input in practice learning environments is that it could allow registrants to work with academic staff and benefit from their knowledge of the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d). Curriculum and encourage more senior students to develop their own teaching style and teamwork skills in preparation for registration. However, as with any model used in education, the approach must be consistently used for quality assurance and to ensure that the supervision given meets the needs of pre-registration students (White and Winstanley,2014; Winstanley and White,2003).

A multifaceted approach that utilises a PAL and AEI-driven response may also create pathways that encourage greater clarity and identifiable support structures; pathways available for preregistration students are not necessarily fit for purpose due to the

removal of the SLAiP course (NMC,2008; RCN,2015). Furthermore, a combined approach could also lead to greater consistency and structure that can be more easily reviewed and evaluated at required intervals and provide flexibility if an influx in placements is necessary. A more long-standing impact of this may lead to pre-registration students, newly qualified and experienced registrants feeling they have insufficient support in placement areas, and therefore reduce an individual's overall "readiness to practice" (Christensen et al.,2016; Haddad et al.,2017; Walker et al.,2016).

1.3 Summary

As part of appraising the more commonly used models associated with pre-registration supervision and assessment, the strengths associated with less formal models such as PAL, CPAL, or similar peer coaching and support models could complement efforts to fulfil the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) but again relies on registered staff being upskilled appropriately to meet the standards themselves and fulfil the *SSSA* (NMC,2018) with confidence (Leigh et al.,2019). Feeling valued and invested may encourage more significant investment in pre-registration students, increasing their sense of belonging and readiness to practise. In addition, with the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) as a focus, there is a greater likelihood of pre-registration students feeling more prepared to fulfil their role as a supervisor at the point of qualification, which leads to more empowered, independent, and autonomous practitioners in the future. The broader impacts may include a more positive and consistent learning culture, increased preregistration students actively participating in their learning, and a greater ability to share and disseminate knowledge inter-professionally (Davis and Richardson,2017; Ravanipour et al.,2015).

The ability to achieve a PAL approach or more structured peer support programme in larger Acute Trusts that lend themselves to larger sample sizes requires further attention. It is repeatedly recognised as a limited source of evidence (Burgess and Mellis,2015). This could be partially attributed to a lack of evaluative data, which

describes how a practitioner may consistently evaluate and adapt approaches to suit pre-registration students in conjunction with their own duties as a registrant (Burgess and Mellis,2015).

The use of terminology and language alluded to within the literature that discusses the provision of pre-registration supervision and assessment indicates that there is an interchangeable use of terms or amalgamation of roles, which makes it hard to precisely evaluate the efficacy of any one role or method for supporting pre-registration students in practice. There are also strong similarities between the roles of a mentor and a supervisor, despite restructuring their role in the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d). In the short term, the challenges faced by registrants to meet these new requirements and the ability to consistently disseminate information about the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) automatically challenge the ability to embed and understand their realigned roles and responsibility, let alone upskill to meet the new pre-requisites.

With these factors combined, little evidence indicates if there can ever be, or if there should be, a standardised approach when facilitating supervision. A large part of this is caused by the inherent nature of being a nurse. Supervision and assessment of a pre-registration student will always rely on the subjective, lived experience of registrants who fulfil the role. As highlighted throughout both objectives, the main barriers to effective supervision in practice learning environments and the provision of adequate support for pre-registration students is the longstanding issue that despite amendments and redesigns being put in place, there has not been any consistent method for investing in the relationship between AEIs and practice placement partners. This has led to decades of inconsistent learning opportunities, a lack of role clarity and responsibility, as well as too much flexibility in guidance, which underpins these influential positions and, in turn, the student experience. This, therefore, reflects chronic challenges and subsequent issues in addressing issues that undermine a registrant's preparedness to become a mentor or Practice Supervisor or a pre-registration student to become a registrant (Mackay et al.,2018; McKenna and French,2011; Zhang et al.,2016).

Although there is no one specific model that may significantly improve practice learning environment capacity and exposure consistently (van Der Riet et al., 2018), a more structured approach to supporting pre-registration students with AEI input may also help new supervisors struggling to identify key priorities beyond their development to establish a greater clinical identity and more substantive methods for supporting pre-registration students. This could be particularly relevant to new supervisors, as newly qualified registrants often feel ignored or discouraged from deviating from the existing workforce culture (Bickhoff et al.,2016), which, in this instance, may be reluctant to adopt changes to the way pre-registration students are supervised and assessed. However, it may also be confusing because the preceding nursing curriculum was running in parallel to the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) being introduced when starting this study. As such, the removal of a SLAiP course, or similar foundation course, to teaching others also removes the AEI's ability to disseminate learning models and theories used in their organisations that can be practically applied to practice settings with a degree of flexibility, bolster the judgements of existing registrants and instil confidence in their decision to pass or fail a pre-registration student based on provided feedback alone. This is so that any efforts made to support pre-registration students from an AEI perspective actively support their experience and cohesively bond with PLP ways of working via local arrangements made, as well as aid existing registrants as they adapt to the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) application of the *SSSA* (NMC,2018) and recommended approaches to their use.

1.4 Thesis Overview and Structure.

This thesis does not follow conventional layouts from several perspectives. The key reasons for this relate to the modified use of Charmaz's Constructivist Grounded Theory (Cons. GT) (Charmaz,2014), the way that I has developed and appraised their positionality in relation to the phenomenon of interest in the subject matter. The thesis also differs as the participant's experiences have been used as central focuses to the findings and develop the findings and discussion. A more detailed breakdown of how these shape the individual chapters will now be introduced.

Chapter One introduces the study using an abstract, impact statement, and consideration of introductory literature, which has been used to form the research question, aim, and subsequent

objectives.

Chapter Two presents a Literature Review, the rationale for its use within a qualitative study and its findings. This extends to revised search strategies conducted in 2021 so that literature delayed due to the Coronavirus Pandemic could also be considered.

Chapter Three provides a detailed consideration of the research's methodological approach. This includes a rationale for why some paradigms, methodologies, and methods were rejected and why Interpretivism and an adapted Constructivist Grounded Theory (Cons. GT) (Charmaz,2014) were chosen. This chapter will also disclose the study's inclusion criteria, sampling strategy, and plans for coding and analysis of verbatim, semi-structured interview transcripts.

Chapter Four considers the Ethical Considerations used to shape the study's conduct, which relied on Beauchamp and Childress's (2019) considerations of Benevolence, Non-Maleficence, Justice, and Autonomy. With these principles as a central focus, this chapter will then discuss the ethical process, ensuring the confidentiality of the participants, amendments followed as part of the process, and how research design can be used to appraise and consistently manage an individual's positionality. As a final aspect, an explanation will also be given for how the study has adapted during the Coronavirus Pandemic beyond the submission of the amendments.

Chapter Five discusses data generation and analysis in that it will identify how the study has generated its data in two distinct phases. Phase One included The Spidergram, initially used to link individuals and the literature. It was also used to consider language and terminology that could be used to synthesise future research questions used in Phase Two.

Chapter Six contains Phase Two of the data collection and analysis process: semi-structured interviews. It also contains what the findings in the study are based on and a discussion as to how these findings have emerged from the data using Cons.GT principles and research methods. It also highlights that the breakdown of themes was synthesised into analytical categories from collecting and analysing eleven individual

interviews. As there is no formal discussion chapter, which can be considered unusual, I chose to introduce the findings but use key extracts to explain and, therefore, discuss how the key findings emerged from the data and led to the interpreted understanding presented.

Chapter Seven considers the theoretical, social, political and historical concepts highlighted in the literature but also features the authors' positionality and methodological underpinnings of the study in relation to the participant's lived experience. This also demonstrates how the use of adapted Cons. GT (Charmaz,2014) underpins the Conceptual Framework and its presentation.

This will then be linked to the justified utilisation of Patton's principles of leadership (Williamson,1982), Benner's Novice to Expert model (Benner,2001), and Hiatt's (2006) ADKAR model for implementing and sustaining change to demonstrate how the conceptual framework has also led to recommendations for AEIs, PLPs and future research that can benefit both parties if not national policy.

Chapter Eight forms the study's conclusions, including the impact that Coronavirus has had on the study beyond alterations to the ethical permission of the study. It also contains a thesis summary that extends to its limitations, why it contributes to the body of knowledge and how acknowledgement of positionality has influenced the general conclusions made from the study.

Chapter Two

Further scoping of the literature

2.1 Rationale for scoping the literature further.

This section introduces the rationale for conducting a separate review of the literature to accompany the introduction and literary objectives but is specifically related to the Standards of Proficiency (NMC,2018a) and the *SSSA* (NMC,2018). Although Charmaz (2014) encourages a temporary postponement of formal literature searches at the beginning of a study, a choice was made to modify their approach and use of Cons. GT (Charmaz,2014), by scoping available literature first. This was necessary as publishing the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) advocated for substantive changes from preceding models of education and support for pre-registration students. There was, therefore, an identified need to gain awareness and explore what was available. To an extent, this would help I develop theoretical sensitivity awareness and understanding of the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d). This included the impact of changes made to preregistration nurse education, what annexes within the *Standards of Proficiency* entailed (NMC,2018a:27-37), and if anything already identified helped AEIs and Practice Learning Partners embed them. As this would require searching for a range of evidence beyond the standards themselves, a further choice was made to formalise this process to synthesise initial concepts already in the public domain. This decision was made to ensure processes and any Priori or specialist knowledge were transparent and that language used within the literature could help to form tentative questions that explored the participants' lived experiences and understand potential insights they have about the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d). If this was fruitful, subsequent questions could continue to build on available knowledge, following Cons. GT principles (Charmaz,2014) and reach a point of theoretical saturation that may otherwise have been prematurely declared or lessen the rigour demonstrated within the study (Charmaz,2014).

Using a larger body of evidence to substantiate any tentative conclusions made in the study, it was thought that more awareness about current nursing issues would create a greater sense of criticality and management of positionality, pre- and post-Coronavirus pandemic. In turn, this could help reduce selection bias and act on pre-

set conclusions, which might otherwise occur through sourcing literature that supports any preconceptions formed on Priori knowledge. In addition, the broader implications of unmanaged positionality and pre-conceptions at the beginning of a study could limit or promote unjustified exploration of themes within the study, depending on the research methodology and methods. However, from an interpretive perspective, the dismissal or suboptimal management of researcher positionality would ultimately detract from the participants' lived experience and voice and work against fundamental principles Interpretivist paradigms are based. Use of a PEO to focus method and search strategy.

The study's initial iteration and the primary question were: *How might registered nurses adapt their practice in relation to student nurses' supervision and assessment to meet the New Standards for Proficiency and Standards for Student Supervision and Assessment in Nursing?* A Population Exposure and Outcome (PEO) framework was constructed to answer this question. A PEO was the most natural fit for this scope of the literature and met the broader aim of the study, which is to develop a conceptual framework that could inform AEIs' ability to support preregistration students beyond their role in faculty within the remits of the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d).

The PEO used for the literature search consisted of:

Population – Adult Nursing

Exposure – Provision of Student Supervision

Outcome – to Assess Pre-Registration Students.

A Population Intervention Control and Outcome (PICO) approach to conducting a literature review was discounted as there was no identifiable control group; it was, therefore, inappropriate and rejected.

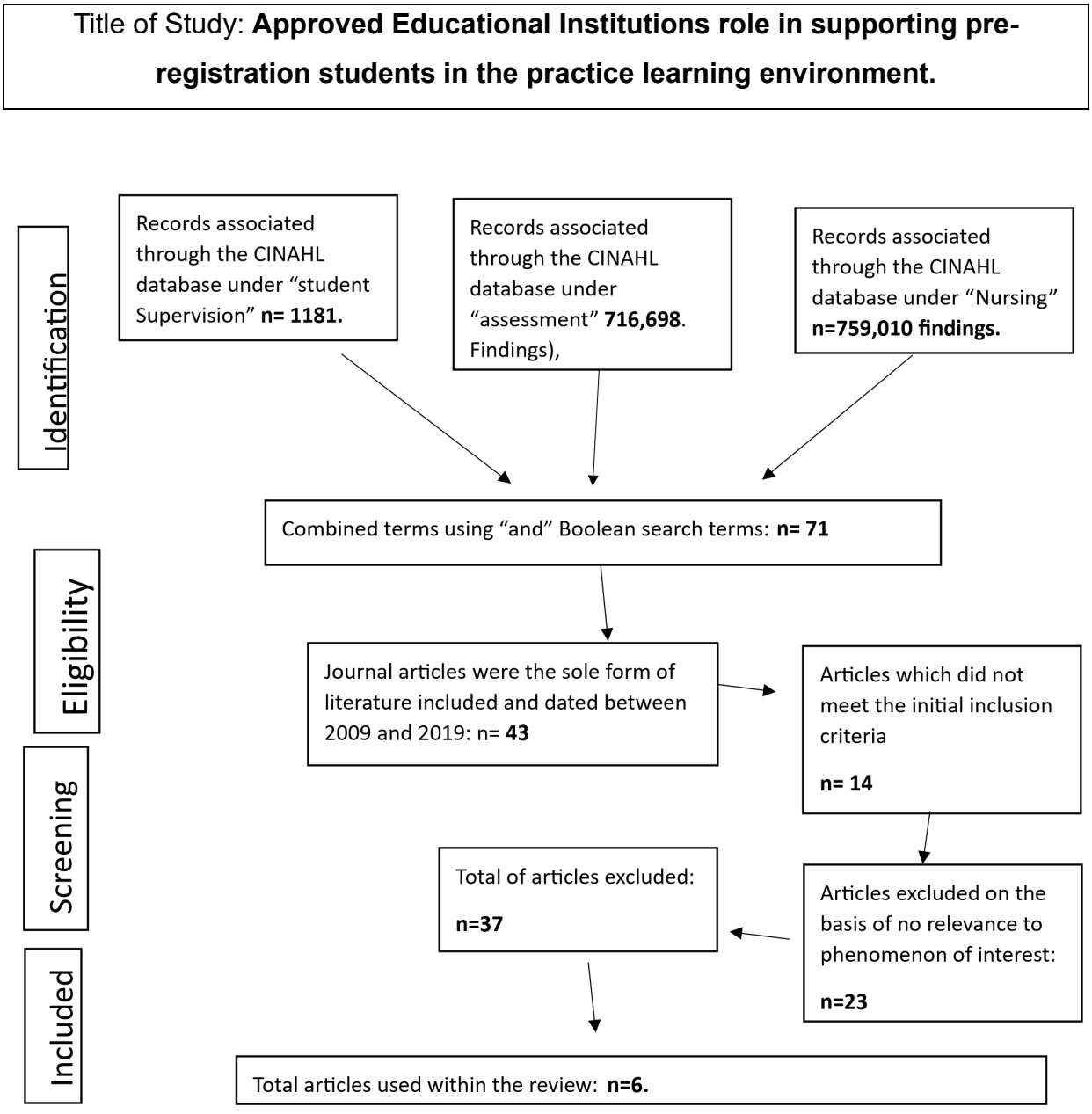
2.2 Identification of Keywords and Justification of Search Strategy

Specific use of keywords to source literature enabled refinement of the amount of literature considered. This was essential, as a vast amount of nursing research is available that discusses student supervision and assessment, and the preceding mentorship and SLAiP standards model embodies the roles of mentor and sign-off mentor.

In addition to a specific keyword search, a strictly adhered to inclusion and exclusion criteria was developed. This ensured that the literature appraised held high currency value to the present nursing climate but still encouraged a broader pre-registration supervision and assessment perspective. At the time of conducting the literature review, an agreement was formed with Gopee's (2023) observation that there was a sharp contrast between the amounts of available literature in the public domain, which discussed the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) generally, in comparison with preceding methods for providing Pre-Registration support. As mentor and sign-off mentor roles are not recognised within the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d), literature relating to Mentorship was excluded from this study's focused literature review. However, this did highlight a point that would need to be further explored and subsequently became the focus of Phase One, in addition to the introduction and included literature, which explores some of the key similarities and differences between Supervision and Mentorship so they can inform new ways of supporting pre-registration nursing students.

To capture this before a more comprehensive breakdown is captured, a PRISMA diagram has been used to demonstrate the inclusion and exclusion process:

Figure 1 - PRISMA Diagram used to show the inclusion and exclusion process



2.3 Inclusion and Exclusion Criteria of Articles

The keywords used for this review were chosen as they directly relate to the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) and their intentions. Information was sourced using the Cumulative Index to Nursing and Allied Health Literature (CINAHL) database, which operates using a Boolean "and" "or" phrasing for searching. The literature search was completed using only CINAHL, as it represents the largest body of literature that is specifically relevant to nursing and allied healthcare professionals. The results of this search are demonstrated in Table Three below:

Table 3- Inclusion based on specific keywords used to generate articles.

Keyword	Result
"student supervision"	1,187 findings
"Assessment"	716,698 findings
"Nursing"	759,010 findings
Articles when "and" was combined	**71**
Articles that were written within the 2009 – 17/12/2019 timespan	**43**

2.4 Exclusion Criteria and breakdown of articles.

Exclusion criteria were based on a sampling strategy used in Phase 2 of the study, which focuses on interviewing a purposive sample of participants using methods specified in Cons. GT principles (Charmaz,2014). This included registrants who work in the acute healthcare sector as adult nurses, existing midwives, mental health, and learning disability nurses, who currently have different skills as a baseline. Midwives also have differing course frameworks and skill expectations when compared to nurses. As such, this literature was also excluded from the study and literature review.

Registrants who work within acute sectors or Trusts also have the broadest range of experience in specific locations available and, therefore, could enable access to a fruitful and rich perspective of the phenomenon of interest without having to diversify between the *Standards of proficiency: Specialist community public health nurses* (NMC,2004) and the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d). Community and public health nurses are also part of a separate practice register (NMC,2004) alongside different skill requirements that excluded them from the study and the review. However, all registrants must speak and understand English verbally and in written form to be registered with the Nursing and Midwifery Council (NMC). This led to the exclusion of articles that were not written in English.

Aspects of the introductory literature also suggest that registrants often felt their level of experience and expertise made them feel more comfortable and able to assume the role of mentor and sign-off mentor (Jokelainen et al.,2011; Meng Chong et al.,2016; Nettleton and Bray,2008). To be a mentor under the preceding standards, a mentor or sign-off mentor must complete a SLAiP course before formally acting in these roles. As such, articles were discounted if their focus surrounded the SLAiP standards or mentorship, as the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) supersede these roles.

The Code: Professional Standards of Practice and Behaviour for Nurses, Midwives, and Nursing Associates (NMC,2018b) only applies to UK registered practitioners, which removes the potential need to consider literature from non-UK or Ireland sources. When articles generated within the literature review were looked at in more detail, a number of them had no specific relevance to the discussion of supervision and assessment for undergraduates beyond clinical skills or simulation. They also spoke more about “failing to fail” and specific pathways in nursing in relation to the mentor and sign-off mentor roles instead of the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) and the practice supervisor and practice assessor roles, as shown in Table Four below:

Table 4-Break down of papers excluded from the review.

Failure to Fail	2
Articles that focus on Mentorship, Preceptorship/ clinical educator roles	2
Articles that focus specifically on midwifery or allied healthcare professionals (such as Physiotherapy, Public or primary health/ Community Nursing, and Diagnostic radiography) which did refer to the Future Nurse	4
Articles that focus on Student Nurses	4
Articles that were not written in English	1
Subtotal of Excluded Articles based on Inclusion criteria	13
Articles that focus on skill performance or clinical skills	2
Articles that focus on Academic evaluation and supervision	1
Articles that feature more than once in the search or have no description of the content	4
Articles that assess, evaluate or review models of supervision, assessment, or clinical placements in non-UK settings and were not comparable with the *Future Nurse*	4
Articles that focus on Student nurse retention (non-UK)	1
Articles that focus on HEI and practice partner relationships or perspectives (Pre-2018 and *Future Nurse standard* implementation (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d)	3
Articles that are focused on patient safety, emergency care, or needlestick injuries	3
Articles that focus on postgraduate nursing – Non-UK	1
Articles that focus on career paths	1
Articles that focus on overseas nursing and placements for them	2
Subtotal of excluded articles	**23**
Subtotal of excluded articles based on inclusion Criteria	**37**
Articles that specifically discussed the Future Nurse standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d).	**5**

Articles already featured in introductory literature and therefore excluded from this review	**1**

Total literature met the inclusion criteria and directly related to the research question: **Six.**

2.5 Review findings and discussion.

A number of the review findings mirrored the key concepts within the introduction and associated literature. These primarily included summaries suggesting that the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) represent a substantive change in the way pre-registration student supervision is now offered compared to preceding methods of providing student support (Donaldson,2019; Heath,2019; Hunt,2019). However, while completing the literature review, there was no agreed-upon definition for what supervision should be based on, which was not dissimilar from challenges associated with preceding models and student support (Lindquist et al.,2012).

The review also highlights a lack of clarity when discussing how registrants and pre-registration students would adapt to a multiple supervisor approach to supervision, as the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) allow other allied health professionals to supervise pre-registration nursing students (Hoy and George,2018; Hunt,2019), but in some respects challenges the long-term nature of revalidation. This is based on concerns expressed by registrants that pre-registration supervision and assessment will not be solely regulated by one professional body and potentially compromise quality when a registrant is fulfilling their role as a practice supervisor (Hunt,2019). However, evidence suggests that despite challenges highlighted around multiple staff supervision, pre-registration students indicated in the literature that students were satisfied with their experience (Ekstedt et al., 2019). Preregistration nursing students also reported positively about having access to more than one registrant as part of their learning experience (Ekstedt et

al.,2019). However, this was still a nursing-based team. There are also identified benefits of separating the support and assessment processes for preregistration supervision and assessment (Hunt,2019), including a degree of impartiality shown as part of the assessment process, as the Practice Supervisor and Practice Assessor duties cannot be performed by the same person for any individual student (Heath,2019; Hunt,2019).

The introduction of guidance within the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) and initial literature review also emphasise the need to establish a more positive workforce culture and learning environment. This is due to the potential benefits of creating a positive learning environment. This includes increasing student satisfaction within placement settings and encouraging them to approach qualified staff for assistance (Ekstedt et al.,2019) and work with multiple interdisciplinary team members (Heath,2019). It also enables pre-registration students to consolidate learning by establishing a good working relationship (Ekstedt et al.,2019) with existing registrants supervising or assessing. However, this does not entirely resolve issues of variable placement quality and experience that were caused by a lack of consistency within the supervision and assessment process for pre-registration students (Ekstedt et al.,2019; Lindquist et al.,2012) as well as who may be suitable in the long term to supervise and assess pre-registration students (Donaldson,2019; Hoy and George,2018). These concerns were transferable to the practice supervisor and assessor role, as automatic transference from preceding roles may lead to inappropriate appointments of individuals who judge the student's progress from afar (Hunt,2019). The review also highlighted that at this time, it is unclear if it is entirely safe to assume that existing experience gained as a mentor or sign-off mentor can be wholly utilised, or entirely relied upon, to supervise pre-registration students in line with the new *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) (Donaldson,2019; Hunt,2019) due to the “failing to fail” phenomenon in nursing and student characteristics, which have led to registrants who should not have reached registration, moving forward to collecting a PIN number (Hunt,2019). The automatic transition to new roles also does not address the long-standing issues of ensuring students are ready to practice as registrants (Hunt,2019) or supervise and assess others. This extends to further agreement

between the review and introductory literature that not every practitioner has developed suitable attributes or possesses the qualities of an assessor, which includes the ability to comfortably and confidently fail a student, regardless of rationale (Hunt,2019).

The challenges existing registrants and newly qualified registrants face due to implementing the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) are also not made easier by themes in the introduction and further scoping of the literature. This is due to the lack of apparent evidence available that would otherwise help identify comprehensive strategies for how registrants could effectively help prepare to act as practice supervisors and assessors (Hoy and George,2018). This is particularly relevant as there is now no mandatory or formal accreditation required to act as a practice supervisor (Hoy and George,2018). However, some literature does suggest that this may be a positive step for registrants who sometimes found that studying for the attainment of a SLAiP course or similar was “demotivating and off-putting” (Heath,2019:497). Instead, the NMC has opted for optional, online guidance for registrants, indicating how they may prepare (Hoy and George,2018).

To conclude, the final finding, which also presented and supported recommendations in the introduction, recognised the fundamental and essential need to form robust and working partnerships between AEIs and practice placements (Donaldson,2019). This is necessary as it will optimise communication between all parties, potentially strengthen strategies to approximate, if not join, theoretical concepts and practical exposures, and ensure that AEIs and Practice Learning Partners identify students who may otherwise perpetuate a “Failing to Fail” culture (Hunt,2019). It may also help agendas put forward by AEIs and clinical settings to be more aligned so that concerns can be addressed earlier in the student's progression through placement (Heath,2019). On the other hand, it is surmised that an element of this will be reduced through the decision to separate the roles of supervisors and assessors, and this has been welcomed in some of the included articles and introduction (Donaldson,2019;

Hunt,2019) but identifies that further research needs to take place once the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) have been fully embedded.

2.6 Limitations to the Review.

As these standards had been recently implemented during the review, no evaluative data has been created yet. No public evidence also evaluates how challenges have been overcome or how these roles have been received and embedded by existing registrants. This data could have enriched the findings and recommendations of the introductory literature and literature review in terms of how universities and AEIs could better support learning in practice, what this role entails, and the process of pre-registration student supervision and assessment.

2.7 Literature Review in 2021.

A further literature search was conducted to ensure there was no new literature since the initial review in 2018 that could prove to be substantive, address identified challenges, or evaluate the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) and their ability to be embedded in practice learning environments. The search still used an “and” Boolean search strategy in the CINAHL database on 08/02/2021. In addition, limiters were applied to ensure that literature remained relevant to countries that recognised the NMC as a professional nursing regulator and only considered the years the standards were implemented. This is represented in Table Five below:

Table 5- First rapid search for literature in 2021.

Keyword	**Result**
“Future Nurse”	46 findings
Limiters	[redacted]
Narrowed to the UK and Ireland	
To only include literature published between 2018 and 2021	
Total	11
Total that specifically discusses the Future Nurse standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d).	4
Articles that had not been referred to already	0

2.8 Use of other Databases to search for Literature.

Although CINAHL is considered one of the largest databases that provide researchers access to nursing-based literature, it was necessary to consider others. As such, the search strategy used in February 2021 was replicated using PUBMED. This search strategy is shown below. In addition, the use of COCHRANE was also considered but later rejected as this largely brought up unrelated literature and, instead, offered information about clinical trials and therapeutic measures of care. This was also demonstrated in a table and can be seen below in Table Six:

Table 6 - First rapid search for literature in 2021.

Keyword	**Result**
“Future Nurse”	4773 findings
Limiters	[redacted]
To only include literature published between 2018 and 2021	
To include ‘Nursing and Midwifery Council’ and ‘2018’ in the search bar	
Total	**Four findings**
Total that specifically discusses the Future Nurse standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d)	**2**
Articles that were not already included in the study	**0**

Once the second search was conducted and compared with the use of another nursing-linked database, it became apparent that all of the articles generated had already been used in the introduction or were presented as part of the formalised literature review. This meant that no additional literature was available at the time of review that specifically related to the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d), addressed the challenges faced by AEIs, practice placement providers, or registrants themselves, or evaluated their use.

To ensure that there were no other documents that had not been included, additional searches that followed these strategies were completed on 07/09/2021. These searches have been captured in Tables Seven and Eight:

Table 7- Second Rapid Search for Literature Using PUBMED.

Keyword	**Result**
Standards for student supervision and assessment	Nine findings
Limiters	[redacted]
To only include literature published between 2018-2021	
Total	**Nine findings**
Total that explicitly discusses the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d).	**Six findings**
Excluded articles based on relevancy	**Three findings**
Articles that were not already included in the study	**0**

Table 8 - Final Rapid Search for Literature Using PUBMED.

Keyword	**Result**
Standards of proficiency for registered nurses	20 findings
Limiters	[redacted]
To only include literature published between 2018-2021	
Total	**20 findings**
Total that specifically discusses the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d)in the title	**Six findings**
Articles that mentioned the NMC as a side focus or mentioned in later parts of the article	**11 articles**
Articles duplicated on the CINAHL database.	**Three findings**
Articles that were not already included in the study	**0**

As there was no literature at this point that was not already considered within the introduction or formal literature reviews, searches were drawn to a close but prompted

greater consideration of the study's methodological underpinnings that encouraged a person-specific position and how this could be managed.

Chapter 3

Research Methodology

Author's Provenance: Why am I a nurse, and why is this topic important to me?

I am a registered adult nurse. I came into nursing because I was inspired by a clinical nurse specialist sitting on my grandad's sofa in 2008/2009. The important thing to note about this sentence is the person: my grandad. My grandad was an inspirational, larger-than-life character. In his later years, he was diagnosed with stage 4 Lung Cancer and non-Hodgkin's Lymphoma. As his illness progressed, I became one of his regular carers amongst other family members so he could remain at home. As his conditions changed and his care needs altered, so did the Clinical Nurse Specialist role. And that was it. I was hooked. And it wasn't so much about what she did, but what she said, how she carried herself, communicated with me and with Grandad, and adapted to meet his needs. I just knew I could do that with other people and enjoy that kind of job.

As part of my nurse training, I had exceptional mentors who have undoubtedly shaped my clinical identity and love for nursing. Still, a part of my training in the older format of block placement periods, which would take you in and out of clinical practice, exposed me to many other practitioners. Some didn't stay in a post for very long, some places had people leave every other week, others heavily relied on agency staff to keep wards open, and some people had stayed too long in their role and appeared disillusioned or had lost their love of caring for others. In hindsight, I also saw quite a few people who had become jaded as they tried to change practice or the surrounding culture.

With these experiences in mind, I realised how important it is to be passionate and informed and share knowledge with people who are just starting on their journey to maintain a collective vision for patient safety. I believe that being a good nurse is to be a teacher and a role model to your colleagues. Of course, this requires significant investment into the profession: mind, body, and soul. However, if nurses give their all, they should have a say in what nursing looks like and how policy translates to their daily work in a way that is accessible and connected to them. Part of this may include asking yourself or others difficult questions, such as what it means to be a nurse and how an education at university ultimately prepares individuals for registration. Since

starting my doctoral study, I have become an educator, which not only in my mind creates a link between what I feel is important within my role as a nurse but significantly influences where I draw from as a researcher ontologically and epistemologically. It also identifies a need to engage and manage my sense of Priori knowledge critically and, essentially, the belief that knowledge gained through exposure is built upon experience, which will now be discussed.

3.1 Initial Strategies considered and used to manage my positionality.

The study was conducted from a position and belief that Nursing is a vocation with intuition that complements its scientific base. It may be suggested that a part of this is rooted in nursing, as the acquisition of knowledge emphasises the importance of balance between physical, anatomical, therapeutic, or pharmacological interventions and the empathic nature of care. Moreover, this combination is a foundation for everyday practice across all healthcare professionals (Lopez and Willis,2004; Quinn,2021). This belief is supported by the recognition that health-related courses are often taught from a combination of biomedical and psychosocial lenses or models (Robinson et al.,2017).

A desire to self-immerse or acknowledge and occupy a position within research requires exploring the self and roots of an individual's ontology. This can often be demonstrated in research using reflexive methods. In turn, openness and transparency generated through the appraisal of self-immersion can be linked to several key benefits (Charmaz,2014). In line with some paradigms, such as Interpretivism, one of these is the ability to 'grapple' with different primary data sources to gain insight and interpret another's perspective to gain an original, unique, or different understanding of a phenomenon. As this paradigm relies on individual perceptions, these sources are consciously and unconsciously informed by exposures to worldly factors, including historical, cultural, political, and social constructs (Bourke,2014; Darwin Holmes,2020) of the time.

During this exploration, different perspectives that give insight into a singular or broad phenomenon can create a spectrum of understanding but have the potential to be

influenced by a researcher and the participant. For some methodologies, this can stem from managing a "shared space" (Mason-Bish,2019; Moon,2008; England,1994) and ensuring a co-constructed or "shared" space remains viable, constructive, and neutral. However, as highlighted in Table Nine below, several strategies may be used to achieve this practically to manage a position and demonstrate reflexivity within research and have been considered in line with Savin-Baden and Howell Major's review of reflexivity (Darwin Holmes,2020; Savin-Baden and Howell Major, 2013).

Table 9- Types of reflexivity, how it relates to the study, and how it has been evidenced in this study.

Type of Reflexivity	**Its relevance to the study**	**How has this been evidenced**
Personal Reflexivity (Willig, 2001, in Savin-Baden and Howell Major, 2013) **Reflexivity as Introspection** (Finlay, 2002 in Savin Baden and Howell Major, 2013)	Emphasises the need to declare interests expressly, personal beliefs, values, and professional practice to remain critical of own positionality and confirm the roots of assumptions and interpretation. This can then be used to reach a deeper level of self-awareness and develop insights and meanings.	• Reflective Journal • Self-Interviewing • Positionality Statement • SWOT analysis • Milestone progression • Supervision and feedback
Epistemological Reflexivity (Willig,2001 in Savin-Baden and Howell Major, 2013)	Explicitly indicates how individual positionality influences the shape of research and how findings are interpreted.	• Careful Research design and selection of Cons.GT with rationale. • Reflective accounts • Compilation of field notes throughout interviews.
Reflexivity as mutual collaboration (Finlay, 2002 in Savin Baden and Howell Major, 2013)	Has a natural fit with Cons.GT principles, in the sense that the interview experience and data collected this way is a co-constructed experience.	• Actively reducing the Hawthorne effect • Rapport building within the interview • Being mindful of non-verbal cues • Opportunity for the participant to review the transcribed text before transcription of an interview

As discussed at the beginning of the research methodology chapter, different individuals form an understanding of the world and exposures based on factors they are exposed to within everyday life. Furthermore, this can generate highly subjective, experiential, and personal accounts of a phenomenon. The same can be said for how they make decisions within the study, and too, has the potential to create subjectivity. When this is compared with learning in a practice learning environment or nursing as a general phenomenon, subjective experiences and knowledge play a significant part in forming a learning culture or a collective ethos. This has the potential to influence learning environments and retainment of knowledge in positive and negative lights.

From a broader perspective, subjective experiences can also account for how an organisation's vision is implemented amongst a body of individuals (Barberà-Mariné et al.,2019). However, this is not always the case, particularly in large organisations that rely on many individuals to function. In this instance, culture can often be set through experience, exposure, individual characteristics, and behaviours that also inform person-centred care witnessed and facilitated by pre-registration students (Haddad et al.,2017; Jack et al.,2018; Webb and Shakespeare,2008). Unsurprisingly, this not only emphasises the link between subjective practices alluded to in the opening chapter of the thesis but also highlights a plethora of interpretations that influence daily life (Alemu et al.,2014), which can be explored for insight and a greater understanding of how individuals shape an environment around them.

In summary, experience and interpretation can lead to subjectivity when implementing a broad vision or using a broad guideline to shape reality. When related to offering and optimising student support in practice learning environments, individual attitudes and behaviour of those around the pre-registration student and the learner can shape the overall experience and what they retain from exposure. This perception links to the ontological roots of the study, which are drawn from "The Code" (NMC,2018b) and guidance points within separate domains that influence the use of the *SSSA* and, in turn, how AEIs can support pre-registrations in clinical practice now the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) have altered how they interact with pre-registration students.

3.1.1 Ontological Considerations.

Within *"The Code"* (NMC,2018b), relevant professionals agree to adhere to a specific ethos or structure for professional standards of practice and behaviour. Although this is broken down into four domains that focus on the Prioritisation of People, Practicing Effectively, Preservation of Safety, and Promotion of Professionalism and Trust, specific provision is made for training and support. For example, one guiding point alludes to a registrant's obligations to understand their roles, scope of practice, and corresponding responsibilities. However, based on the literature (Bennett et al.,2017; Devlin and Duggan,2020; McKenna and French, 2011), this has not always been achievable as registrants have not always understood the role of a former mentor or been prepared to enact it. Furthermore, evidence also suggests that in many cases, registrants are guided by what they have experienced themselves. This not only shaped their understanding of the preceding mentor role but also influenced what individuals may feel pre-registration students should prioritise as part of their training or how much emphasis one aspect of their exposure should be focused on (Mikkonen et al., 2020; Tuomikoski et al., 2018).

From this, it could be suggested that this sense of subjectivity also influences how *"The Code"* is interpreted and applied by others and the self (NMC,2018b). For this study, recognition of this presented numerous challenges. These challenges seemingly stemmed from common aspects alluded to within the literature, which focused on a registrant's understanding of mentorship (Gopee,2023; Zhang et al.,2016) and how a lack of collective understanding shapes common perceptions that are not necessarily accurate. In turn, it can also affect how individuals perceive their roles and associated responsibilities. As such, personal interpretation of *"The Code"* (NMC,2018b) affects a whole host of factors that impact pre-registration supervision and assessment. For example, these may include ethical considerations, clinical decision-making, justification of care, and, to a greater degree, advocacy, despite having a unifying *Code of Professional Standards and Behaviour* (NMC,2018b).

Another challenge that had to be addressed ontologically was highlighted when perceived subjectivity, created by the lived experience, extended to the literature

surrounding the supervision and assessment of pre-registration students. More specifically, this included the assessment process, how existing practitioners instilled a learning culture, and how responsive they were to the learning needs of pre-registration students (Cantanese and Shoamanesh,2017; Underwood et al.,2019). As this seemingly also changes with the appropriation of evidence, experience, and exposure to different practice learning environments, this, too, presents an additional layer of subjectivity within nursing. This was also something I had noted in my reflective notes, as shown below:

Reflective Extract: *"…From my experience, when the Future Nurse standards were introduced, what I understood from the standards as I initially read them was different from how I saw others explain and utilise them in my training update in the practice learning environments…."*

Through the acknowledgement and critique of my own experiences and drawing links between this and the literature, it could be inferred that if registered nurses experience training that relies on the experience of existing registrants en mass, this may partially explain why pre-registration students provide mixed accounts of quality within their own experience (Freeling and Parker,2015). In substantiating this link, it also cemented a chosen ontological insight that informed the epistemological roots that would be set down in the study and, by extension, what would be a methodologically sound approach. These roots centred on the notion that if the study was to gain an informed and nuanced understanding of nursing as a current phenomenon, it should be considered *"through the subjective lens of people experiencing it"* (Karp 1996 in Johnstone et al.,2017) instead of considering the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) as an isolated entity.

This most naturally corresponds with Whitley's (1984) theory, which acknowledges that the subjective nature of human existence is a crucial feature of Interpretivism. However, as an overarching paradigm, it ultimately relies on principles intended to help researchers acknowledge multiple realities that coexist but influence an individual or societal understanding of a phenomenon. This can be more simply captured by

acknowledging and incorporating six characteristics generally aligned to qualitative research that fits with the nature of interpretivism. These characteristics are:

1. The belief in multiple realities;
2. A commitment to identifying an approach to understanding that supports the phenomenon studied;
3. A commitment to the participant's views;
4. The conduct of inquiry is in a way that limits disruption of the natural context of the phenomenon of interest;
5. Acknowledged participation in the research process;
6. The reporting of the data in a literary style rich with participant's commentaries.

(Shorey and Ng,2022; Clarke, 2014:134; Speziale and Carpenter,2007:21)

The adoption of Interpretivism as an overarching philosophical paradigm within this study also naturally links with an idealistic ontology, in the sense that the nature of subjectivity and subjective meaning is directly formed from the individual (Savin-Baden and Howell Major, 2013). Using the six characteristics, it is then possible to prioritise and commit to understanding and valuing the participant's views throughout the study. However, this makes it essential to consider how knowledge is constructed and articulated. This will now be discussed about the epistemological considerations of the study.

3.2 Ontology and Epistemology.

Acknowledging that this study's ontology focuses on knowledge derived from the subjective exposures and cumulative experience registrants gain in nursing, identifying how a registrant's experience leads to knowledge construction and growth is crucial to how AEIs may support preregistration students in practice learning environments. As this relies on acknowledging the six characteristics of qualitative research and their links with interpretivism and ontological idealism, a deliberate choice was made to discard positivist-driven methodologies and underpinning methods for constructing knowledge. This is partially due to positivism typically opposing recognition of subjectivity or understanding the natural world through many lenses (Lewis and McNaughton-Nicholls, in Lewis et al.,2014). The exclusion of a positivist-driven construction of knowledge was also based on the understanding that outside of a mixed, methodological approach, positivist-driven research typically seeks understanding from an objective position (Bowling, 2014; Burke Johnson and Onwuegbuzie,2004; Davies and Fisher, 2018). By proxy, this inhibits assuming a position or self-immersing in the study. Instead, there is a decision to adopt a 'value-free' position, as Positivism encourages deliberate omission of any preconceptions or pre-existing knowledge that may be held and relate to a phenomenon (Clark et al., 2021; Charmaz,2014; Wahyuni,2012). In turn, this could mean that a study is initiated from a position that does not pose a bias toward the phenomenon (Doyle et al.,2016). A part of this may be attributed to the perceived suitability or efficacy of an experiment design, protocol, or a choice of instrument to not only elicit answers and quantify data or results but also it may be used as a closed approach to seeking answers to pre-formulated hypotheses or questions based on a specific, or niche, aspect of a wider problem or subject matter (Charmaz,2014).

In considering how the self and its specialist or Priori knowledge can provide strengths and limitations while exploring a phenomenon through the perceptions of others, a choice is also made to utilise inductive methods of knowledge construction instead of deductive methods. This is based on the understanding that deductive reasoning

typically relies on a research approach that starts with developing and testing a hypothesis or theory. This can then be used to either concur or nullify a pre-existing school of thought or existing theory (Creswell and Plano Clarke,2011).

With the choices made so far, exploring how many experiences can be understood is linked with Kantian theory and recognition that an experience is a credible form of knowledge construction.

As practice is fundamental to how registrants learn and consolidate their knowledge (Hulse,2018), Kantian theories (Kant,1781; Chignell,2007; Smith,2011). This will now be discussed.

3.2.1 Epistemology: Justification of appropriating Priori or general experience to construct new or consolidate existing knowledge.

This section looks at Immanuel Kant and Critique of Pure Reason (1781) from the Translated perspectives of Smith (2011) with perspectives from Chignell (2007) and Goldmann (1971).

Smith's translation of Immanuel Kant's Critique of Pure Reason (1781) alongside Chignell's (2007) and Goldmann's (1971) perspectives of the Enlightened Prussian philosophers' theories help to align aspects of Kantian theory with the six characteristics of qualitative research (Shorey and Ng,2022; Clarke, 2012; Speziale and Carpenters, 2007).

Translations of Kant's work indicate that exploring subjective realities enables one to form assumptions about the natural world and identify transferable roots of knowledge. One of these assumptions is that experience acts as a catalyst for all consciously held knowledge to generate new thoughts and understanding constantly (Smith,2011).

Kantian theory reaches this assumption by suggesting that for judgements to be ever-rooted in knowledge, it is necessary to identify that knowledge is firstly driven by experience but ultimately requires an individual to develop and contextualise its origin. This is shared with others through the creation of "sensible impressions", which can then be observable, read, or verbally shared with others (Smith,2011:34). These

“sensible impressions” can be based on sensory or intuitive input registered “upstream” in the unconscious, which in due course is brought into the conscious, subsequently considered, understood, and contextualised (Chignell,2007:323). However, before permission can be acted on, the individual must deem the “sensible impression” objectively or subjectively sufficient. Kantian theory suggests that this involves processing stimuli in relation to how confident an individual can be in the judgement once it has been consciously formed. This requires a degree of *persuasion* and how much *conviction* the individual has in this thought – with or without evidence (Chignell, 2007).

In some ways, this allowed Kant the freedom to discount Lockean theories, which suggest that all judgements or “assents” must be evidenced and, therefore, objectively proven (Chignell, 2007). Instead, Kantian theory recognises that the unquantifiable nature of knowledge based on personal knowledge and how an individual reaches their “assent” or judgement carries a unique and equal value (Goldmann,1971:154) to knowledge that is objectively proven, which is fundamentally captured in two different, but universally transferable, forms of human knowledge. From this, Kant was then able to identify theoretically that this led to the knowledge that coexists but stems from two different but weighted and articulated perspectives, which Goldmann (1971) identifies as:

1. Knowledge based on experience – *“the idea that man creates the world which he perceives and knows in experience”* (Goldmann,1971:15)
2. Knowledge based on synthetic, a priori knowledge – *“that in experience there are no necessary connections a priori. Experience is Atomistic”* (Goldmann,1971:106) – preexisting, non-tangible knowledge: it just exists, and we subconsciously factor this into our preconceptions.

However, as knowledge is considered rooted in an individual's experience and based on their perceptions of a situation, it should also be considered a ‘true’ interpretation of the individual’s persuasions, convictions, and what has motivated them to make a specific judgement or assent. The finished product of this process is, therefore, a

weighted, conscious judgement or “assent”, which an individual has applied to “downstream” or external circumstances (Chignell, 2007:323). This acts as a basis for interpretation and how researchers can understand or gain insight from the participant and what their lens considers to be “true” (Chignell,2007: 324), explaining their lived experiences. As such, these ‘truths’ are also a natural part of interpretation formed from immersion in the phenomenon and, in part, emphasise the importance of credible appropriation of another’s experience in codes representing key aspects of the data that can be explored and discussed within subsequent analysis. It could, therefore, be suggested that for some qualitative researchers, the nature of ‘Truth’ and ‘Belief’ in the participant is symbiotic with the pursuit of knowledge based on participant insights. The subjective nature of multiple realities emphasises the importance Kant placed on experience shaping and informing individual understanding but extends to the concept that experience and subsequent knowledge act as a precursor to developing Priori Knowledge, which informs broader decision-making transferable to many situations. Furthermore, the spirit of knowledge and ‘Truth’ is rooted in the lived experience of participants (Chignell, 2007; Goldmann,1971). It has been shown to carry value through how knowledge is first weighted before being assumed and considered credible (Smith,2011; Goldmann, 1971).

This highlights the importance of faithful and accurate interpretations of the collected and analysed data within a study and lends itself to the notion that physical experiences are not the full extent or measure of how we come to learn, develop meaning, or form understanding (Smith,2011:4). Still, without it, we cannot reach a point of separating, combining, or transferring concepts that lead to “sensible impressions” (Smith, 2011:34). This is essentially driven by human nature, asking questions about the world that cannot yet be answered through a consensus or attainment of purely objective knowledge. Instead, individuals are left to explore, believe, and learn through exposure and experiences in whatever way they see fit, providing their knowledge can be reasoned or justified (Chignell, 2007; Goldmann,1971). This has subsequently influenced the study's justification of research aims, objectives, and overall structure. It has also confirmed initial plans to reject positivist-driven methodologies and methods, which will now be described, starting with recognising the paradigm wars and subsequent divides.

3.3 The Paradigm Wars and Discounted Research Methodologies

Given Clarke's (2012), Speziale and Carpenter's (2007) and Shorey and Ng's (2022) acknowledgement of the six characteristics of qualitative research, related ontological and epistemological underpinnings that draw from Kant's search for 'Truth' 'Belief' and acknowledged strength in a subjective reality (Kant,1781; Smith,2011; Chignell,2007; Goldmann,1971), selection of an appropriate methodology and methods should include an in-depth appraisal of key differences between qualitative and quantitative approaches. This is most easily identified in discussions surrounding the "paradigm wars" coined by Gage (1989). These discussions are based on dominant concerns for researchers starting in the 1960s (Gage,1989; Given,2017; Wilding, 2019) and relate to ways of conducting research and ontological underpinnings, which then influence the alignment of paradigms with an appropriate methodology, methodologies, and subsequent methods applied to, or within, a study.

From these considerations, it may be suggested that the nature of the theoretical "paradigm wars", commonly referred to as a "turn" or "paradigm shift" from positivist-based research, was primarily driven by a common belief that purely scientific means of inquiry were often an ill-fitting or incompatible approach when exploring, theorising and conceptualising aspects of the lived experience (Kuhn,1970 in Bowling,2014:137; Bryman in Alasuutari et al.,2008; Burke Johnson and Onwuegbuzie,2004). However, in the initial drive towards the synthesis of experience through alternative lenses, researchers still used quantitative methods to produce research that focused on lived experiences to increase perceptions of rigour (Holloway and Galvin, 2017; Holton and Walsh, 2017). This was necessary as historical schools of thought initially labelled early qualitative research as "impressionistic, anecdotal, unsystematic and biased" (Charmaz,2014:6; Charmaz, in Jarvinen and Mik-Meyer,2020) in comparison to a "Gold Standard" of positivist-styled research (Doyle et al.,2016:177). However, quantifying data in studies that researched into or on more socially driven topics generated mixed success for research outputs due to challenges in developing a consistent method for quantifying the lived experience (Holloway and Galvin, 2017; Singh and Estefan, 2018).

Initial attempts to quantify the lived experience during this period were also governed by strict or 'purist' adherence to any chosen paradigm and did not recognise the benefits of combined approaches (Burke Johnson and Onwuegbuzie, 2004; Doyle et al., 2016), which altered once debates between Positivist, Interpretivist, and later Critical Theory paradigms developed into appraisals of different approaches (Given,2017). However, as researchers became more familiar with mixed-method research and its ability to bridge the gap between quantitative and qualitative research (Doyle et al.,2017; Johnson et al.,2019), it not only addressed the need as mentioned above to review the perception of quality in research but prompted researchers to adopt seemingly more personable or sensitive qualities when conducting studies (Fink,2000). This then developed into a desire to discover and explore the lived experience beyond preconceived notions or hypotheses (Butler et al.,2018; Charmaz, 2014).

With these in mind, the rejection of other methodologies that followed took place before a cemented research design was constructed. These rejections included consideration of Symbolic Interactionism (Blumer,1969), classical grounded theory (Glaser and Strauss, 1967, 1968), Glaserian Grounded Theory (Glaser, 1978, 1992, 1998), and Strauss and Corbin Grounded Theory (1990,1994 in Heath and Cowley,2004).

3.4 Rejected methodological underpinning: Symbolic Interactionism.

Symbolic Interactionism was initially a promising option for this study, as this approach influences the nature of Constructionism and Cons.GT (Charmaz,2014) in terms of how researchers may seek to explore and gain an "intimate familiarity" with the participant's lived experience (Bryant and Charmaz,2019). In particular, Blumer's Symbolic Interactionism (1969) enhanced an opportunity to focus on the critical 'unpicking' of lived experiences in the form of symbols or the interpretation of individual actions shared (Rock,1979; Segre,2019). The benefits of using Symbolic Interactionism are based on these links to lived experience but rely on analysis of the

data through symbols, units, and observation that a researcher may choose to define or analyse quantitatively (Bowling, 2014). It might also be suggested that studies that use Blumer's Symbolic Interactionism (1969) would benefit from a more objective position due to its positivistic origins. Based on the declaration and strength of my positionality and the need to immerse myself as a nursing researcher exploring the lived experience with other nurses, this was not ethically achievable in this study. Therefore, as a sole approach, Symbolic Interactionism was rejected.

3.5 Rejected methodological underpinning: Classical Grounded Theory.

As a general approach to conducting research, GT, in its numerous forms, has increased in popularity over decades and is used within qualitative, quantitative, and mixed-method studies (Bryant and Charmaz, 2019; Charmaz, 2014). However, as there are different iterations of this methodological framework, using any GT iteration in a study must be carefully considered and rationalised to be the most natural fit for any particular study (Bryant and Charmaz, 2019). As part of such considerations, *The Discovery Of Grounded Theory* (Glaser and Strauss,1967), alongside Glaserian iterations of GT, are recognised as seminal and founding examples of methods that demonstrate seeking to employ quantitative measures as they attempt to explore the lived experience (Charmaz,2014; Holloway and Galvin,2017; Singh and Estefan,2018). An aspect of achieving this stems from adopting a neutral or objective position (Holton and Walsh,2017; Singh and Estefan,2018) and researching a phenomenon from a pre-arranged lens or a hypothesis. This naturally deviates from the six characteristics of qualitative research (Shorey and Ng,2022; Clarke,2014; Speziale and Carpenter,2007) and instead looks to collect data and validate results through instruments, establishing the validity of findings as their statistical significance. The result of this will lead to either a confirmation or refutation of pre-existing thoughts or hypotheses, which beliefs will lead to the creation of a new theory that is grounded in 'proven' data (Kumar,2014; Ormston et al.in Ritchie et al.,2014; Singh and Estefan,2018).

Cons.GT (Charmaz,2014) principles differ on this account, as fitting data to pre-existing ideas or concepts can sometimes lead to unchallenged biases, the premature declaration of theoretical data saturation, and contaminating data (Singh and Estefan,2018). It may also cause a researcher to exclude themes or concepts which could clarify themes and concepts that relate to the phenomenon but remain unexplored because they do not align with a preconceived lens or hypotheses.

Another critical difference between GT and Cons. GT (Charmaz,2014) is that in its classical form, GT actively discourages the construction of a literature review before data generation, as it accepts that theory emerges from themes or concepts in the data (Flick,2018). There is also a tendency for researchers who use GT to adopt theoretical sampling approaches for participant recruitment so that larger sample sizes can create generalisability (Butler et al., 2018) and, therefore, align with historical perceptions of quality and methodological rigour (Flick,2018; Holton and Walsh,2017; Strauss and Corbin,1990). In addition to these considerations, the ontological underpinnings of the study highlight a perceived inability to replicate the knowledge a nurse has accrued through exposure and lived experience (Karp, 1996 in Johnstone et al.,2017) through alternative roles and professions. This is due to the fundamental nature of care and the creation of subjective exposures which cannot be fully anticipated or planned for in a study. This lends itself to exploring the phenomenon through a purposive body of participants relevant to the study's focus and is weighted by evidence suggesting that the SLAiP standards (NMC,2008; RCN,2015) were a non-mandatory element of the study registrant progression. This means that if the study were to consider all nursing registrants, a proportion of them would not have completed the SLAiP course or similar qualifications and, therefore, have formalised experience acting as a mentor or sign-off mentor for students.

The choice to conduct a literature review also does not align with GT principles. This is due to the suggestion of delaying the conduct of formal literature searches. However, early literature review synthesis and consideration of earlier literature have been increasingly useful for several reasons. The first is that the *Future Nurse*

standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) were only implemented in 2018, and there was a need for me to familiarise myself with the documents. This naturally led to comparisons between what they experienced as a pre registrant and how they have adapted to meet the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d). Consideration of the similarities and differences between the Mentorship model and the use of supervisor and practice assessor roles was also beneficial as it prompted greater sensitivity and engagement to identify key differences in the language and provision of support offered to pre-registration students in a period of transition and beyond. It also encourages its users to look beyond a sole set of experiences and explore the phenomenon and assumptions from a balanced and 'shared space' that, for some, affords greater criticality. As such, Classical GT and subsequent Glaserian adaptations were deemed unsuitable and were also rejected.

3.6 Rejected methodological underpinning: Classical Grounded Theory. Strauss and Corbin's (1990) adaptation of GT.

Within her seminal work, *Constructing Grounded Theory* (Charmaz,2014), Charmaz seemingly takes influence from several paradigms from an ontological perspective. Such influences include Classical Grounded Theory (GT), Ethnography, Phenomenology, and Symbolic Interactionism with its Chicago school of Pragmatism Heritage (Charmaz,2014; McCrae and Purssell,2016). However, the influence drawn from GT stems from an appreciation of other integral works that relate to Classical GT (Glaser and Strauss,1968) and the Strauss and Corbin (1990) adaptation. Other seminal works that have contributed to the formation of Cons.GT may also include positivist Glaserian GT, which is aligned with the development of theoretical sensitivity (Glaser,1978,1992,1998) and the more constructionist, interactionist and Interpretivist based Straussian GT (Strauss,1987; Strauss and Corbin, 1990, 1998; Strauss and Corbin, 1994 in Health and Cowley,2004)

The lack of suitability for this study was not as clearly defined when Strauss and Corbin's GT (1990) was considered compared to Glaserian of Classical GT

approaches, as Strauss and Corbin's (1990) iteration of GT had positivistic tendencies but did encourage researchers to grapple with realities' existence and their impact on the individuals involved in a study. This process allows a study to consider and represent reality in its design cautiously because reality is considered a subjective aspect of the lived experience (Singh and Estefan,2018). However, Strauss and Corbin's (1990) adaptation aligned more with Classical GT. This adaptation renewed the need for a researcher to assume an objective position because this would also form the basis of a systematic approach. This was considered an appropriate action for researchers as an objective position was thought to minimise the subjective biases created by personal immersion and interaction with the phenomenon of interest (Singh and Estefan, 2018). Based on this consideration, this methodology was also seen as unsuitable for this study.

3.7: Selected methodological underpinning and applied research methods: Constructivist Grounded Theory (Cons. GT) (Charmaz, 2014).

In comparison to other methods, full justification of Cons. GT's as an underpinning methodology and methods for this study Cons. GT's main attraction for this study stems from the methodological focus on the subjective nature of lived experiences and the interpreted richness that Constructivism naturally encourages (Charmaz, 2014; Charmaz, in Jarvinen and Mik-Meyer, 2020). This is because Constructivism centres on the ability *"to illuminate the reality of others through the process of detailed descriptions of their experiences"* (Doyle et al.,2016: 177). Cons. GT. (Charmaz, 2015,2006 in Alemu et al., 2014) also finds its roots in Pragmatism as it encourages the exploration of a phenomenon using a critical, inquiring approach to avoid taking aspects of a phenomenon for granted. Instead, this theory prompts researchers to scrutinise their data and adopt a reflexive stance to develop an explicit and self-conscious interpretation of the phenomenon (Charmaz, 2015). However, to achieve this level of detail and interpret experiences justly or faithfully, one must remain 'open' or flexible to unanticipated lines of potential inquiry. The same level of scrutiny and critical engagement should also be present during the data generation and analysis stages (Bryant and Charmaz, 2019; Charmaz in Wertz et al., 2011; Charmaz,

2015,2014). This critical engagement extends to the scrutiny of coding techniques and subsequent data analysis, which should be a transparent, traceable, and flexible process so that codes can be demonstrated as meaningful or substantive in the data instead of generating codes for the sake of generating code (Charmaz,2014). Although reflective journals and forming field notes may aid this process (Palaganas et al., 2017), carefully considered approaches allow for checking coding processes applied to the data (Charmaz,2014; Flick,2018).

In addition, another benefit of using Cons.GT as a methodological approach, Charmaz advocates adopting a position within the study and appraising their immersion or positionality within the phenomenon of interest before collecting data (Charmaz, 2014). This acknowledged position then encourages the development of a greater sense of transparency within the research process and the participant, alongside additional benefits, which include measures to help reduce the over or inaccurate assumption of shared social norms that participants and researchers may share (Adu-Ampong and Adams, 2019; Charmaz, 2016). The impact of not seeking clarification for key themes and concepts could damage the level of transparency and lead to misconstrued meanings or inaccurate assumptions based on unclarified data or concepts that are 'taken for granted' (Charmaz,2016; Mann,2016). Cons. GT also acknowledges immersion, individual positionality, and encouragement to actively and continually challenge or appraise. This extends to how researchers have constructed their sense of knowledge and justified selected points for further exploration and inquiry (Charmaz, 2016,2014; Johnstone et al., 2016) and interpreted data through each point of the study.

However, it can be easy to become distracted by the fruitfulness of participants' lived experiences or desire to build rapport and lose focus of the research aims and objectives. Cons.GT (Charmaz,2014) allows researchers to situate and acknowledge their strong positionality and prompts them to repeatedly question and appraise their preconceptions, biases, and sense of Priori knowledge, which shapes the interpretation of data. In this case, exploration of Priori knowledge includes my positionality and completion of Phase 1, which looks to expressly declare and appraise a positionality and stance adopted within the research but focuses on the development of understanding beyond their own experiences and preconceptions, which are generated from clinical and academic environments. In some ways, this was important

for the initial synthesis of tentative areas of inquiry and initial questions (Charmaz,2014) as researchers attempt to be open-minded in their attempts to "grapple with the data" (Silverman,2021: 302) in line with Cons. GT (Charmaz,2014) principles, this process is complemented by using field notes and the upkeep of reflective journals (Palaganas et al.,2017). This is done throughout the study's progression process to help establish and maintain criticality, review, demonstrate continual growth of understanding, and develop transparency and trustworthiness (Charmaz,2016,2014). However, some studies that utilise Cons. GT may wish to include observational research and line-by-line focus coding as part of the process (Charmaz,2014). However, this study rejected this approach on the grounds of perceived authenticity and consideration of literature, suggesting that observed practice is rare and may not represent the actual reality of providing pre-registration student support (Johnson et al.,2019). It, therefore, offered no significant value to this particular study.

3.8 Summary of selected methodological approach: Cons. GT (Charmaz, 2014)

In conclusion, an adapted version of Charmaz's (2014) Cons. GT, as a methodology and series of applied research methods, has been fully justified for use within this work (See p.101-103). Primarily, this is due to the perceived natural fit with the study's aims and research objectives, as these looked to ground the study within the lived experience. Cons. GT (Charmaz,2014) also provided ample opportunity as a methodology with applied methods to grapple and situate myself within the research from a positionality perspective. Its use also fulfilled a need to remain consistently reflexive and critical of my own role during the generation and analysis stages of this study.

As there is also room within Cons. GT to consider broad concepts, there is a degree of fluidity to explore the lived experiences which could improve the overall understanding of a rich and highly diverse career such as nursing and how individuals from a range of roles and Participant Information Centres identify or interpret the *Future Nurse Standards* (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d). The approach also influenced the methods for gathering data and exploring the phenomenon and why others were rejected. This process started with interviews being

identified as a natural fit with Cons. GT (Charmaz, 2014), the exploration of experience that leads to cumulative knowledge, aligns with the six characteristics of qualitative research (Shorey and Ng,2022; Clarke,2012; Speziale and Carpenter, 2007). It also poses a need to discuss the ethical considerations of the research before data collection and analysis take place.

Chapter Four

Research Ethics

4.1 Ethical Considerations.

Ethical principles were carefully considered to continue the study beyond the theoretical perspectives and required me to take steps and ensure participants were supported, remained autonomous, and treated with respect and dignity throughout and beyond the study (Clark et al., 2021). Although there are different considerations for researchers who undertake qualitative research when compared to quantitative methods of inquiry, ethical conduct remains an integral aspect of all research and, in some respects, acts as an indicator of quality and transparency for the study as a whole (Charmaz,2014; Holloway and Galvin,2017). Broader impacts of developing transparency with participants throughout the study are multifactorial but include the ability to facilitate conversations that not only lessen any intimidation inadvertently caused through the interviewing process and unequal power balance due to the Hawthorne Effect (McCambridge et al.,2014; McCarney et al.,2007) but helps to actively preserve the relationship made between both parties (Webster et al., in Ritchie et al.,2014) and ensure the study's practices are carried out with integrity and fairness. In achieving this and valuing the relationship and rapport built between researcher and participant, it is commonly accepted that the data generation process could be more fruitful and generate a greater, and sometimes more defined, understanding of the phenomenon of interest (Charmaz,2014). However, the success of this somewhat relies on the demonstration of integral practices to research, such as obtaining informed consent, that the research carried out has a purpose which may be reached through making reasonable requests of the participant (Clark et al., 2021), and that all data collected aligns with an expressed reason which relates to the study.

Additionally, ethical practices should ensure that all study-related protocols and intended uses for the data should be made clear to the participants before data generation, that all participants taking part in research do so without feeling compelled to participate, and that there are clear steps for avoiding harm to the participant and researcher (Avery,2017; Clark et al., 2021). This includes exploring the phenomenon with sensitivity, being realistic and clear surrounding participant expectations, and ensuring that each question is phrased appropriately. This extends to exercising discretion when asking for clarification of specific aspects of interviews if required. As

such, it is important to establish a balance between obtaining rich data and how a researcher may, in some cases, seek to gain clarity on a specific point raised by the participant. This may include further explanation or explicitness being needed but prompts the need to do so with tentativeness without creating a sense of intrusion (Webster et al., in Ritchie et al., 2014).

However, challenges faced in research when adopting an Interpretivist and, in this instance, semi-structured approach to gaining data include the lack of ability to pre-empt insight into another's lived experience or anticipate content and related themes that may be shared. This is based on the concept that due to the nature of qualitative research, it is not guaranteed that, despite a rigorous ethical process being put in place, a researcher will be adequately prepared emotionally and psychologically or have a question that suits all content that may be disclosed as part of the data generation process (Webster et al., in Ritchie et al., 2014) or if, indeed, it is appropriate to continue. Moreover, the ability to pre-empt all themes and concepts disclosed in Interpretivist or semi-structured methods may be indicative of unethical conduct, as the pre-empting of all concepts may suggest biases in the line of questioning, as well as flaws in the study design as it may not correspond with the principles of a semi-structured approach, depending on that selected methodological underpinning adopted by (King et al.,2019). As such, risks associated with research could then also include a lack of situational awareness or unintentional bias and insensitivity, as it can be easy to lose sight of the power dynamic present, which can then lead to consequences, such as over-prompting or overburdening participants (Webster et al., in Ritchie et al., 2014), or imprinting your preconceptions on the participant and prematurely narrowing the lines of inquiry (Charmaz,2014).

For these reasons, it is imperative that the personal application of generic, virtuous, ethical principles, which have been identified as relevant to the study and the role of a registered nurse, is fulfilled with care. In addition, a duty of care to the participant ensures that there are pathways to ensure both parties can access support, either as part of or after the data generation process (Webster et al., in Ritchie et al.,2014). In some circumstances, where harm is either more easily perceived or is more likely to occur, an aspect of gaining informed consent means that participants choose to participate with this in mind and should be made aware of available support (Clark et

al., 2021) with anonymity. Although support and signposting information may be offered in these instances, individual participants may still not wish to access support despite sharing intimate or personal experiences, which may cause them distress or upset. Therefore, autonomy is not only a reciprocal process in terms of protecting all parties involved but relies heavily on respecting the participant's right to choose what they feel most suits them, trusting them to not only give informed consent but make informed decisions (Avery,2017), and utilise their right to withdraw without penalty or reason at any time if they wish to (Beauchamp and Childress,2019).

For this study, being explicit about the procedural elements of the interview included the importance of anonymity, where the interviews would be conducted, who would have access to the recordings, the transcriptions taken from them, and how they would be used. The need to protect and not disclose the names of Trusts or interviewees individually also included anonymising any anecdotes related to a particular patient, pre-registration student or staff member. This extended to any example given of training staff or students or specific assessment process details.

For this reason, data would be stored on an encrypted device provided by my institution, would not be able to be viewed by anyone but myself and the supervisory team and were stored in password encrypted files that only I could access. No hard copies of the participant's consent form or PIS were made, and copies of transcripts were not produced until the data analysis stages took place, which only included the participant number and PIC site. All parts of the transcript which may have otherwise identified a specific Trust or Person were also redacted from the text so it was impossible to relate hard copies to specific people who may have participated in the interview. When hard copies of the transcript were made, they were always secured in a manner which complied with the Data Protection Act (1998) and was not available to anyone else, with the exception of sample extracts that were discussed with my supervisory team to ensure critical interpretation of the lived experience and how this would contribute to overall themes within the thesis. This also ensured that the study remained faithful to the details in the Participant Information Sheet, which considered data use and storage as the sections originally outlined by the Health Research Authority (see Appendix 6).

My positionality was also considered and influenced the construction of a specific paragraph within the Participant Information Sheet (PIS) (see Appendix 6) and consent form (See Appendix 5). This was reasoned as it forms a part of *'The Code'* (NMC,2018b) and Duty of Candour (Care Quality Commission,2022), which states it is necessary to escalate disclosed processes that would be used if potentially unsafe or unethical practices were disclosed. and the potential need to break confidentiality in this instance. This was particularly important from a safeguarding perspective and helped to fulfil a duty of care as well as non-maleficence principles that apply to each and every participant. It also helps to ensure that if there is a need to make a referral to an external person, this would not be done lightly or prematurely and would be based on understanding gained from the individual through the clarification process.

4.2. Gaining Ethical Approval and submitting amendments.

As such, the virtue ethics recommended by Beauchamp and Childress (2019) have directly shaped this study's ethical considerations. They also applied to the construction of a qualitative protocol, as well as my personal conduct as the conductor of this study. This included being mindful of my own position as an insider/ outsider researcher (Adu-Ampong and Adams, 2019), being faithful to the chosen methodological approach and acknowledging challenges that occur between participant and researcher. These virtue ethics have been identified as Autonomy, Non-Maleficence, Beneficence, and Justice (Beauchamp and Childress,2019; Holloway and Galvin,2017).

The need to be clear and offer the opportunity for further advice and ask questions related to the study extends to information within the Participant Information Sheet and consent form. It is made clear that the participant also may choose not to answer a question, as well as their right to pause or terminate any data generation process (such as an interview) and at any time without reason (Holloway and Galvin,2017; Webster et al., in Ritchie et al.,2014). This includes clear indications that should the participant either change their mind or not wish to continue the data generation process, they will not be denied access or incur any form of penalty to care or other services. In addition, there was an obligation to the participant to ensure that plain or explicit language has been used (Avery,2017) to explain the following information:

- The aim of the study;
- The study's inclusion criteria;
- Expectations of the participants;
- Potential risks associated with the study and participation;
- Arrangements made to ensure confidentiality is maintained.

To remain transparent, a participant is also offered the opportunity to keep a copy of the Participant Information Sheet and consent form in a format that suits their needs, such as a paper or large font copy, as well as a scanned copy of the signed consent form. Having adopted this process, the principle of informed consent is also prioritised.

It ensures that the study is conducted transparently while allowing consent to be seen as an ongoing process so that the participant's needs or preferences may be continually met. As part of meeting the individual needs, a debrief can also be offered to facilitate further discussion in the collected data as part of sharing their lived experience, as helping others is not only a virtuous and beneficent act (Avery,2017) but can also be cathartic for individuals who partake.

Before each interview started, but during the recording used for transcription purposes only, the author asked if the participants had any questions, if they were satisfied with the information provided in both forms issued and were happy to proceed. The choice to then focus on the use of semi-structured interviews was to give the participant the freedom and, therefore, the autonomy to answer or explore questions in their own time, a form of expression and use terminology and language which is familiar to them. The author who facilitated the interviews then would seek clarification if needed so that explicit understanding can be gained, allow for participants to feel heard, as well as listened to and for their contributions to be interpreted as accurately as possible.

In taking time to fulfil these criteria, I would be able to ensure that the participant is treated as an autonomous individual at all points. This was continually enhanced by being mindful that I could also create opportunities to clarify points for explicit understanding and offer the participant an opportunity to review the transcript and/or withdraw from the study at any point until the coding of the transcript took place. This ensured that the focus of the study remained on the participant's well-being and, therefore, fulfilled the study’s need to do no harm, apply non-maleficence and act with beneficence. Non-maleficence extended to the need to ensure the anonymity of the participants and provide them with information, which includes the ability to access pastoral support if aspects of the lived experiences and reliving experiences that may be traumatic (preexisting or relating directly to the Coronavirus Pandemic). There was also explicit documentation within the PIS (see Appendix 6) as to how to make complaints or escalate concerns about the study to external bodies or to speak to the Chief Investigator, who could offer the opportunity to debrief objectively.

All of these considerations were the same for every participant. The information provided to each participant was identical. The process of gaining consent, confirming that the participant understood the information provided and was happy to proceed,

made the process fair, equitable and appropriate for the study. This, therefore, fulfils the core characteristics of Justice as a virtue ethic (Beauchamp and Childress,2019). However, as this study was also looking to gain access to existing staff who work for the NHS, this study was also subject to proportionate review, which was submitted via the Integrated Research Application System (IRAS) and was considered by the Health Research Authority (HRA).

As the HRAs ethos is to be open and transparent in how it "Protects and promotes the interests of patients and the public in health and social care research." (NHS Health Research Authority, 2024), undertaking research that requires proportionate or full REC, therefore has the benefit of encouraging a researcher to establish greater links between the theoretical principles and protection of the participant's and wider implications that may be generated by the study and its findings. As this study looks to inform pre-registration nursing education and how the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) can inform AEIs support in the practice learning environment, it is intent on doing good, or in line with the principle: achieving its aim and objectively in a beneficent manner.

As part of the proportionate review, it was also made explicitly clear that the author of the study would adhere to stipulations within the Data Protection Act (2018) and is inclusive of GDPR regulations. This includes but is not limited to the importance of ensuring privacy and confidentiality, which consists of storing and anonymising data where needed. This was initially considered and documented in the Participant Information Sheet (Appendix 6) but was subject to conditions also outlined in the consent form (Appendix 5). From my perspective, it was morally and ethically correct to highlight that all data collected, analysed, and interpreted as part of the thesis would remain confidential. The same premise would apply to the contents of interviews as the participant would be the sole recipient of the fully transcribed interview. By implication, unless conditions arose which would lead to whistleblowing initiatives being followed (see Appendix 5) and would therefore also allow the author to also adhere to whistleblowing policies and safeguarding principles and remain mindful of the NHS Constitution (Department of Health and Social Care, 2023).

In extension to these considerations, information/data and the identity of individuals who took part would not be shared outside of the supervisory team. This restriction on

sharing data, therefore, applies to any and all organisations or parties that participants work for or are affiliated with. It is hoped that these combined measures would help participants feel assured that employers would not be able to reappropriate interview content and, therefore, could speak freely and feel heard without recrimination and penalty. From a theoretical perspective, this may help to reduce participants' given policy-driven answers or develop a rhetoric interview style and rapport.

Although undertaking a proportionate review process was longer than initially anticipated, the extra time to refine the study's protocol and ethical considerations allowed for greater thought into the initial interview schedule (Appendix 3). In addition, this particular study's case included the ability to adapt to guidance from a local and national level in response to the Coronavirus, collecting and storing data, and gaining initial access to research participants. As such, amendments were necessary, creating points of introspection and the need for personal resilience in the study.

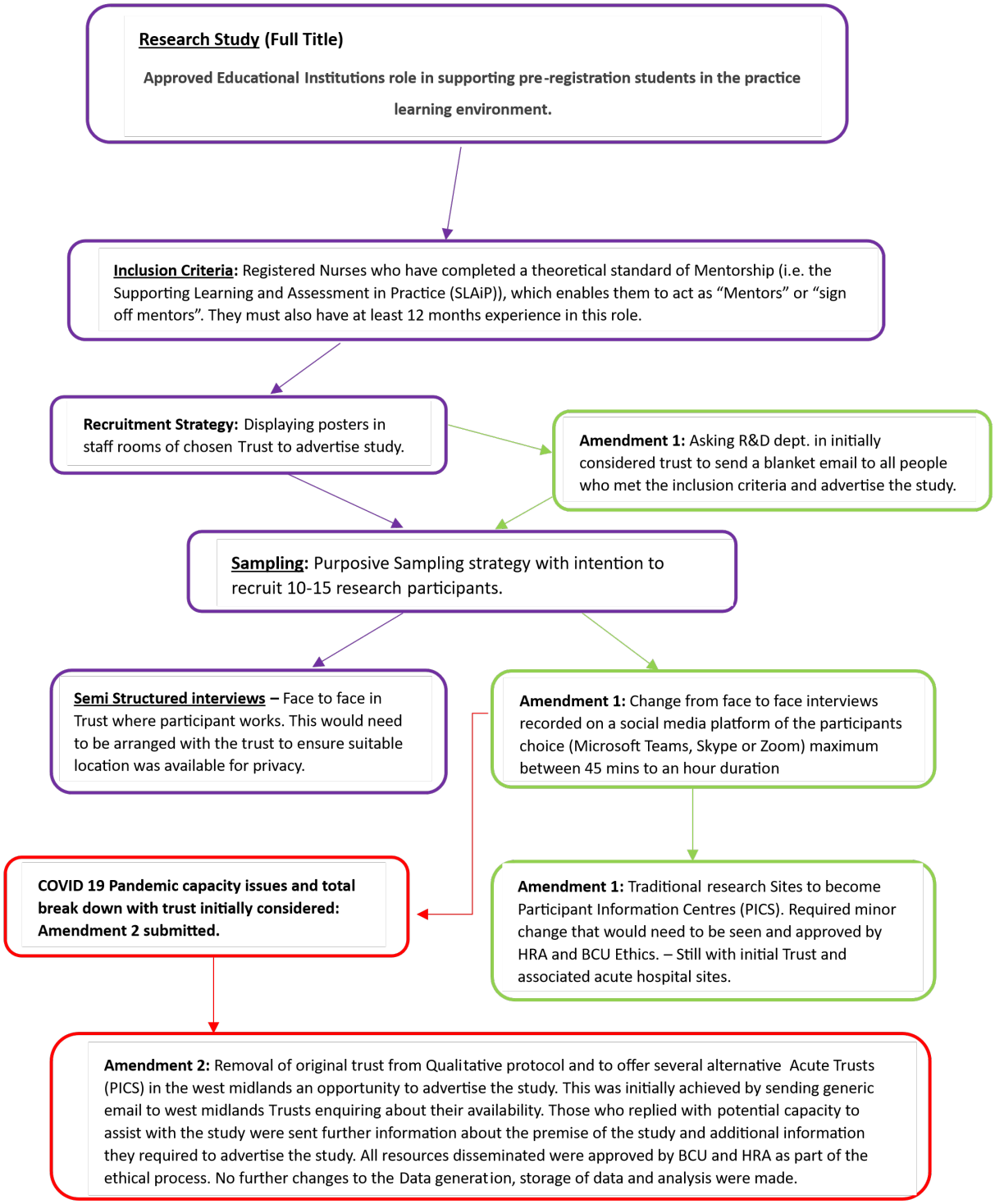
Reflective Extract: *The need to create a qualitative protocol became a landmark in the study's progress as it helped in the refinement and justification processes that underpin the research design and its aligning methodologies and methods. Although the questions in the IRAS form and BCU ethics are similar and do require careful consideration, I believe the creation of the protocol, in particular, demanded a level of clarity that I did not initially anticipate and found challenging to grasp as it was being completed. This is because the wider considerations of a research study are things that you may not have been exposed to, and the required answers are not what is at the forefront of a person's mind. However, in retrospect, after I completed the qualitative protocol, it became apparent that part of meeting ethical requirements naturally enhances the development and use of language to form explicit meaning and document intentions but also ensures the premise of the study fully considered the participant's privacy and dignity in all parts of the process. In many respects, this helped me as a researcher to develop a sense of humility while I was fulfilling the requirements for both BCU and HRA approval, as it encouraged me to think more about the human cost of gathering data beyond the practicalities involved with the collection and storage of data.*

4.2.1 Amendment 1: Change to the method of Data Generation.

Coronavirus not only represents a globally unprecedented event (World Health Organisation (WHO), 2020) but has mutated several times over, giving the virus the potential to generate more diverse outcomes for those affected by its transmission and highly infectious profile. Furthermore, it is also not fully known what the long-term effects of moderate and life-threatening presentations of the virus will be for those who survive and how it will affect their psychological health and physical morbidity. As such, all factions of the research communities have been affected either directly or indirectly by the pandemic.

In line with BCU ethical principles and restrictions set by the UK government and some healthcare settings (including my initial research site), non-essential travel, contact, and access to hospital sites were not permitted. This meant that my initial plan for visiting the selected sites to display posters advertising the study could have been more feasible, as was the ability to conduct semi-structured one-to-one interviews in the Acute Trusts that the participants work in. I designed a flow chart to plan for the contingency considered in my initial application with BCU and went into the IRAS proportionate review to partially mitigate this. An additional amendment was added to reflect additional changes required for the study to continue, indicated by colour, and marked as Amendment 1, and then Amendment 2, as Figure Two depicts below:

Figure 2 - Flow Chart of original process and Amendment 2 submitted to ethics.



Reflective Extract from time DURING PEAK of COVID-19: *This was a real low point for me in my journey, as there was a significant delay in taking the study from a theoretical concept to being able to work with participants and collect data. As time passed with the initial Trust, responses became more and more limited due to the prioritisation of COVID-related research; the time in between approval being granted for the amendments and refining concepts within the introduction and included literature gave rise to a deeply personal conflict that arose due to COVID-19. On reflection, my feelings stemmed from my positionality and ability to reconcile the continuation of research, fulfilling my GTRA role, and not postponing the study to do more as a registered nurse at the peak of the first wave. Part of this was exacerbated by nursing culture, media coverage (on social media platforms online and in the news), and the perceptions of my friends and colleagues during the peak, who seemed to think that the contribution to education and continuing my studies was not a priority. There was also a general assumption that because the physical building was closed, there was no student content to offer and that I was just away from practice instead of doing additional hours. In some ways, this made me question the value of the contribution I had to offer as a registrant who wasn't full time working in my local hospital full time during the peak and that my contribution when I was working in the sites as a non-critical care nurse was devalued despite that the time I did spend in ITU prompted me to do the same as other people. Overall, this period led to intense frustration, low mood, and guilt that I could not do more or that my contribution did not feel as validated because I was not "on the front line" full-time.*

6.2.2. The rationale for Amendment 2 and initial taste of success

Owing to the natural prioritisation of COVID-based research, despite several months of communication and meetings, all required steps for access to the initially chosen Trust, a second contingency plan was needed and formed. Although discussion about this amendment in supervision meetings did include a potential change in the sampling group, a different group of participants at this point in the study might not generate the same insight required to construct theory and address the primary research question. This is based on the idea that the *Future Nurse* standards (NMC,2018; NMC,2018a;

NMC,2018c; NMC,2018d) apply to registrants who work in practice placement settings and are directly involved in supervising and assessing preregistration students. They are also a specific group of individuals who are directly affected by the skills annexes that form part of the Future Nurse: Standards of Proficiency (NMC,2018a) and are expected to adapt from the preceding models of Mentorships and SLAiP standards (NMC,2008; RCN,2015). Thus, they hold a unique position that cannot be entirely replicated from an alternative position or role. Basing the conceptual framework on alternative perspectives may also mean that AEIs might not be able to offer support that not only addresses potential gaps created when the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) was published in 2018 but that any interpretations of these gaps may not form an accurate representation of what registrants typically find challenging as they fulfil the daily duties of supervision and assessment of pre-registration students.

Instead, a generic email was composed and sent to all Acute Trusts in the West Midlands; they were listed as having a Research and Development contact on a Research and Development forum. This email was based on the access request letter approved by BCU ethics and the HRA, which introduced the Primary investigator, the reason for contact, and inquired about their capacity to aid the study. Four alternative Acute Trusts responded within a week of writing to them with positive news that they did or should have the capacity and asked for further information. The access request letter then became the template for an email that was generically sent to the Trusts who had responded, which included the premise, outcome of the study, and participants' expectations with the offer of more information (Appendix 4). Within three weeks, I gained four expressions of interest in the study, which prompted further communication via email and the provision of the Participant Information Sheet. The protocol was followed to give each participant at least two weeks to read through the information before a polite email confirming their interest in the study or willingness to participate. After three weeks, Trusts with whom I had initially corresponded but had no further communication were also contacted to confirm their capacity to aid the study's recruitment process. However, despite four initial offers of assistance, only two generated interest within Trusts and recruited participants from Acute Trusts.

Reflective Extract: This initial interest was a real high point in the research for several reasons, but most of all, it gave me a sense of validation and feeling that I was doing a piece of research that people were interested in and willing to participate in. It also made me feel a greater sense of achievement and recognise that despite all the time initially spent waiting and refining other areas of the study. Instead of feeling frustrated and anxious that the study was not progressing and data generation was delayed, it was worth it. I think a greater part of the frustration I felt on reflection is that there was nothing I could do to progress the study further despite the work that had already gone into understanding ethical principles, its translation into the study, and subsequent amendments. It was also a big learning curve not to have completed a master's or form of the research project before as a post-graduate and then be required to write a qualitative protocol that would be well-rounded and suitable to guide the study, let alone to get it approved in the IRAS application and be awarded HRA approval with no alterations beyond the amendments that were later required.

This also formed other considerations and a point of reflection after the initial wave of the pandemic, which also features as a reflective extract within the thesis and can be seen below:

Reflective Extract from POST COVID-19 entries: *In some ways, adjusting the study by considering other Trusts proved beneficial, and dialogue could now be established between multiple Trusts. The smaller sites were particularly helpful and responded quickly to my queries, which typically included their willingness to help. In widening the use of PIC sites, the main benefits of the study were generated:*

There was potential to recruit from all West Midlands acute Trusts, allowing for comparative analysis between participants and the Trusts they work for. This could be of huge benefit when the introduction and included literature are considered, as there is well-documented variation between local practices in the same trust, let alone different hospitals and regional practices or perceptions of the supervision and assessment roles. However, I was mindful that in gaining access to a diverse population, their experiences may be variable and generate many themes that may not overlap. It would, therefore, be a challenge to the participant to ensure that theoretical data saturation was either achieved convincingly or was not

reached because it was non-existent at the end of the interviewing instead of interpreting the data poorly and not synthesised from the collected data.

There would be a greater opportunity to recruit the number of people I needed. However, this would now have to rely on a first-come, first-served basis in regard to recruitment and avoid potential over-recruitment of participants for the study. This may also lead to a more diverse population that may have a variety of years of experience or life experience based on their local demographic and how approaches adapt depending on the experience of amount of pre-registration students in the area of the participant's work.

By recruiting from acute hospitals in the west midlands, I could access registrants who did not work at the Trust where I fulfil my position as a registered nurse. This would not only minimise my ability to recruit from people that I know or may have worked with (excluding staff that is on relevant Trust banks and work multisite) but also keep my positionality in line with professional boundaries that would have been more of a challenge if I interviewed people that I was more closely connected with in practice learning environments or may have been a mentor or supervisor to before the study. In short, this would minimise the risk of biasing the study using selecting participants willing to be interviewed.

4.2.3 One step forward, two steps back: Further challenges accessing staff in acute hospitals.

Despite completing two interviews, a lag did occur between these interviews and other participants who came forward. During this period, I renewed contact with Acute Trusts. They initially offered help advertising the study via the Trust intranets and included several conversations between myself and their Research and Development Teams' members. This, too, generated mixed responses and varying challenges for accessing potential participants across multiple sites.

One of these included conversations with research staff who had read initial plans for the study but had not read the amendments or accessed approval documents for the changes that took place, which included justification for reaching out to other sites to promote the study and generate participant interest. However, the conversation extended to concerns related to clinical governance and confidentiality arrangements,

as the staff member within a Trust's Research and Development department thought I was asking for details of registrants in their Trust so that I could approach people directly, despite there being clear plans and expectations of participants and staff being stated in the protocol and subsequent amendments. This included the need for Trusts to circulate the information on behalf of the Primary Investigator (PI) and for interested parties to contact directly. This led to a conclusive remark of "well, it would be better for you to do the study in your Trust" and insistence that the poster approved could not be displayed due to COVID restrictions, which again had been addressed in qualitative protocols, email communications with the Trusts R&D department and amendments which were approved by BCU ethics and HRA (see Appendices 7 and 8) . However, this was transferred to another staff member from the same organisation and led to a third interview taking place – I am truly thankful for the Trust's later cooperation and assistance.

Reflective Extract from Post 1st wave pandemic entries: *And here we go again…. More frustration and anxiety I associated with the progression of the study. Despite a generic protocol being written with amendments, proof of what the amendments contained, and approval from the sponsor and HRA in full for all amendments, more hoops were present, which weren't even consistent between Trusts that were initially open to the study. This led back to negative feelings about the study's value and that I may not get the opportunity to capture data vital to my study and the phenomenon I was exploring.*

It also made me curious as to why the staff was now either unavailable or why some Trusts were reluctant to grant me access to their staff despite their ability to control the circulation of information circulated, given that in these instances, COVID was not stated as a reason for not granting access. Part of me wondered if this was because of my status as a registered nurse. Another part of me wondered whether it reflected organisational "insider" and "outsider" concerns regarding a stranger speaking to other people in a different clinical setting and Trust.

4.2.4 Amendment 3: Reaching out to all West Midlands Trusts instead of the Primary Acute Trusts and expanding beyond the four other Trusts considered in Amendment 2.

At the same time, a Trust that did not initially respond and was included in Amendment Two responded and confirmed that it had capacity and capability. As this could happen for any of the numerous Trusts approached within the West Midlands, a third amendment was submitted to include any registrant who met the inclusion criteria for the study to be potentially included within the West Midlands region.

4.2.5 Amendment 4: Advertise the study within a closed social media group and instigate a snowball sampling strategy.

Despite the initial success and three participants coming forward from Trusts and newfound interest in the study thanks to introductions by my Academic Supervisor, there was still very little interest and uptake from registrants who had directly acted as former mentors and sign-off mentors in Acute Trusts. As such, a need to broaden the recruitment strategy further was identified. This included gaining permission from BCU Ethics and submitting an amendment to the HRA to use snowballing as a technique and advertise the study via a closed Facebook group so that practitioners I am familiar with could potentially spread interest in the research and allow me to recruit others. Unfortunately, despite this being implemented on the 10/02/2021, this too proved unfruitful.

4.2.6 How these challenges were addressed: Amendment 5. Change of Sampling strategy, the focus of the sample group, and justification.

During all this, my Academic Supervisor introduced me to the senior nursing staff responsible for updating registrants and implementing the Future Nurse: Standards of Proficiency (NMC,2018a) and the *SSSA* (NMC, 2018). Although this still fulfilled the inclusion criteria, in the sense that a participant had to be a current NMC registrant and have met the theoretical standard of mentorship required, other members of the nursing fraternity less involved with the direct supervision and assessment could still be of value to the study and address the strategic gap identified. This led to my supervisor utilising her existing network and canvasing Trust intranets to introduce the study to Practice Placement Managers (PPMs), clinical development leads, head nurses, chief nursing officers, directors of nursing, and members of the NMC. These individuals were also contacted as they are typically very experienced and potentially hold a more strategic perspective. They have also gained and consolidated a wealth of clinical and non-technical knowledge in these advanced roles, which they may choose to share with other registrants. However, as they were explicitly approached and asked to circulate the study to similar participants once interviewed, this represented a combined sampling strategy instead of a purely purposive one.

Additional challenges were also encountered throughout this study due to the initial and subsequent waves of the Coronavirus pandemic, which impacted the study's ability to access registrants in Acute Trusts, who represented the population of interest. Although such challenges proved to be multifactorial, they partially arose due to larger Trusts' inability to facilitate and circulate the study. It was also found that due to high volumes of COVID-related research projects occurring in Acute Trusts at the time, delays were also prevalent in the initial promotion of the study, and each Trust that was approached required different information before they could advertise the study as a whole. A further impact of the Coronavirus Pandemic and constraints associated with practice learning environments, an additional challenge, was access to the staff as they continued to fulfil their clinical demands in "hot" and "cold" COVID sites. Although it is important to note that restrictions and amendments were made during the project to gather data using an online platform and restricted access to the hospital

sites directly, some registrants who initially showed interest could not commit to the time required to participate in the study. Although some initial interest was made in the purposive sample approach employed throughout the study, it became apparent that it was recognised through Cons.GT methodology (Charmaz,2014); a purely purposive sample was not tenable. It made it difficult to progress with the study but meant that it could not access participants and collect data without a review and amendments.

Instead, a more fruitful strategy was reached when the third amendment was submitted to access any registrant associated with an Acute Trust in the West Midlands, providing they could provide proof of their registration and testified that they had achieved a mentoring qualification, which acted as a form of theoretical baseline for all participants. This meant that although the primary mode of advertisement of the study still relied on Acute Trusts, who had the capacity and capability to advertise the study, recruiting participants could align themselves with any trust in the West Midlands and promote snowballing techniques to complement the intended purposive sampling strategy. This was reasoned as participants could recommend the study to colleagues who may have missed the circulars or were affiliated with the Trusts on a more flexible basis (such as permanent Bank staff or individuals who fulfilled dual roles as educators) but would still have the potential to contribute fruitfully towards the study's aim and objectives. It also meant that registrants who work at Trusts who could not necessarily circulate and advertise the study could still express an interest and potentially participate provided they met the inclusion criteria and worked in Acute Trusts.

An additional benefit of having to adapt the recruitment strategy was also identified through the potential challenges in initial access and then recruiting participants, snowballing, and generation of interest via word of mouth, providing greater access to more people in the West Midlands, despite initial reservations about using a snowballing technique, and ensuring the credibility of the study was maintained. To rationalise the shift in the thesis towards a combined approach, my initial reluctance was based on the concept that traditionally, snowball sampling is sometimes more necessary or commonly used when a study is looking to gain access to a potentially vulnerable, specific, or potentially closed community of participants (Clark et al, 2021; Bowling,2014) which does not automatically apply to registered nurses who completed

a mentoring qualification and had at least 12 months experience in their supervision or mentorship of pre-registration students.

There was also very little I could do as a researcher to opt for the snowballing technique and demonstrate that I did not rely on people I was familiar with to form my recruited sample. In retrospect, maintaining credibility would have been challenging if snowball sampling had been used from the offset to adapt the study and combine multiple sampling techniques and specifics with my immediate colleagues. Instead, I encouraged the participants to talk about the experience with anyone they knew who met the inclusion criteria and they thought they might be likely to contribute. Anyone I did know clinically was not interviewed or considered for the study. This led to broader and unanticipated benefits associated with this need to manage positionality, and preconceptions or potential biases were found when Cons. GT provided more significant amounts of flexibility and an opportunity to adapt the study without changing the focus or changing the sample population and, in fact, created greater generalisability and transferability of themes as the data collected came from different Trusts, different demographics and prevented me from biasing the selection of the participants as interviews occurred on the first expression of interest, first interviewed basis. As there were no preconceptions about the individuals or their specific experiences, predicting their responses and following the coding processes outlined in Cons was impossible.GT principles before questions could be reshaped, and subsequent interviews could occur.

Chapter Five:

Phase One:

Data Generation & Analysis

5.1 The Spidergram: Phase One of Data Generation.

Although a pilot study or initial exploration of a phenomenon is not always warranted in qualitative research methods, a researcher may undertake a pilot study to develop greater theoretical sensitivity before initial forms of data generation occur (Holloway and Galvin,2017). The perceived benefits of doing this, in some cases (such as interviews), include the ability to practise asking questions, develop greater familiarity with data generation processes and ensure that questions asked of participants are relevant to the aims and objectives of the study (Holloway and Galvin,2017; Yin,2015). In mixed or quantitative research, a pilot or initial scoping exercise may also be used to refine and appraise areas pursued within a final study design, fieldwork procedure, or instruments (Holloway and Galvin, 2017; Yin, 2015).

When more directly focused on this study, exploring the existing literature before collecting data was beneficial and justified as the *Future Nurse* Standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d), the *SSSA* (NMC,2018), and Annexes A and B in the Future Nurse: Standards of Proficiency for Registered Nurses (NMC, 2018a) represent a significant change for supervision and assessment processes in practice learning environments. However, registrants' support offered to pre-registration students required a broader consideration in Phase 1 as the Standards of Proficiency for Registered Nurses (NMC,2018a) and *SSSA* (NMC,2018) were not yet implemented or disseminated in the clinical areas. This was overcome in Phase 1. The introduction and literature reviews recognise a vast amount of preexisting information that alludes to pre-registration students' supervision, assessment, and mentorship, which existed before 2018. In choosing to adopt a modified Cons.GT (Charmaz,2014) approach, the identified gap to be explored not only justified further research taking place but somewhat encouraged to use of language and terminology that the registrant would be familiar with or encourage support.

The development of the Spidergram (Phase 1) achieved this by framing an initial question which allowed for analysis of the concept of mentorship and identification of terms or phrases that could be used to appraise the sourced literature and recheck interpretations that have been used to highlight similarities and differences that exist between mentorship and supervision. However, as part of this rechecking process and

attempting to develop greater theoretical sensitivity, Phase 1 invited clinical and non-clinical individuals to participate. This was based on the idea that a general interpretation could help tentatively explore the phenomenon before more refined data generation took place instead of choosing things that were familiar to or related to their own experience. It has also been evidenced within the introduction and first literature review that mentorship or supervision is used in other professions which are not healthcare-focused. As such, the concept or intent behind mentorship extends beyond clinical application and pre-registration students but may still differ in its application. As such, different professions may highlight benefits that are not currently related to mentorship and somewhat prompt exploration.

5.1.1 Phase 1: The Spidergram at CSPACE 2018

Birmingham City University's (BCU) internal research event, CSPACE, allows researchers to explore alternative methodological processes through seminars or workshops and disseminate their research through presentations. Usually, this event is themed in relation to common areas of interest or practice present within the university. However, this event focused on disseminating research through an artistic medium. A perceived benefit of using a creative means of data generation was associated with the potential to encourage participants, who may otherwise have missed or declined the opportunity, to engage with a research study and fulfil the study's intention to consider and interpret the phenomenon from a multitude of perspectives.

After confirming the design for Phase 1 and considering the discrepancies within the introduction, the initial question 'What is a Mentor?' was chosen. This rationale included acknowledging that no agreed-upon definition in healthcare answers this question and represents a potential point of shared reference for clinical and non-clinical participants. The specific design of Phase 1 also allowed the study's content to be visually disseminated as a continual, anonymised, and transparent process as participants contributed to it.

The design of the Spidergram separated participants through four colours that represented individuals who self-identified as one of the following groups. These groups also had an allotted colour to ensure that coding could be compared between individual participant groups, as well as what the data suggested as a consensus, and have been demonstrated in Table Ten as follows:

Table 10 - Coded participant group and colour of contribution cards used on the Spidergram

Name of Participant Group	Allotted Colour
Undergraduate Student	Green
Post Graduate Student	Pink
Staff Member	Blue
“Other”	Yellow

In constructing broad groups for participants, the number of people associated with the term ‘mentor’ and who may wish to contribute could be optimised. However, it may be argued that language used within Phase 1 could inaccurately inform questions and create suboptimal avenues for exploration.

Extract from Reflective Journal: *At the time, this made me think: well… if the literature says that students perform better when there is a proactive and constructive relationship… why is there a need to supplement the role with an overseer or a “suitably prepared professional, trained to support students in practice” (NMC 2018; NMC, 2018a). I also didn’t understand how a person who didn’t necessarily have experience as a registrant of the same profession could deem me competent in the same way that another nurse would? – We’ve all been taught differently and shown how to perform a skill, haven’t we?*

5.1.2 Results from Data generation using The Spidergram (Phase 1).

On 03/07/2018, The Spidergram was exhibited. As the Primary Investigator for this study, a choice was made not to be present throughout the period when the Spidergram was exhibited. This was to prevent any potential bias or unintentional influence over content. Instead, tables with Participation Information Sheets, consent forms, and the necessary supplies were set up before the morning break for participants to contribute. Instructions left as part of the exhibition stated that if participants wished to contribute to the Spidergram, this should be represented in a keyword or sentence related to the Spidergram's focus.

At the end of the event, 23 cards were added to the Spidergram in varying locations on the web, with all groups generating at least one response. No cards had identifiable handwriting or identifying marks, allowing all content to be used within the initial coding process. All keywords were removed from the contributions, including four related but non-specific sentences, sorted into tables that denoted occurrences or trends in the data that would influence questions in Phase 2 of the research.

Through the initial coding and analysis of data, three emergent categories that coincided with the literature emerged and related to Personal Qualities that a mentor should have (1), Professional Qualities that a mentor should have (2), or a combination of the two (3). The third category was devised as there was no consistent method for aligning a specific contribution with the previous categories. In total, 26 individual keywords were identified out of the contributions with four particular statements. The participants who identified with the allotted colour, Pink, displayed the highest contribution used in the Spidergram. However, this category had no significant alignment with these contributions and coded groups. This indicates that a range of qualities was identified as necessary when defining a mentor and that a host of qualities were needed to aid the pre-registrant or 'mentee' to grow and become a 'jack of all trades' and a 'mirror to reflect upon.' This forms a concurrency with defining characteristics in the introduction but is not easily translated into the roles of the practice supervisor and assessor.

As such, it may be argued that the findings of the Spidergram indicate that the term ‘mentor’ for overseeing undergraduates in practice was not entirely suitable from its inception and instead aligned with more pastorally driven characteristics. This may explain why a ‘Failing to Fail’ (Black,2014; Duffy,2013; Hunt,2014) culture became a prevalent issue and accounts for the varying success that registrants have when fulfilling the role (Cassidy et al.,2017; Jervis and Tilki,2011). In light of the findings as a whole, links between Phase 1 and the introduction allowed me to identify that the term mentor is most strongly related to a “critical friend” in the perceptions of others.

5.1.3 Appraisal of Phase 1 (The Spidergram)

To evaluate the success of Phase 1, a Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis was completed (Appendix 1). A SWOT tool enabled a reflective account of the Spidergram, its design, and the initial form of coding and results to be considered. This offered the opportunity to amend or refine aspects of the data generation tool and further analyse the results. If used correctly, the use of a SWOT analysis also aids in looking for potential gaps in the way Phase 1 was either conducted or designed, as well as identifying how useful it was to the larger project as a whole and the potential for it to be used in further areas of the study (Wareing,2016).

Although there were several points for each of the SWOT analysis categories, the key points to highlight were that the research design was appropriate for the type of event that it was displayed in, it showed external validity when common themes were initially identified from the basic coding that took place, and that every group had at least one response represented (Appendix 2). It was also easy to compare the literature's contributions initially and demonstrated the accuracy of interpretation instead of relying on their positionality. However, as this was completed on a small scale that relied on voluntary participants already part of the event, a different location may have generated a different response. It is also difficult to comment on how much time would have been needed to generate more responses to answer a broad question as detailed in the research design. However, these categories provided an opportunity to

sense-check the tentative interpretation of data in the literature review and help synthesise the focus of questions in Phase 2.

Conclusively, using the 'Spidergram' allowed me to acknowledge preconceptions due to their immediate positionality and the findings within the literature review and challenge their understanding of a mentor. This includes the language that forms part of the nursing culture and the predisposition to using profession-specific language and terms which were inconsistent and did not form a consensus. It also allowed the researcher to use appropriate terms used by the participants to influence the initial questions in later parts of the study. This aided attempts to remain grounded in the participants' lived experience, shared understanding of the phenomenon generated by the participants, and demonstrated how interpretation has been formed.

Reflective Extract: *I was excited about this step in my study as it combined my past studies of Fine Art with the ability to gather data and experiment with data generation processes. As I wanted to use the data within the study, this required me to gain ethical approval for the event, so not only did I gain experience through participating in a research event, but I also gained exposure to ethical considerations early on and implemented them in the studies foundations.*

I have believed throughout the study that sensitising myself and exploring the initial literature was also important, as it made me more aware of other people's perceptions of mentorship and how easy it could be to appear insensitive or dismissive of their perceptions when collecting data. Although this would be unintentional, I think this could have happened had I not considered broader opinions and only looked at the material that fitted with my own experiences of mentorship or broken down my own experiences and questioned my understanding.

Considering the ethical principles and how this aligns with qualitative research, identifying a method that can be consistently used in a responsible, sensitive, and responsive way is also important. As such, several considerations were formed for how this study would conduct its research. These will be presented in the next section, which considers how data will be collected and analysed.

5.2 Data Generation

5.2.1 Interviewing is a method of exploring a phenomenon and generating data.

Interviewing is an increasingly popular method for collecting qualitative data, not exclusively used within GT or Cons.GT (Clark et al., 2021; Kumar,2014), which forms a purposeful conversation and opportunity to engage with others. These purposive conversations provide particular insight into the phenomenon of interest (Holloway and Galvin,2017). Interviewing participants allows them to capture data pertaining to the individual but gain access to concepts that were either unanticipated or require further exploration (Bowling,2014; Holloway and Galvin,2017; Mann,2016).

However, interviewing participants may lead to a more fruitful exploration of a phenomenon if it constructs appropriate questions and gently keeps the conversation relevant to the phenomenon of interest (Holloway and Galvin,2017). A common way to guide the exploration of a concept or area of interest can include the use of topic guides or interview schedules, as they can help to balance the relationship between participants being free to express and discuss points of related interest and having a way to bring conversations back to the primary area if there is a loss of focus. The significant benefits to this within qualitative research, however, rely on the ability not to close areas of explorative inquiry prematurely, and a topic guide can, therefore, help to consider and explore salient points of interest, theoretical gaps in the phenomenon, or consolidate on existing data and themes collected (Charmaz,2014; King et al.,2019).

5.2.2 Type of Interview: Open-Ended Questions.

Using open-ended questions that form part of a semi-structured or unstructured interview approach offers strength when considering the ethos of GT approaches. Open-ended questions do this by allowing me to tentatively introduce a topic and prompt discussion. This may be particularly helpful if a related subject is mentioned by

the participant and forms an unpredicted or unanticipated perspective. In that case, an open question can help gently probe for clarification or more fully explore the meaning of what is said (Charmaz,2014). This method differs from other types of interviewing; it is not a method that solely directs the interview or that advanced preconceptions dictate the questions asked within the interview. However, open-ended questions can also complement the ability to paraphrase within the interview so that the participant's language and terminology may be used to build rapport.

Tone or cadence of voice and level of curiosity are also important, as the Hawthorne effect can influence how an open statement or question is received and understood by others (McCambridge et al.,2014; McCarney et al.,2007). In addition, depending on engagement when participants disclose their experiences, a researcher's nonverbal communication or body language and observations can also influence interviews (McCarney et al.,2007). This is not dissimilar from a poorly chosen environment to conduct an interview, as external stimuli around the participant can distract them or make them feel ill at ease during the interview process (Holloway and Galvin,2017). Additionally, by taking the individual out of their usual setting, there is limited scope for observing the mirroring of action to the word, and this effectively acts as a bubble between the theoretical concepts explained in the interview arena and the situation in which a phenomenon occurred, or the potential that recourse bias has on what is shared or how accurately this depicts the reality that the individual experienced (Holloway and Galvin,2017; King et al.,2019). This has informed subsequent rejection of other forms of data generation.

5.2.3 Rejected methods of Data Generation: Telephone and Email.

The interview is method may also be a weakness within the study due to technical errors or missed cues. For example, telephone interviews have positives and negatives, as the person's geographical location does not necessarily hinder accessing appropriate participants for the study. It also provides an immediate way of interviewing with simultaneous back and forth between researcher and participant. However, more structure is required to create that type of dialogue, which could cause

missed cues that may otherwise have generated a more meaningful or rich form of data. This may include non-verbal communication that may otherwise be noted and explored in face-to-face interviews (Holloway and Galvin,2017; King et al.,2019). As such, it was discounted from this study as a method of data generation and collection.

There are similar considerations and benefits when using emails to create a rapport, rapidly exchange views, and not be limited to distance. However, an additional benefit of email is that there is a written form of documentation that can be constantly referred to and used to confirm links or justify codes and their relevance to the data (Clark et al., 2021; Bowling, 2014).

5.3 Selected Approach for Data Generation: Semi-Structured Interviews.

Semi-structured interviewing, as a concept, fits within both qualitative research and Cons. GT. (Charmaz,2014) and recognises the need for reflexivity and growth of ideas that emerge from the participant's shared experiences that can be explored in-depth with smaller sample sizes. Within this growth and sharing of experience, emerging themes can influence how other questions are asked and afford the participant significant freedom within a loosely guided interview process, providing that a researcher is sensitive to the topic of discussion and the participant. Furthermore, flexible interview constraints can prevent fragmentation or loss of potentially valuable data during the analytical process. However, it is essential to keep the interview relevant to the discussion area within a reasonable timeframe, which can often be a failure of researchers (Charmaz,2014). It also allows going back to points of interest that may require further exploration, emphasising the importance of a flexible sample size that is manageable for semi-structured approaches to be successful (Alemu et al.,2014).

This interview technique also allows for various opinions to be shared in relation to an individual’s sense of reality and understanding of a phenomenon. It may be suggested that this method, combined with line-by-line coding, allows one to recognise more easily and appropriate common language or terminology and draw on viewpoints, themes, or points of discourse related to the exploration phenomenon.

However, there were some prominent considerations for methods of data generation that were considered before selecting the method of semi-structured interviews for this study.

5.3.1 Consideration 1: Focus Groups and Group Interviews.

The use of terms such as group interview and focus group are exchangeable within some of the research literature (Holloway and Galvin,2017; King et al.,2019; Then and Rankin, 2014) and affords a specific opportunity to be explicit in the terminology used, and why these were excluded in this particular study. The term group interview, for example, can highlight various techniques used to interview people within a formal or non-formal interviewing process (Holloway and Galvin,2017; King et al.,2019).

Focus groups were a substantial consideration initially, as it was easier to collate a large amount of data at the same time, as well as provide individuals with the opportunity to challenge a shared opinion or one's perspectives surrounding a topic of conversation within the interview (Jayasekara,2012; King et al.,2019). Additionally, a group interview or focus group may be more comparable to everyday life and potentially act as a standalone method of data generation in a study when exploring a particular phenomenon or set of experiences, while the results remain 'grounded' in the individual's interpretation of an experience (Jayasekara,2012; King et al.,2019).

This type of interviewing technique could be justified within the study, as this interviewing advocates for the acknowledgement of historical time, culture, and social context, as well as recognising the value that subjectivity brings to discussions and generating new meaning through constant comparative analysis (Jayasekara,2012). This is particularly poignant, as these are changing in the current nursing climate and include how people experience the transition from pre-registration student to registrant status. It also creates rapport amongst the participants and encourages others to discuss their methods for supporting students. However, there is currently a limited amount of literature within the public domain that focuses on the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d), which might reduce talking points amongst participants and create superficial knowledge or conjecture

about the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) and lead to a lack of engagement from the participants.

When considering the nature of health and social care, some aspects of the organisational culture and individual experiences related to this study may also uncover topics of conversation that require more sensitive exploration. Despite the need to be sensitive around aspects of disclosed experience, evidence suggests that this does not discourage the use of group interviews or focus groups, and in some literature, the shared sense of a problematic situation can strengthen others in sharing their opinion (Jayasekara,2012; King et al.,2019) However, this can only be achieved if there is collective respect and understanding for the individual's confidentiality, although this should always be encouraged in any form of interview.

In addition, it may be argued that capturing the voice and true meaning of multiple individuals' experiences in detail and monitoring their specific inputs is more difficult (King et al.,2019). It may also be more challenging to keep the interview focused on the phenomenon of interest and prevent stronger voices in the group or more senior/experienced staff members from governing or dominating the conversation without stifling their creativity or contribution to the discussion (Jayasekara,2012). The use of group interviews or focus groups can also lead to individuals either censoring what they share within the group or subconsciously diluting their raised points of discussion based on what other people may think about their ideas. However, evidence states the opposite of this within the literature (Jayasekara,2012). In some cases, this may cause anxiety amongst research participants or fear that they will be judged for a difference of opinion. This is evidenced as there is a documented culture within the literature that healthcare professionals "eat our own young" and can be quite judgemental towards one another as professionals (Benner et al.,2010; Johnson,2018), although it is debatable how much of this is caused by the litigious nature of the organisation as a whole. The relevance of a focus group on nursing education is also arguably limited (Jayasekara,2012).

5.3.2. Consideration 2: Guided/Structured Interviews.

A guided interview on a one-to-one basis may have also provided enough flexibility to accommodate individuals who may have been challenging to meet with on a group basis or may not be able to get to a specific geographical location. It also allows a particular group of questions to be asked, potentially to confirm preconceptions or hypotheses. Arguably, the structured approach to the interview would gain consistency by asking the same questions to an audience and adopting a consistent demeanour with every participant to maintain uniformity within the research process (King et al.,2019; Yin,2015).

However, a more structured interview contrasts the methodology chosen for this study but inevitably narrows the ability of the individual participant to expand on what they believe or may feel. It may also be suggested that the ability to have a more structured interview may be easy and less time-consuming but may create more closed questions and increase the likelihood of asking more leading or prescriptive questions that may simulate closed-ended answers (Holloway and Galvin,2017; Yin,2015).

When considering the personable nature of a shared experience, the more formalised approach to interviewing may clash with individual participants and make them more reluctant to be open and descriptive about their life experiences. In extension, the ability to conduct a more structured interview does not necessarily demonstrate any depth of understanding or that there is value to building equality between participants that may aid a greater rapport among the interviewees (Charmaz,2014; Kumar,2014).

5.3.3 Consideration 3: Unstructured/open-ended questions.

In contrast, an unstructured or non-standardised interview enhances the ability to identify the participant's unique and personal feelings or perspectives in relation to a phenomenon or subject of interest (Holloway and Galvin,2017; King et al.,2019; Yin,2015). Using broad concepts or themes known through Priori knowledge, an aide-memoire or topic guide can provide a basis for exploring an area of interest but does not limit any discussion of these aspects of practice. In some ways, this implies that different techniques are more effective for other sample groups and sizes for their study (Moser and Korstjens,2018).

To ensure that the study could fully utilise Cons.GT principles align with its roots of Pragmatism as well as Grounded Theory, Phenomenology and Ethnography (Charmaz, 2014). A mix of semi-structured and open-questioning approaches were utilised. This is because the research would have a basic premise to introduce to the participant, but the participant may choose to answer in a variety of ways which cannot be fully anticipated. This includes choosing not to answer a question at all, or to discuss related topics which prompt additional or further inquiry. It also allows interviews to be more conversational, which in some instances can be therapeutic and lead to a richer data pool to draw from.

In selecting to adapt Charmaz's Cons.GT (2014) as an underpinning methodological approach with inbuilt research methods, the author wanted to understand the process and how it would feel about interviewing someone, listening and ensuring the participant felt heard and that the experience could be meaningful instead of paying lip service to theoretical concepts that were considered earlier in this chapter. This led to my decision to complete a mock interview using the interview schedule that was initially composed for the study (see Appendix 3), as ethical approval was awarded for this. The mock interview took place and lasted approximately 45 minutes, but it was with someone that I knew within the university, who was in a position to act as a critical friend but was independent of the study.

The interview utilised semi-structured methods and used a recording device attached to the computer in a private space so that I could record the interview while adhering to Beauchamp and Childress's principles in Chapter Four. It also allowed me to practice rephrasing questions, following on from what was said and helped me to acknowledge and use the participants' language and terminology or ask for further clarification or for an example if I did not understand a point raised. From a practical perspective, the conduction of a mock interview was also very useful, as it enabled me to practice introducing myself in a formal context. This extended to thanking the participant for their time, going through the consent form, and ensuring that they understood all the clauses and could withdraw from the interview at any point. At the end of the interview, the participant was also informed that I would transcribe the interview and send it back for review and that they would be able to amend or withdraw their transcript up until the point of coding. This process as a whole is also featured in my reflective journal in the following extract:

Reflective Extract: "…. I could really see the benefits of doing a mock interview as it gets you thinking about how you want to come across to others. I remember having a conversation with a fellow Terry Pratchett fan, who stated that the artistry of reading and loving Pratchett was the enjoyment, and the magic of the Discworld novels was that the "devil was in the details," which for me included all the rich descriptions of the characters and the world around them.

From the interview's perspective, I felt really privileged to sit there and listen to someone else's experience someone's life and was genuinely very interested as they had come to know nursing in ways that transcend my own experiences and points of reference.

Although I was also nervous because it was someone that I knew and that this would involve me adopting a different role and setting different expectations, it did help me to understand my own conduct and find a sweet spot between the formality and the approachable tone I wanted to set, so that people would speak to me and feel comfortable enough to share. I think more than anything, I wanted the people to feel as though their time was worth spending with me, but that their experiences would be treated with kindness and dignity while the interview had a conversational but purposive undertone…." When this came to interviewing people, I didn't know the practice of being able to talk to people and use transferable skills was then used to read tones in words and sentences. In

points, it was also important to understand the importance of silence… letting a point hang or wait to see if a person expanded on their point but find that balance between natural pause and awkwardness. As the nature of interviews changed due to interviews taking place on MSTeams, and that a few participants were not overly familiar with this platform, I continued my decision not to conduct observations. In retrospect, this may also have been due to the difficulty I sometimes experience interpreting non-verbal cues with people that I don't know well (and even to some degree with people that I know due to how Autism shapes my life and interactions with people, social situations that I am unfamiliar with and understanding behavioural traits of others…)."

From a data collection perspective and initial consideration on p. 106, exploring this method and experimenting with the data collection method taught me how to facilitate an informed and insightful discussion while keeping it relevant to the phenomenon of interest. From a procedural perspective, it also taught me that the interview schedule was important but should not be the dominant structure within the conversation: There is a need to be curious and mindful of the person and their interactions in the space and being prepared to stop, take a pause or to be led by the participant and their interest.

5.4 Sampling

The principles of sampling imply that data is collected according to specific properties they wish to explore and that participants have potential insight to offer about a particular phenomenon (Charmaz,2014; McCrae and Pursell,2016; Palinkas et al.,2015). Although various sampling strategies and methods will be discussed shortly, selecting participants is refined through one or more approaches to recruit individuals that complement the study's overall aims (Etikan et al.,2016; Palinkas et al.,2015). In some literature, it is suggested that all qualitative sampling is purposeful (McCrae and Purssell,2016), but researchers should be explicit about their specific sampling strategy, or strategies, and provide evidence for how their sampling has been used,

as it is often missing in qualitative research (McCrae and Pursell, 2015; Palinkas et al.,2015). The rationale for establishing a clear rationale stems from the idea that the chosen sampling strategy significantly influences the collection of data and its natural progression as themes are discovered within the data, memos taken, and reflection (Charmaz,2014). As such, the employment of any sampling strategy or combination of strategies is directly influenced by the study's individual needs. For example, a snowballing technique may recruit further participants if a study focuses on a niche community or population that is challenging to contact (Etikan et al.,2015). In contrast, quantitative studies may involve a large set of data or a broad population of potential participants, randomly or theoretically sampled (Kumar,2014).

It is also essential to consider the ethical implications of collecting data. It is suggested within some of the literature that, in some cases, the use of theoretical sampling promotes the over recruitment and collection of data. Although this cannot be preconceived, the data generated could lead to areas of interest that may not be envisaged from an ethical perspective, and data not to be used within the study, and therefore wasted. Arguably, both of these potential flaws could damage the findings and credibility of the research if pursued without revision (Charmaz,2015,2014; Charmaz and Belgrave,2018).

5.4.1 Use of Purposive Sampling.

Purposive sampling is the deliberate recruitment of specific individuals with pivotal influence, understanding, or lived experience of a phenomenon or field of interest (Etikan,2016). It forms an aspect of non-probability-based sampling that should require the voluntary and informed consent of individuals who participate in research (Butler et al.,2018; Charmaz,2014; Kumar,2014). The use of ‘experts’ or ‘specialists’ to capture information relating to a phenomenon not only allows access to appropriate participants but gains data that has a natural fit for the research aims and recruits from individuals that meet a specific and strict inclusion criterion (Etikan et al.,2016; Gray,2014; Kumar,2014). It is also reasoned that this is a remarkably fitting sampling method for this study, using a purposive sample and Cons. GT. principles to recognise

that the participants are ‘experts’ of their reality and articulate individual, lived experiences (Charmaz,2014; Palinkas et al.,2015).

In relation to this study, the recruited participants have developed specific experience mentoring students and facilitating clinical supervision as part of a student’s support system in practice learning environments. They have also quantified their ability by means of passing a theoretical standard of mentorship, by means of the SLAiP course, with some individuals extending their role (and assessing skills) with sign-off mentorship status (NMC,2008). Although mentorship has been extensively evaluated and discussed within the literature, there is little information in the public domain about the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d). In such cases, purposive sampling may also be used to investigate a phenomenon about which little is written or known, as it requires reaching a point of theoretical data saturation instead of larger samples lending weight to findings (Etikan et al.,2016; Kumar,2014).

To summarise, sampling strategies suitable for large groups may not be practicable based on the need to explore a phenomenon with participants in an immersive, often detailed way, as Charmaz advocates for in Cons.GT (Charmaz,2014) principles. Based on existing literature, which suggests that there was also a lack of trained mentors in the practice learning environment (Dirks,2021; Lobo et al.,2014), not all registrants could meet the inclusion criteria for the study, and this indicates that a purposive sample may be more appropriate and was duly selected. However, a definitive size in relation to a specific strategy is important to consider and justify within a study.

5.4.2 Sample Size

There is debate within the literature about an appropriate sample size and how it is justified for individual studies (Clark et al., 2021; Bowling, 2014). Some of this debate relates to how researchers address challenges presented in qualitative research as they attempt to justify theoretical data saturation and the point that they stop collecting data (Clark et al., 2021; Kumar,2014). If Cons.GT studies become the focus, it may be

argued that due to the evolving nature of the research, the themes presented during concurrent data generation and analysis do not allow for a complete insight of inquiry from the start (Charmaz,2014). As mentioned previously, this may be due to common themes in the data that relate to the lived experience or newly discovered paths. However, both instances influence the number of people required to participate in any qualitative study (Clark et al., 2021; Charmaz,2014). The sample size also depends on the scope of detail the study looks to discover about a phenomenon (Clark et al., 2021; Charmaz,2014; Kumar,2014). Therefore, when considering the nature of qualitative research and the Cons.GT, a specific number of a predetermined or fixed number of participants, is potentially limiting and pointless (Clark et al., 2021; Charmaz,2014; Etikan et al.,2016) but contrasts the somewhat prescriptive nature of qualitative research in earlier attempts to demonstrate methodological rigour and quality (Clark et al., 2021). For example, it was previously thought that if the phenomenon is wide-reaching and affects many individuals, the sample size should be larger to accurately represent a generalized population (Clark et al., 2021). Instead, studies that use a Cons.GT approach offers the potential for a point of saturation to be reached with a relatively small sample size that does not compromise the quality of interpretation or how it may relate to a general population (Charmaz, 2014; Clark et al., 2021; Etikan et al.,2016). This rationale is based on Charmaz's original argument surrounding theoretical data saturation and the phenomenon of interest, and opposing the concept that only large samples generate valid and trustworthy findings (Charmaz,2014).

However, the recognition of theoretical data saturation and when to stop collecting data present subjectivity in any qualitative study regardless of the number of participants recruited to a study. This is suggested as the interpretation of codes, or when no new data is being shared, is directed by personal judgement as to when saturation of data has been achieved (Clark et al., 2021; Kumar,2014; Yin,2015) and therefore represents several benefits to this study and the use of Cons. GT. The first of these included is that Cons.GT provides sequential steps that help define and rationalise the tentative assumptions made at the point of saturation based on the data instead of the primary investigators lived experience and continues to hold their positionality to account. It also means that researchers are less likely to over-recruit

for a study and not use all data collected, which would be ethically reprehensible. In some ways, this further emphasises the importance of gaining awareness when determining theoretical saturation in Cons.GT studies related to the critical appraisal of ethical conduct within a research study and builds a well-constructed understanding of the participant's reality that they have shared and have been captured in a transcript. This is suggested as an obligation to use all the information gathered for the purposes it was collected for and treat the participant's contributions with sensitivity and respect (Charmaz,2015; Yin,2015). In achieving this and ensuring that adequate sample sizes are recruited, the outcomes not only become more realistic but help to ask specific questions of people with particular knowledge or experience of the phenomenon of interest.

5.5 Coding

5.5.1 Grounded Theory Coding

The coding of data in Cons.GT represents the primary data analysis process and directly shapes the study's results. Although the exact coding process in Cons. GT differs from Glaserian and Straussian GT, the similarities among the three methodologies indicate that the coding processes act as a method for separating the data and defining aspects of the lived experience (Charmaz,2014). Charmaz achieves this "by identifying concepts or themes are identified and named during the analysis" (Holloway and Galvin,2017:185) of the data and grouping it to form themes and categories (Holloway and Galvin,2017; Holton and Walsh,2017). When using Cons.GT, coding should begin parallel to the data generation to keep critically engaged in the data generation process, which becomes constantly comparative (Flick,2018). It also allows each coded incident to generate an unspecified number of categories from the data analysis (Flick,2018). Collecting and constantly refining codes that emerge from the data can also check that these themes or lines for further inquiry remain pertinent reflections of the interpreted data (Holton and Walsh,2017).

The Classical GT coding process was arguably influenced by Glaser's (1968) preceding work, whereby followed a structured coding process. This enabled the data to be constantly compared but the theory to be significantly grounded in the final presentation (Flick, 2018). The structure includes the following steps:

- Comparing incidents applicable to each category;
- Integrating categories and their properties;
- Delimiting the theory;
- Writing the theory.

In comparison, in the Glaserian and Straussian GT (1968), open or substantive coding is followed by theoretical coding of data until a point of theoretical data saturation, and synthesis of theory has been achieved (Flick,2018; Holton and Walsh,2017). Researchers who adopt this method of coding analysis also look to establish codes based on the data collected and form quantitative results for qualitative data (Flick,2018). However, open or selective coding methods are used within classically styled Grounded Theories but differ in their application to the study (Holton and Walsh,2017). Open coding looks to capture the phenomenon's essence via in vivo codes identified in the data. The specified codes identify seminal codes or incidents within the data or link to more themes. Selective coding may be used as an alternative to open coding. It would allow us to conceptualise incidents shared as part of the data generation process, and to recognise specific properties and dimensions of the identified category or theme (Holton and Walsh,2017). On completion of open or selective coding in GT, Theoretical coding may be utilised to establish a link between the core concept or concern and other themes that have been identified as relevant. This synthesis shapes and integrates specific theories (Holton and Walsh,2017). This study rejected open and selective coding because Cons.GT does not use data to fit preconceived ideas or shape the data to form specific categories or codes.

Instead, Cons.GT (Charmaz,2014) uses a process that influences GT coding but relies on data generation to guide data coding and dictate future exploration points. This extends to unanticipated areas of further exploration, as we cannot predict what the

participants will share during interviews. However, the use of Cons.GT enables to identify gaps quickly but defines the process of coding as (Charmaz,2014:125):

- Breaking the data up into their parts or properties;
- Defining the actions on which they rest;
- Looking for tacit assumptions;
- Explicating implicit actions and meanings;
- Crystallising the significance of the points;
- Comparing data with data;
- Identifying gaps within the data.

As I am a current registrant and wanted to explore nursing as a phenomenon of interest outside of my own lived experience, part of gaining explicit understanding was generated through the ability to capture, process, analyse and interpret data. In this instance, this includes “breaking up data”, grappling with presented content and constructs discussed from another’s perspective and defining actions to identify gaps. This helps to find points of interest, gaps in research or differing perspectives and generate understanding and awareness, which can lead to meaningful change. As there is an identified gap in the research as well as a real-world skills and procedural gap for staff due to the differences formed between SLAiP standards (NMC,2008; RCN,2015) and the *Future Nurse* standards (NMC,2018; NMC,201 8a; NMC,2018c; NMC,2018d), discovering and developing an explicit understanding of how to address this from the participants perspective lent itself to the selection of Cons.GT (Charmaz,2014) as a methodology and series of applied methods in this study.

5.5.2 Theoretical discussion of Initial/ Line-by-Line Coding

Additional consideration may extend to the premise of category construction. As part of the theory evolution from the research participants, the study's categories must come from the refined data generation to minimise bias caused by Priori Knowledge and positionality.

Successful refinement is achieved by accurately sorting, focusing, and interpreting the participant's contributions instead of knowing or assuming that specific categories exist before their emergence (Charmaz,2014).

To adequately understand and interpret the data as accurately as possible, line-by-line coding provides an opportunity to read and re-read transcriptions of interviews recorded for accuracy and familiarisation (Charmaz,2014) and distinguish between different parts of the lived experience (Giorgi et al.,2017). This extends to researchers becoming more familiar with the participant's language during the interviews and aids the generation of meaning within the field of interest as a broad concept. This still may not have been possessed before this study and, therefore, becomes an important part of understanding and encourages a constant involvement with and in the data (Charmaz,2014).

In essence, line-by-line coding is conducted "by labelling a line, sentence or paragraph of interview transcripts or any other piece of data (such as a segment of an audiotape, video record, etc.) with a short and precise line" (Charmaz,2006 in Alemu et al.,2014) The ability to use code effectively determines the success in that these "segments" are closely related to the data that they represent (Charmaz,2014). This, in turn, leads to an analysis of the lived experience, as the interpretation and understanding of data supersedes the need for concrete statements present in the data (Star,2007) and prevents premature theory construction (Charmaz,2014). In addition, these codes can also indicate non-verbal language at the time of interviews related to the data and may create rich data beyond a transcript or field notes (Charmaz 2014).

5.5.3 Theoretical Discussion of Focus Coding and Tentative Category Formation.

Following this process, a more concise focus of codes is generated from the data quickly. However, it is advocated that coding broadly in terms of content shared by the interviewee aids a better understanding of personal narratives. It can also accentuate any actions in the interview or explanations surrounding the experiences within an interview setting (Charmaz, 2014). However, it differs from classical Grounded Theory

as the iterative process of coding each line was seen as overcomplicating emerging categories in data sections in some of the literature (Glaser,1992).

A second part of the coding process is also essential when utilising Grounded Theory. Although the line-by-line coding of the data represents the initial phase, the next step of analysis advocates for focused codes to be created (Charmaz,2014). More specifically, once the data has been deconstructed and its meaning tentatively shaped, the more dominant or significant codes noted in the transcriptions can be used to organise more substantial amounts of data (Charmaz,2014). It also enables condensing the previously gathered codes and polishing them to form essential points within the evolving analysis. Finally, they are also used to guide the route that the data will form part of the study but rely on the diligence that the earlier coding process was undertaken for success (Charmaz,2014).

It is also a conscious choice to reject forms of electronic transcription such as CAQDAS Software, despite its rising popularity (Roberts and Wilson,2002), as not only does it is suggest that the research not only becomes more involved with the data through its manual coding and transcription but also the full extent and meaning of the participant's contributions could be lost in the computerised interpretation. Instead, Purposive sampling was chosen to ensure that interviews with participants could be relevant to the study, meet the inclusion criteria set, and help me to explore the phenomenon critically.

To ensure that these coding processes related to the way that theoretical sampling was explicitly demonstrated, initial consideration needed to extend beyond my adapted application of line by line and focus coding processes. As Charmaz suggests, there are different ways of self-immersing in transcripts and the participants' narratives. However, theoretical sampling as part of an overall analytical process can "help you make explicit distinctions about experiences that appear to be similar on the surface" (Charmaz,2014:200). Undertaking theoretical sampling can, therefore, aid researchers who use this method to test the strength of one or multiple categories that emerge from the data and help those who adopt theoretical sampling to avoid common pitfalls in research as identified by Charmaz (2014). These are:

- Prematurely closing down analytical categories,
- Describing trite or redundant categories,
- Unfocused or unspecified categories.

Charmaz (2014:205)

Robust theoretical sampling also has the additional benefit of explicitly encouraging researchers who engage with theoretical sampling to form an explicit understanding of contributing factors that create variances or similarities as they grapple with the data (Charmaz,2014). The exceptional pitfall that has not been included in the list that Charmaz cites pertains to “overreliance on overt statements for elaborating and checking categories” (Charmaz,2014:205). This is based on the identified contrast to Lois’s perspective, which states, "You should keep coming back to quotes that won’t leave you alone” (Chamraz,2014:194). Within this study, the author felt that it was almost counterintuitive not to rely on the participants' lived experience due to their positionality. It would also be easy to misconstrue elements of what was said and, therefore, detract from the participants' voices being heard. On reflection, using an adapted data extraction table helped the author to highlight unanticipated, intriguing, but relevant lines of inquiry or exploration to be more easily noted. In some ways, it also enabled the participant's perspectives to be more clearly represented, take stock of poignant moments within the interviews, and more efficiently note potential gaps in the data.

This process also helped to promote effective theoretical sampling consistently in the study and further justified why the findings focus on the participant’s lived experience and extracts leading the discussion, and therefore, the discovery of concepts which directly inform the conceptual framework.

5.5.4 Memo Writing

The use of memo writing aids this. It enables specificity from the participant's contributions and applies a consistent strategic analysis or systematic approach to forming tentative categories. This should be done to check the data for fair interpretation of the participant's contribution and ensure that the theory is constructed from the participant's experience of reality instead of extending the primary investigator's positionality (Charmaz and Belgrave,2018; Charmaz,2014). The paralleled coding and interpretation of data can also enable gaps to be identified, which can prompt further discussion points before data saturation is perceivably achieved.

The accompaniment of memo writing alongside line-by-line coding as part of the interview process enables you to remain engaged with the data, as well as identify how you have interpreted the thoughts and opinions expressed by the interviewee and confirm more accurate interpretations of the data at a later time (Charmaz,2014). In some respects, this aids the establishment of credibility and trustworthiness in the study. It holds them accountable for ensuring their preconceptions are accurate and accurate in the content they share during the interview process. This also links to the amount of scrutiny and mindfulness displayed and the importance of keeping perspectives open to the varying meanings or interpretations of interviewees' experiences and understanding of the data (Charmaz and Belgrave, 2018; Charmaz,2014;2008).

5.5.5 Data Analysis Process

The specific analysis of data involved in a Cons. GT's approach to conducting research also has slight deviations when directly compared to Classical GT and Cons.GT, with particular reference to the use of line-by-line coding, focused coding, and conclusive but tentative category formation (Charmaz,2014). This also influences the selection of Cons.GT for this study, as the application of both coding techniques (as per Cons. GT principles), allows expedient and meaningful recognition of codes and points of

interest for later interviews and performs data analysis alongside the data generation (Charmaz,2014). Furthermore, this method of analysing data also compliments the study's efforts to gain clarity and explicit understanding of the participant's lived experience (particularly important when considering the ethical considerations that will be discussed later), as well as the continual appraisal of their reflexivity, and grows as the interviewer gains more experience in this method of interview technique (Charmaz and Belgrave,2018; Charmaz,2014).

However, similarities that have been utilised within Cons.GT and are present in Classical GT, including the advocacy of memo writing throughout the study (Alemu et al.,2014; Charmaz,2014; Flick,2018; Charmaz in Wertz et al.,2011), will evidence memo writing by accumulating private field notes (taken throughout the interview) and coding in relation to this study. Undoubtedly, this adds depth to the level of understanding established around the phenomenon, as this emphasises the level of scrutiny that the phenomenon is explored, as well as creating the potential for increasing the purity and interpretation, construction, and analysis of data and ensuring the findings are rooted in the personal narrative or understanding of a phenomenon, as well as remaining in the participants own language (Alemu et al.,2014; Charmaz and Thornberg,2021; Charmaz,2014,2008).

Credibility, transparency, and trustworthiness may also be gained through the ability to constantly reflect on the codes assigned to the data, check these assumptions against these interpretations, and minimise the interviewer's positionality features in relation to the phenomenon. This is also enhanced when considering how recruited participants are through the sampling process. This rationale is based on the assumption that individuals within the health service could attract multiple meanings or constructions of reality. Still, it is dependent on the job that is held within the health service, which will depend on the factors that feed into the interpretation of a shared society.

Cons.GT also presented a seemingly natural fit between the study's aims and its emphasis on being immersed in the data, alongside the need to establish rapport among the participants to expand on existing knowledge. It also prioritised a need to become explicit in presenting a rationale for tentative assumptions and which themes were further explored or discounted after their identification in the initial coding

process. In adopting this method of tracing ideas and thought, it may be argued that trustworthiness and credibility can be established through evidence of this process taking place, as well as reducing the risk of research supplanting their positionality within the findings (Charmaz,2014,2008; Mills et al.,2006).

There are adaptations in how data is analysed, providing a framework for other steps in the research study and informing how this process forms a continuum of knowledge that influences future questions asked of research participants (Charmaz,2014; Flick,2018). Arguably, this approach reduces the ability to incorporate any preconceptions and helps to counteract biases that may be demonstrated when interpreting the gathered data.

5.5.6 Theoretical Saturation of Data

I will follow the principles as identified by Aldiabat and Le Navenec (2018) and Charmaz (2014), which suggest that the purpose of refining codes within grounded theory approaches is to continue to sample and analyse data until no new themes emerge. Once this point has been reached, I could develop clear descriptions of their meaning within a broader concept or category which informs their findings and discussion.

5.6 Application of data analysis and presentation of findings

As the study followed a Cons. GT approach, it was necessary to distinguish between the different phases of the coding process and state how this has informed the presentation of findings and discussion of Phase Two.

Revisiting the transcripts and checking the data for consistency of coding, and that theoretical data saturation was reached, led to the acknowledgement of language and terminology as a core component of the study. It also led to two unanticipated findings within the data. The first was that there were, in many instances, significant discrepancies between how different groups of participants in the study referred to

aspects of the *Future Nurse* standards within their individual transcripts. It also identified deficits in knowledge, awareness, and understanding of the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) amongst distinct pockets of the nursing population as a trend in the study's data.

Consideration of how to capture this led to the creation of Table Eleven below, which highlights participants and their associated PIC sites. It has also been paired with a descriptor taken from how participants described their roles as they worked within Acute Trusts:

Figure 3 - Participant number and PIC – color-coded based on the group

Participant Number ↓	PIC 1	PIC 2	PIC 3	PIC 4	PIC 5	PIC 6	PIC 7
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							

Role Descriptors relating to participant groups:

1. Full Time or Dual Role practitioners that work or have access to an Acute Trust in a nursing capacity (Shown in Yellow);
2. Senior nursing staff such as placement managers, practice development leads, or clinical educators (Shown in Purple);
3. Lead nurses, head nurses, or chief nursing officers (Shown in Red);
4. Representative(s) of key stakeholders such as the NMC (Shown in Blue).

These role descriptors and the table above have also informed how key extracts from the transcripts have been introduced in the findings chapter. This is because the

decision was made to colour code seminal extracts from the data and display them in tables. Differentiation between the different participant groups has also helped highlight the differences in lived experiences and concurrence, which has influenced the findings and discussion. The choice to break down roles and essentially group participants also proved advantageous, as recognition of language and terminology discrepancies also indicated niche bonding participants based on their roles and responsibilities.

Prior to the presentation of the findings, a brief overview will be given of the application of the data analysis approach as informed by Cons.GT (Charmaz,2014).

Chapter Six Phase Two:

Application of data analysis and presentation of findings

Revisiting the transcripts and checking the data for consistency of coding, and that theoretical data saturation was reached, led to the acknowledgement of language and terminology as a core component of the study. It also led to two unanticipated findings within the data. The first was that there were, in many instances, significant discrepancies between how different groups of participants in the study referred to aspects of the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) within their individual transcripts. It also identified deficits in knowledge, awareness, and understanding of the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) amongst distinct pockets of the nursing population as a trend in the study's data.

Completion of rechecking and confirming data collection processes resulted in 34 initial and tentative themes, which have been fully presented in Table Eleven below:

Table 11- Tentative themes that were initially generated in the study in comparison with individual participants and PICs

Theme Number	**Tentative Theme Name**	**Participant Number: this theme was significant for**	**PIC site this aligns to**
1	Student Experience in Practice- Teaching, simulation, and feedback-specific	1, 2, 4, 6, 7, 8, 9, 11	1, 2, 3, 4, 5, 6
2	General Exposure/ Lived experience in placement - Student	1, 2, 5, 6, 9	1, 2, 4
3	Adapting practice or placement opportunities – student needs	1, 2	1, 2
4	Student Competency and Personal Development (Clinical or Academic)	1, 2, 5, 6, 7, 9, 10, 11	1, 2, 3, 4, 5, 6, 7
5	Individual Participant Characteristics and Clinical Expertise	1, 2, 4, 5, 6, 8, 9, 10, 11	1, 2, 3, 4, 6, 7

6	Optimising placement provision-pathway exposure and opportunity	1	1
7	Role-specific decision-making, awareness, and responsibility of the registrant	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11	1, 2, 3, 4, 5, 6, 7
8	Time, duration of an activity, and time management	1, 2, 4, 6, 9	1, 2, 3, 4
9	Non-technical support/ Pastoral Care (incl. health and well-being of staff and pre-registration students)	2	2
10	Assessment boundaries and pass or fail decision (incl. "failing to Fail.")	2, 3, 4	2, 3
11	Specific mention of SLAiP, The mentor role, or mentor updates	2, 8	2, 6
12	Adjustment to a registrant's role, incl. skills, competency, and alignment	2, 4, 6, 10	2, 3, 4, 7
13	Registrant and Pre-registration student personalities and personal conduct	1, 2, 9	1, 2, 3
14	Reflection and personal opinions based on participant's own experiences	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11	1, 2, 3, 4, 5, 6, 7
15	Use of Non-technical skills to prevent illness or injury (incl. Compassion fatigue and burnout)	2	2
16	AEIS: Specific role and interactions with practice (incl. Placement capacity and student placement	3, 4, 6, 7, 8	2, 3, 4, 5, 6

17	Perceptions reached through dual role or change to the existing role and its responsibilities	2	2
18	Nursing-Specific Factors: Skill Mix, Staffing, and Teamwork	1, 3, 4, 6, 9	1, 2, 4,
19	The *Future Nurse* standards (NMC,2018;NMC,2018a;NMC,2018c;NMC,2018d), Skills annexes and related staff updates	3, 4, 6, 7, 8, 10, 11	2, 3, 4, 5, 6, 7
20	Existing registrant Training incl., clinical skills, ad hoc sessions, and formal	3, 4, 6, 7	2, 3, 4, 5
21	Alternative models or ways of training staff and preregistration students	2, 4, 5, 6, 7, 8, 9, 10, 11	2, 3, 4, 5, 6, 7
22	Clinical environment (incl. routine of the ward)	1, 2, 5, 6, 7, 9, 10, 11	1, 2, 4, 5, 3, 6, 7
23	Documentation – nursing and progress related	6, 7	4, 5
24	Participants' secondary experience – feedback offered, but students and other staff	5, 6, 8, 9, 11	2, 4, 6, 3
25	Technical Communication with existing staff and preregistration students	6	4
26	Alterations to normal ways of working – Coronavirus specific	2, 5, 6, 9, 10	2, 4, 3, 7
27	Coronavirus	2, 6	2, 4

28	The registrant's specific clinical role, visibility, and role presence in the clinical area	3, 6	2, 4
29	NMC's Role as a Regulator, the register or specific remits	8, 10	6, 7
30	Nursing Education: Theoretical concepts and theory to practice (incl. “theory- Practice Gap”)	8, 9, 10, 11	6, 4, 7
31	Transferable skills and knowledge	8, 9, 10	6, 4, 7
32	Nursing Culture	8, 9, 10, 11	6, 4, 7,
33	Patient-centred care- incl. patient assessment, care, and interventions	2, 9, 10	2, 4, 7
34	Embedding, implementing, and interpreting the *Future Nurse* standards (NMC,2018;NMC,2018a;NMC,2018c;NMC,2018d).	11	6

In accordance with Cons.GT principles, the next phase within the coding process, relied on refining and focusing on initial impressions formed from emerging codes and themes in the participant transcripts. The ability to ensure that the structure of this coding process remained a dependable method for appraising individual and group concepts in participant transcripts hinged on two dominant factors. One of these included the ability to recognise and appropriately categorise a theme's content within one or multiple transcripts so that appraisal of multiple meanings and interpretations could highlight how different participants associate with a phenomenon within nursing.

The second factor is how this process can be applied to all aspects of the data collection process to ensure that the weight of a code and themes these contributed

to remain a methodical and systematic part of the study, as the following reflective extract identifies:

Reflective extract: *"…Once I'd done three or four interviews, there were codes I could identify as a common theme alluded to in the participant's lived experiences. However, in my experience, it was nigh on impossible to recognise the strength of these codes without quantifying them using a table to find trends that consistently emerge from the data. I believe this is because of the strength that my positionality poses to research and recognition that while something may be commonly referred to and poses the weight of a concept within the study, understanding and relationships to nursing issues based on my passions and interest may also create a false impression of weight. This prompted me to look for a consistent method for identifying codes and tentative themes as significant aspects of the phenomenon to be considered in the study."*

The consistency of theme formation was also important to consider in relation to my own positionality (as the researcher), as unmarshalled coding and theme categorisation could have led to the exploration of concepts that were of personal interest. This would then represent a source of selection bias and could lead to the inclusion of material that has limited relevance to the primary research question or assumptions loosely based on data. To avoid this, the study achieved consistency by including themes in a table to capture the number of occurrences (Appendix 9) and carrying forward the significant themes that emerged from the data as a concurrent process (Appendix 10). As a collective series of processes, this helped to methodically consolidate the 34 initial themes to form 5 concentrated codes, as demonstrated in Table Twelve below:

Table 12 - Themes that were common within the data amongst participants and PIC sites

Focused Themes	**Participant Number**	**PIC sites these aligned to**
1. Student Experience a) Ways of teaching b) Use of simulation c) Feedback	1, 2, 4, 6, 7, 8, 9, 11	1, 2, 3, 4, 5, 6
2. Culture and attitude to learning a) Willingness to work with pre-registration students b) Encouragement of student development c) Recognition of student's prior learning	1, 2, 5, 6, 7, 9, 10, 11	1, 2, 4, 5, 6, 7
2. Individual Participant Characteristic and clinical Expertise a) Exposure within the practice learning environment	1, 2, 4, 5, 6, 8, 9, 10, 11	1, 2, 3, 4, 6, 7
3. Decision-making, awareness, and responsibility	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11	1, 2, 3, 4, 5, 6, 7
4. Reflection	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11	1, 2, 3, 4, 5, 6, 7
5. Understanding and access to the *Future Nurse* standards (NMC,2018; NMC, 2018a; NMC, 2018c; NMC, 2018d) a) Training b) Fear and resistance to change c) Different ways of teaching/training	3, 4, 6, 7, 8, 10, 11	2, 3, 4, 5, 6, 7

As described in Charmaz's approach (Charmaz,2014), theoretical categories should be designed to capture the seminal essence or large portions of lived experience that describe or relate to the phenomenon of interest. In this instance, it empowered me to grapple with, explain and interpret aspects of the lived experience and explain how "a relationship with your data, and with your respondents" (Star,2007a in Charmaz,2014:111) has allowed me to develop explicit understanding, which in turn,

helped to “create robust categories and penetrating analyses” (Charmaz,2014:224) which were used to explore themes and links between participants. Although this process was followed in this study, a decision was made to label these as analytical categories instead, as the categories have been formed through the refinement and focusing of the participants' experiences during the concurrent collection and analysis process.

Forming analytical categories in this way also led to a key observation about this data which focused on language and terminology. This is because analysis of the transcripts showed numerous, independently strong themes, but language and terminology formed an integral part of understanding the participant's lived experience and appraising the challenges faced at the point of implementing the *Future Nurse* standards. As this was only possible to explore at the point on analysis, this was an unanticipated emergence from the data and led to a further decision being made to talk about the analytical categories being linked to the use of language and terminology within all analytical categories. Forming a link between the analytical categories was particularly useful as participant narratives were often lengthy, complex, and interwove several of the focused themes at any one time. It also became clear that this was due to language and terminology forming critical points of inconsistency between participant groups and PIC sites. This is somewhat reflected in the extract below but justified the use of one category which fits into all categories instead of being discussed in an isolated way:

Reflective Extract: *As I went through the coding and analysis process, specific points or pieces of a longer narrative that a participant shared were rarely spoken about as a singular entity. Instead, one aspect of the data would lead to two or three things being woven together: this seemed to make more sense and explain more about the phenomenon. This was not dissimilar from patterns within existing literature and how other people associate or bond with nursing as a whole."*

This has, therefore, significantly influenced how data has been presented but is captured in Table Thirteen below, which looks to prepare the reader for what to expect in each tentative, analytical category and where the thread is present:

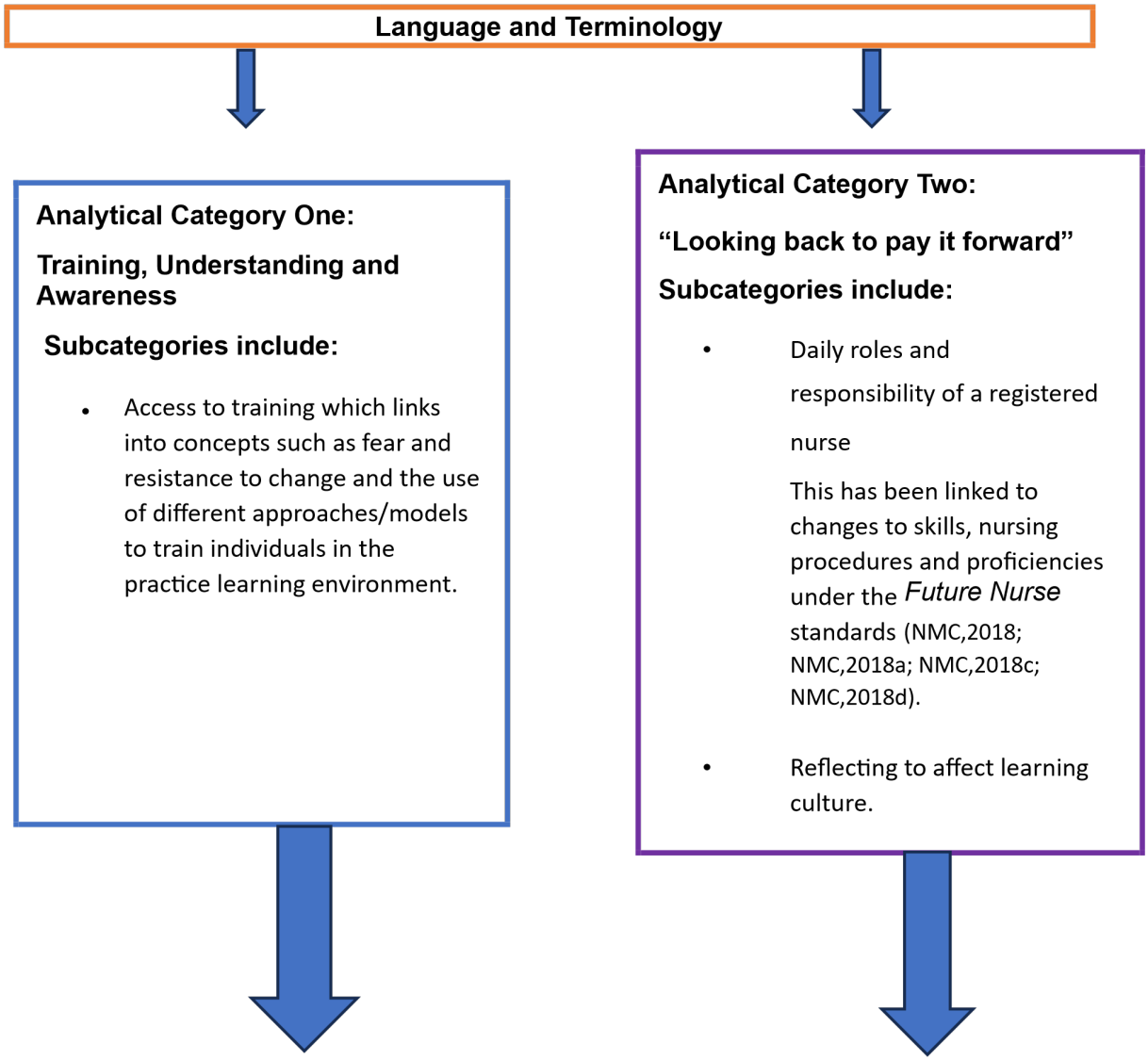
Table 13 - Linking the category of language and terminology with coexisting and tentative analytical categories and sub-categories based on the focused codes with meanings.

Analytical Categories and Meanings	**Participant Number**	**PIC sites these aligned to**
Analytical Category One: Training, Understanding, and Awareness: **Focus code origin is used to convey meaning within its sub-categories:** i) Understanding and awareness of the *Future Nurse* standards (NMC, 2018; NMC, 2018a; NMC, 2018c; NMC, 2018d) ii) Access to training iii) Fear and resistance to change iv) Ways of teaching/ training **Links to language and terminology:** • How training is given or how ideas are explained, • How changes are explained, introduced, or "sold" to individuals. • Accessibility of Language and terminology used within the *Future Nurse* standards (NMC, 2018; NMC, 2018a; NMC, 2018c; NMC, 2018d) as a reference point.	3, 4, 6, 7, 8, 10, 11	2, 3, 4, 5, 6, 7
Analytical Category Two: Looking back to pay it forward **Focus code origin is used to convey meaning within its sub-categories:** i) The registrant reflects on or "remembers" their own time as a ii) preregistration student and how this influences perpetual nursing culture iii) Construction of feedback given to students within the practice learning environment iv) Understanding different approaches/models may perhaps more v) easily adapt to the needs of individual pre-registration students. **Links to language and terminology:** i) How does an explanation of individual experience and their exposures influence how ideas or concepts are explained to peers or preregistration nurses,	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11	1, 2, 3, 4, 5, 6, 7

ii) How do language and terminology influence how feedback is received or constructed for the learner iii) How do existing registrants explain their approaches to preregistration learning?		

However, to represent these more clearly, they have been shown in Figure Four below:

Figure 4 - How language and terminology, as a linking thread, informed the two analytical categories presented in the study.



Creates several barriers to effective implementation and how the *SSSA* (NMC,2018) and the Future Nurse: Standards of Proficiency for Registered Nurses (NMC,2018a) can be applied and used to develop a "positive learning culture" in practice learning environments.

From this Figure, Analytical Category One will now be presented.

6.1 Research Findings - Analytical Category One: Training, Awareness and Understanding

Exploration of analytical category one, Training, Awareness and Understanding, was based on three of the five tentative themes that emerged after code refinement was completed. The focused codes this chapter will refer to are presented in Table Fourteen, which reintroduces the theme name, individual participants for which themes were significant, and which PICs they aligned.

Table 14 - Tentative theme and meanings that are specifically related to this category

Analytical Category and its content	**Participant Number**	**PIC site that participants align to:**
Training, Awareness and Understanding: i) Understanding and awareness of the *Future Nurse* standards (NMC, 2018; NMC, 2018a; NMC, 2018c; NMC, 2018d). ii) Access to training in the clinical environment iii) Ways of teaching/ training	3, 4, 6, 7, 8, 10, 11	2, 3, 4, 5, 6, 7

The strongest finding from these codes was that in the participants' experience, inconsistent understanding and/or awareness of the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) was acknowledged to affect and, therefore impact on newly qualified registrants, experienced practitioners, and pre-registration students in several of the PICs who participated. By proxy, this also has high relevance to the research question and corresponding aims. From a discussion perspective, it was also considered the most robust finding within the study, as it linked many of the focused codes together and acted as a bridge for several of the study's recommendations.

The emerging concept of a lack of awareness/ understanding and ability to utilise the *SSSA* (NMC,2018) was cited as a primary concern in the lived experiences of

participants who self-identified as Group Two (senior nursing staff such as placement managers, practice development leads, or clinical educators). This is partly due to their position within the Trust as they were amongst a small number of persons who were responsible for interpreting and disseminating the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) to existing registrants and support the *SSSA*s use with pre-registration students.

Revisiting, rechecking the analytical processes and interpretation of the data from Group Two participants indicated that three out of four participants attributed a lack of understanding and awareness to the Coronavirus pandemic and subsequent rippling effects. These have included:

- Demands on the practice learning area and redeployment of staff to new or unfamiliar environments. For some participants, this later included redeployment of eligible students so that they could aid registered staff in practice learning environments.
- Working up to and beyond normal remits that were typically indicated within a nurse's normal working environment.
- “Constantly reprioritising” tasks or duties to accommodate any patient requiring ventilation and interventions relating to the treatment of Coronavirus.
- Closure of wards and departments to commit resources elsewhere.
- Cancellation of placement exposures for students within several Acute Trusts in order to minimise risk to pre-registration students at the height of the pandemic.
- Responses and implementation during the initial response to the Coronavirus Pandemic, as well as subsequent adaptations through the recovery standards (NMC,2021a).

For individual participants, as well comparison of all transcripts, the prevalence of the Coronavirus pandemic and its impact on nursing as well as pre-registration nurse education was directly attributable to clashes with early efforts to disseminate and embed the *Future Nurse* Standards (NMC,2018; NMC,2018a; NMC,2018c;

NMC,2018d) by a host of participants. This will be presented in subcategory one: Access to Training.

Sub-category One: **Access to training** or "staff updates" during the initial implementation of the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d): pre and during the Coronavirus pandemic. This included registrants responsible for training using different methods of training staff and embedding the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) in their respective PICs. Generally, this included using “ad-hoc” teaching time in clinical areas while balancing "ad-hoc" training with other parts of their role, formalised teaching arrangements, and online platforms. For some participants, this led to fear and resistance to change, impacting pre-registration supervision and assessment.

This also led to discrepancies in skill or existing proficiency levels of the existing workforce and how the attainment of newly aligned proficiencies would be managed. This, in turn, would shape how the existing workforce was prepared to support pre-registration students to gain sufficient exposure to newly aligned skills and nursing procedures outlined in the corresponding procedural and skills annexes (NMC,2018:27-37).

6.1.1. The format adopted to present findings and discussion in Sub-Category One.

To give greater substance to these sub-categories and their relationships to the umbrella title of 'Training, Understanding, and Awareness,' core findings and discussion will take place in this study using tables containing quotations from one or more interview transcripts. This method can be seen throughout Sub-category One below but will be a consistent format throughout the remainder of this chapter.

6.2 Sub-category One: Access to training.

Exploration of the first sub-category and its relationship to Analytical Category One: 'Training,

Awareness and Understanding' suggested that different training formats were used by individuals aligning to participant groups 2 and 4. The ability to disseminate how individual

AEIs and PLPs had interpreted the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) for their organisations was essential to disseminate and embed the related roles and corresponding responsibilities.

Some examples provided by participants discussed how they approached training, developing the workforce understanding and awareness of the Future Nurse standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d), included the use of formalised training sessions that could be attended through appointment or an in-house booking system. Within the data, using formalised teaching sessions has mixed success in PIC sites. Participants 2, 3, and 4, in particular, explicitly discussed the challenges they had encountered as they tried to initially disseminate the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) and teach staff about the roles of the practice supervisor and practice assessor.

One particular example of this includes insight from Participant 3's transcript in the quotes below, which attributed their mixed success to the availability of existing registrants to attend formal training in pre-scheduled sessions. Specifically, this included an acknowledgement that while the participant stated that in their experience, there was a comparable and positive difference between attendance for the *Future Nurse* training and SLAiP updates, as a proportion to the wider workforce in need of training, attendance was still poor:

Quote from Participant 3 interview transcript:

Participant 3, PIC site 2:

"…lots of training for the staff in the clinical environment which I find is the best way to catch the staff: particularly under the moment an Coronavirus and anyway with their clinical workloads being very heavy. So we do put on training session, formal training sessions for these standards in the education centre: they're not particularly well attended though.."

Prior to this training being offered however, again in Participant 3's experience, existing registrants they came across were not aware of the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d), the roles of the practice supervisor and practice assessor despite the standards being published in 2018 and practice guides being available for staff to access freely, as the following quote highlights:

Quote from Participant 3 interview transcript:

Participant 3, PIC site 2:

"…. I mean, since the NMC changed, brought in the education standards I needed to be even more visible in the clinical area because a lot of those staff were unaware of it, so because they were unaware of it I needed to go out to tell them about the changes to the education standards and while I was doing that try to train them equally……"

This led to the recognition that almost in response to poor attendance at a formal training session, decisions were being made to offer "ad-hoc" sessions to existing staff in ward areas as an alternative method for disseminating the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d), This was an alternative method later found to be adopted in multiple PIC sites as extracts from Participants 4 and 7 indicate:

Quote from Participant 4 interview transcript:

Participant 4, PIC site 3:

"…but equally the only way that we're preparing out staff is by going to the clinical areas if we can and doing these updates…."

Quote from Participant 7 interview transcript:

Participant 7, PIC site 5:

"…we've got professional development nurse who tends to go out more on to the ward areas and actually visit patients, sorry, visit students on wards, so do as we say walkabouts but we also provide support session for the students..."

For Participants 3,4 and 7, the perceived benefits associated with this approach were based on being seen by pre-registration nursing students and existing staff in the practice learning environments. For the participants, it also gave them alternative abilities and, therefore, access to a greater number of individuals who were otherwise not free to attend formally offered training slots. This was recognised as a consistent and significant barrier, which existed prior to the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d), In some instances, this is because attendance commonly relied on clinical staff having to go in their own time to attend core training or updates:

Quote from Participant 3 interview transcript:

Participant 3, PIC site 2:

"…*They were poorly attended for various reasons, I think, partly because they never had time to come to them and most of them the staff would attend them in their own time and try to get that time back… the only the staff that tended to attend in their clinical time were staff that were necessarily patient facing...."*

However, this ability to create a presence and be seen heavily relied on the responsible persons being available to go to an individual ward or clinical setting and deliver training while registrants were on day shifts. As such, being able to offer either ad-hoc training or more formal cascade training could affect pre-registration nurse education but extracts so far have highlighted some of the changes prior to and during the pandemic. It may also be suggested that despite its established validity as a training system (Seyedhosseini-Davarani et al.,2020), retainment of information in "ad-hoc" training can increase subjectivity in an already complicated embedding process. To further explain, for some PICs, who could only prepare staff through an "ad-hoc" method of training, inconsistent delivery and availability was also due to each PIC employing varying numbers of individuals who had sufficient knowledge to disseminate the local interpretation and dissemination of the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) formed an additional aspect of an existing and expansive responsibilities, it also relied on physical time of staff being available to deliver sessions and keep track of how many nurses were trained during the initial embedding phase, as the following quotes allude to:

Quote Participant 3 interview transcript

Participant 3, PIC site 2:

"…so I have to balance it. To be honest, something has to give, and when I'm asked by my line manager to place the redeployed students, that had to become my priority and going to do some training that I had planned last week, I didn't get to do. So it's just a matter of having to prioritise on a daily basis as to what's going to be more important on that day and what… can that appointment wait for another day?..."

Based on the cumulative constraints or challenges, this also made it difficult to recheck understanding of the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d), and if existing registrants could apply the training with pre-registration students. For those not seen during day hours or in an ad hoc capacity, there was also no access to further guidance, with perhaps the exception of emails.

By extension, if training was provided while people were actively working within the practice learning environment, it is also difficult to fully envisage how assessment of training quality could be consistently assessed or reviewed in relation to the *SSSA* (NMC,2018).

To some degree, the wider organisational culture and drive to increase attendance and uptake of the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) is also relevant to consider. For example, in Participant 11's to ensure existing registrants understood the significance of the practice supervisor and practice assessor 'update' some Trusts have replicated methods that they use for other types of mandatory training:

Quote from Participant 11 interview transcript:

Participant 11, PIC site 6:

"…it's like, you know like your fire training? You get a reminder saying you've gotta do your fire training, erm it was, it was in that erm, in that same process, which you know, in, in, if I just has to put on my blue sky thinking it might be a terrible idea, but actually from a pragmatist, it's going yeah! We got people release to go to training: that's how it was valued by managers because if they got less than a 100% score on the outstanding training of their staff: that was something they sat up and took notice of…."

This implies that for staff and management to encourage registrants to attend training that allows them to transition from mentor to practice supervisor or practice assessor, training has to be almost thrust upon individuals to be valued. This too is referred to in another extract from Participant 11 in the following quote:

Quote from Participant 11 interview transcript:

Participant 11, PIC site 6:

"…Erm and that's kind of how we achieved it, so the challenge was getting it to that level of being respected by managers that it was important and something that practitioners needed to embrace. Erm, and I'm not talking ward managers, I'm talking beyond that: people who account for nurses time spent on study. …."

This then could lead to an alternative interpretation, that attainment of targets is a greater incentive than ensuring that practice supervisors or practice assessors are sufficiently prepared and able to fulfil their role and understand the expectations aligned to the role. It also does not align with Hunt's research (2019) which indicates that automatic transference from a mentor or sign-off mentor to a practice supervisor or assessor suitably addresses findings within "Failing to Fail" (Black,2014; Duffy,2013; Hunt,2014).

As a completely different but arguably more flexible method of raising awareness and understanding of the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) delivering training around the *SSSA* (NMC,2018), creation of online platforms was also considered an appropriate route for registrants to gain awareness and access information. However, as participants have so far alluded to, constant need to reprioritise workload made this format difficult aspect to prepare and offer, as explicitly discussed by Participant 4 in the following quote:

Quote from Participant 4 interview transcript:

Participant 4, PIC site 3:

"…that we can't target because of a pandemic we've been working through and the online supervision that I was trying to create for our team, I haven't managed to do either because I've been working flat out doing something else…"

While online provision could have been access as a consistent method, or act as an interim measure while registrants were waiting for training, inability to complete and therefore offer this provision left Participant 4 sharing that they felt guilty that while so much was being done, specific support relating to the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) was not possible. This is explicitly captured in the following quote:

Quote from Participant 4 Interview Transcript:

Participant 4, PIC site 3:

"..But then I can't do my work about doing the preparation for SSSA can I? So, it's one of those things I feel incredibly guilty about, but I can only fit so much in one day: So I've got staff now that are not prepared,…"

The cumulative interpretation of these extracts forms a consensus with the limited amount of literature in the public domain (Gopee,2023) and the lived experience. This is because, at the time the data was collected, a potentially large group of the population were not aware, had not accessed training and therefore not developed a significant or potentially accurate awareness of the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d). In some ways, this emphasises the need for collaborative partnership and training in practice learning placement settings. By pooling resources, AEIS and PLPS could do this for existing and pre-registration nurses.

Additional interpretation of provided explanations allows the findings to suggest, that the initial pandemic and subsequent actions created multi-layered disruption within the initial embedding period. It also significantly challenged the ability to train en-masse based on space that allowed adequate social distancing and staff availability. In Group 2's collective experiences, many participants also stated that this had inevitably influenced the opportunities to raise the profile, or general awareness of the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d), From this, is it possible to suggest that further research to establish a true understanding of the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d), is

needed to address and offer training opportunities to registrants who did not have the opportunity during the initial embedding phases to attend or access training.

Another consideration drawn from the participants lived experience is that while the standards were seen as reflective of patient and organisational needs prior to the pandemic, alterations to a way of working occurred as a consequence of initially implementing the emergency recovery standards (NMC,2020a), their recent iteration (NMC,2021a) and, therefore, may require further reviews to ascertain if the standards, as they were published in 2018, still meet these needs, are fit for purpose and sustainable.

A lack of access and/or an ability to attend training sessions has secondary impacts because limited understanding and awareness of the *Future Nurse* standards and how individual PICs have interpreted them can lead to the disparity. In turn, these affect the pre-registration student experience, the potential to manage expectations and perpetuate the suboptimal learning culture already evident in the literature (Feeney and Everett,2020; Mitchell,2022a). These factors can, therefore, also affect a registrant's performance when they fulfil the roles of the practice supervisor or practice assessor in the practice learning environment in real-time.

This was later substantiated as an existing reality for three out of four Group One participants (full-time or dual-role practitioners who work or have access to an Acute Trust in a nursing capacity) who did not discuss the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) at all. Participant 5 also reported that they had not accessed face-to-face training as scheduled sessions were being cancelled, and they did not have another opportunity to attend. Participant 5 also stated that while they understood that the training alluded to something different and the SLAiP course had been discontinued, there was no expansion on what had replaced, as the following quote depicts:

Quote from Participant 5 interview transcript:

Participant 5, PIC site 2:

"Erm yeah, so I did do the SLAIP course, I don't think that's a thing anymore, but I did it before…."

This state of confusion was illustrated in other participants' experience and linked inconsistent training and awareness to the use and change to language and terminology. For example, Participant 1 spoke about their experience working with pre-registration students but in several places referred to their "style of mentorship" and placements following a "hub and spoke" model to increase placement exposures and transferability of skills. Although this is similar to the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) there is now an identified need to create substantive exposures in alternative clinical areas. In the preceding standards of education for pre-registration nurse education, this was not only an optional aspect of training but also acted as a point to highlight the difficulty in trying to ensure that preregistration students get a meaningful learning experience instead of a "whistle-stop tour", as Participant 1 discusses in the following quote:

Quote from Participant 1 Interview transcript:

Participant 1, PIC site 1:

"now with the hubs and spokes, they typically only get put with us for a week, so erm it's more of a whistle stop tour .. Just as an overview rather than an expectation that will be up and running with erm a theatre background….."

Participant 1 also linked this difficulty back to the coronavirus pandemic and created a bridge between experiences shared with Participant 6 in group 2, in the sense that the coronavirus update not only disinhibited potential knowledge and awareness, but also impacted the types of exposure available and what knowledge base staff had in the areas that people were working in during, and immediately post-pandemic phases, as the following extracts depict:

Quote from Participant 1 Interview transcript:

Participant 1, PIC site 1:

"I think erm prior to COVID, our working practises were different and we erm had got erm more of a set team, but since COVID our working practises have changed and are obviously changing frequently depending on the new research, erm but it also means that depending on shielding staff and staff that are considered to be high risk erm people who would have originally been in one team are perhaps working in other areas to help out. Erm so you don't always get the set team that you would have had a year ago, so that can have a big impact…."

Quote from Participant 6 interview transcript:

Participant 6, PIC site 4:

"I think on this site, theatres closed and has remained closed to leaners: that's a major learning opportunity that's not available to all learners and one, the one that really affects is midwives, cause they have to as part of their programme complete and have exposure to that element, I think they've maintained or started to reintroduce ODP students but that, that was a major service that was impacted and then a knock on effect from that obviously day case is a medical outlier bedded down unity now for the foreseeable …"

It may therefore be possible to suggest that more Trusts has difficulty disseminating the revised nature of pre-registration student support, supervision and assessment, due to redeployment of staff to help with the Coronavirus pandemic as well as chronic staff shortages.

From this study's perspective, this is relevant to the wider impact because although part of an initial lack of awareness and insight into changes since the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) were implemented can be attributable to the pandemic, it is possible to recognise that other factors which are well documented (Horton,2017; Waters,2022) also contribute to a ripple effect of why the *Future Nurse standards* (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) may be inconsistently understood and implemented. This included insights that linked a lack of access and insight to the speediness of implementation when many registrants are now expected to fulfil the *Future Nurse standards* (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) and be able to supervise and assess students in line with the *SSSA* (NMC,2018).

Enabling sufficient time and having enough resources to train the existing workforce extends beyond the concept that there is inconsistent understanding and awareness due to a lack of training but reignites past failings in implementing SLAiP and registrants understanding the former role of "mentor" and "sign-off mentor" (Meeuwissen et al.,2019). This is due to the recognition that despite attending training appointments or receiving ad-hoc training, some registrants remained unsure how to implement the *SSSA* (NMC,2018) independently.

From Participant 6's perspective, this led to a recognition that the *SSSA* may be poorly utilised amongst a larger group of individual practitioners, due to a lack of understanding, as shown in the following quote:

Quote from Participant 6 interview transcript:

Participant 6, PIC site 4:

"cause automatically it's like "I can't do this… no" The week I broke up for leave an A&E sister was actually doing Practice Assessor training with her with a student during his final assessment – "well I can't sign it because I haven't worked with him" and I said "you haven't listened to anything [laughter] that I've said…"

This was somewhat transferable amongst pre-registration students in a different PIC, as they also did not fully understand the new methods for supervision and assessment, as shown in an extract taken from Participant 4's experience:

Quote from Participant 4 Interview transcript:

Participant 4, PIC site 3:

"…if there's a query with assessment or working with another assessor or something or even understanding what an academic assessor is: because believe me, some of them don't even know, even when the university have told them…"

A blanket training approach which emulates that of other mandatory training is seemingly married with another concern raised in Participant 4's interview, who stated that there was too much material related to resources and information needed by individuals. More specifically, due to the amount of flexibility and the way that the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) could be utilised with pre-registration students, the timeframe allocated for practice supervisor and practice assessor training was deemed insufficient to ensure regulated professionals could fully understand and be able to apply the interpreted standards sufficiently, as shown the quote below:

Quote from Participant 4 interview transcript:

Participant 4, PIC site 3:

"Well I think by trying to condense the training into an hour for a supervisor and two hours for an assessor, I've tried to condense my training when we used the KUDOS model as a [Annonymised] Approach erm, and I remember thinking when I'd got it in front of me "How am I going to put all of that information into two hours?" because it's easy for me who understands it, so trying to translate what it actually meant into an update: I just felt that's not going to help with the roll out. I mean, there's that much information in terms of what you can do in an assessment – what is the most important part?.."

As established in prior chapters, this is somewhat reflected in the broad style and ways that the standards are written and rely on local interpretations by AEIS and PLPS. The number of ways, therefore, generate lots of content that may or may not feature in training, which was not easy to refine and present coherently for registrants of all experiences to understand, retain and then use, as Participant 4 now suggests:

Quote from Participant 4 interview transcript:

Participant 4, PIC site 3:

"…I remember thinking when I'd got it in front of me "How am I going to put all of that information into two hours?" because it's easy for me who understands it, so trying to translate what it actually meant into an update"

Cumulative appreciation of extracts so far, therefore, considers that while multiple methods of disseminating the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) were available, a multitude of challenges have been faced by those who are attempting to supervise support and assess pre-registration students. A pooling of training resources and greater time to prepare before the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) were implemented into nursing programmes and Trusts could have helped to support and enhance assess understanding and practical implementation of the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) along with several, other benefits. Firstly, pooled resources would have allowed for collaboration between AEIs and PLPs to be consistent. It would have also allowed for shared access to

resources and the ability to share the potential large task of introducing and clarifying understanding and awareness amongst a population that, in many Trusts, affects a sizeable amount of people. This has further scope to include resources for non-nursing and midwifery members who may also participate in the supervision of pre-registration students, which then has the potential to inform practice assessment. As this could also be a multimodal portal for training, there is potential for this to become an additional resource which allows registrants to gain CPD hours and bridge the gap between formal training sessions and the optional practice guides offered by the NMC to support the roles of the Practice Supervisor and Practice Assessor (NMC,2018e). This would also help to address pre-existing concerns that existing staff have in relation to meeting current revalidation targets, as highlighted in Participant 7's quote below:

Quote from Participant 7 Interview Transcript:

Participant 7, PIC Site 5:

"…previous programme, the SLAiP programme was an accredited programme and so you had to take, I think 12 weeks erm preparation and then you had an assessment at the end and then you had either 10 or, it varied depending on the various universities but it was either 10 or 20 credit module, so that's something that staff could actually use erm for their personal development. With the new SSSA standards, the erm transfer from practice assessor, sorry the practice supervisor to the practice assessor isn't accredited so I think now staff are now having to identify another way of getting those accredited, accreditation really…."

Interpretation of these factors has also led to the suggestion that while the standards are available in the public domain and there are additional and optional practice guides (NMC,2018e) to support their use, accessibility due to the flexibility of the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) also challenges fundamental understanding and how to apply the *SSSA* (NMC,2018). This is substantiated by links that can be drawn to the beginning of the thesis, whereby similarities and differences between the SLAiP and the *SSSA* were appraised (see Introduction and Table One). More specifically, content within the literature and interview transcripts suggests that the preceding standards for practice and education were limiting and interpreted in a somewhat prescriptive manner and could be seen as an "industry in their own right", as Participant 8 describes in the following extracts:

Quote from Participant 8 interview transcript:

Participant 8, PIC site 6:

" …So even with all of that was written down in a very very tight and prescriptive way, you know people were still getting bad experiences, students were not being supported, or the mentors were doing the mentor programme but they didn't want to do it: they switched off in their heads or they had too many students to give them the quality of the learning experience.." …."

Quote from Participant 8 Interview Transcript:

Participant 8, PIC site 6:

"… And that whole thing about the SLAiP standards: they had become an industry in their own right and people had you know progressed it so far and some of it was the fault of the regulator in a way because the standards were written in such a way that you counted things?.."

This is an almost polar opposite of the *SSSA* (NMC,2018), as these standards emphasise the overall aim of the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) to:

"provide Approved Education Institutions (AEIs) and practice learning partners with the flexibility to develop innovative approaches to nursing and midwifery education, while being accountable for the local delivery and management of approved programmes in line with our standards."

(NMC,2018:4)

Interestingly, this extract also alludes to experience being a determining factor for being able to use them in an "easy" way. This implies that it takes time to read and understand the documents as they are written and to appreciate how this can be achieved through the Trust's interpretation of the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d), The concept of understanding based on experience was also spoken about in Participant 11's interview also gives the impression of time needed to understand and appreciate the *Future Nurse* standards.

Quote from Participant 11 interview transcript:

Participant 11, PIC site 6:

"when I got my head round them…."

The combination of quotes so far could suggest that the *SSSA* (NMC,2018) is not wholly accessible when consideration is given to the potential seniority and position of these participants. It could also lead to a disparity between more experienced individuals who have had the opportunity to attend more substantive courses before the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d), which have abolished all mandatory prerequisites beyond training that can last for a maximum of "two hours." (see p.179)

Further discussions relating to training understanding and awareness, the findings of this study established that in the experiences of registrants responsible for disseminating the Trust's interpretation of the *Future Nurse* standards, (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) registered staff and pre-registration students did not grasp key principles in the *SSSA* (NMC,2018). In addition, in Participant 6's experience, pre-registration students took longer to adapt to the use of the *SSSA* (NMC,2018) for several reasons. For example, in Participant 6's experience, this was partially due to a cross-over of language and terminology amongst cohorts of pre-registration students or them being used to the preceding model of support, supervision, and assessment, as Participant 6 highlights below:

Quote from Participant 6 Interview Transcript:

Participant 6, PIC site 4:

"…The students we as well, at that time they were end of second year on the old framework, so they weren't even on the new curriculum, so they didn't know anything else either…..and they weren't happy well "I'm used to having a mentor and who's my… I'm used to forming a relationship with one person, and have that person who's got my back…"

However, a smaller thread from this indicated that pre-registration students did not necessarily have realistic expectations as there was confusion between what AEIs were aware of and what local Trusts could reasonably accommodate, particularly during the initial waves of the Coronavirus pandemic. This was particularly relevant to Participant 6, as articulated in the extract below:

Quote from Participant 6 Interview Transcript:

Participant 6, PIC site 4:

"..We're finding we're having meetings anyway, when they join the organisation: we're doing them online now but we're undoing a lot of mixed messages erm, that's been communication which leads to frustration from the students perspective …."

This was also seen in how documentation such as the MYEPAD should be used to chart a pre-registration student's progress if they have intermitted or have had an interruption of placement exposure due to the Coronavirus pandemic. In Participant 6's experience, this extended to being unable to track individual students in the practice learning environment, as the following quotes from their transcript illustrate:

Quote from Participant 6 Interview Transcript:

Participant 6, PIC site 4:

"..- most of them come back out then, but…. there were some that didn't and I don't know why? It must have been a decision from the programme lead or what, or whoever but they, and then again there may have been more but I only know about the ones that had conversations with me, erm, and it was because of that that submission date, and it, I didn't, when I asked the university like were like "oh yeah, you have got this student now, and I was like well can I have a breakdown of what I need to do with them?" …."

Quote from Participant 6 Interview Transcript:

Participant 6, PIC site 4:

"..Because we, I've never seen a retrieval document, I mean I've gone to lots of piloting events with the MYEPAD, you know [Annonymised] navigated us towards PAN London and their website: you can look at the MYEPAD on their and they are on there… I don't know why, but every,[laughter] every pilot session, I went to about 3 or 4 with the MYEPAD, she hadn't got a copy of the OAR, and she kept saying " I keep meaning to, I keep meaning to bring it but I don't, I always forget" ,….."

Quote from Participant 6 Interview Transcript:

Participant 6, PIC site 4:

"…it's not that dissimilar to the previous one but I'd never seen, no one had ever seen this retrieval document or had any training on how to use it, when to use it, which sections etc. and when it was broken down and [Annonymised] broke it down erm, cause we were like we need to know what we're doing with these students, there were about 4, 4 or 5 different options depending on what was going on with the student: it was really, really confusing [pause] erm…."

Furthermore, Participant 6's experiences indicate that as these frustrations and miscommunications were occurring, it left both pre-registration students and those responsible for them in the practice learning environment feeling isolated and as if the university were not interested in the cumulative impact that the coronavirus had generated in their workload, as shown in the following quote:

Quote from Participant 6 Interview Transcript:

Participant 6, PIC site 4:

"…think we have been talking with each other but it's been in a group format: more or less around allocations and what's going on site wise, which is fine but we need to look at the detail of the student experience and I think there's lots more that they could do to help facilitate that and support that because I think because myself and my colleagues feel quite isolated from the university at the moment …."

Quote from Participant 6 Interview Transcript:

Participant 6, PIC site 4:

"…. Erm, so I think form the cohorts that I've had interactions with, I think they're feeling quite [pause] neglected….. I know it's a very strong word but they don't feel like the university are very interested in what's going on, in terms of their assessment and placement. One student said "it's like they've just closed the doors and gone home…"

Although it is hoped that pre-registration students would not feel isolated in periods beyond the pandemic, this too would require exploration. While it is also acknowledged that this is not in the scope of this study, it may be useful for future work and may link to other research required and set in the recommendations of the study, such as consideration of the former personal support tutor role. It may also present a point where further consideration is given to the former personal tutor role instilled as part of local arrangements to meet SLAiP standards. The benefits of this role were seen in Participants 3 and 4's experience of creating a tangible link between AEIs and the practice learning environment, which is visible in the following quotes:

Quote from Participant 3 Interview Transcript:

Participant 3, PIC site 2:

"…This is where we need more feet on the floor, and this is where the role of the PST which has been none existent from the university is, is helpful…. I mean I've had EXCELLENT PST support with one of the university staff …and that was when I first joined in this role and when I came out of theatres and came into this role, She was HUGELY experienced, gave me loads of support, loads of advice and without that PST I probably wouldn't have existed in the first place and carried on in the job to be honest…."

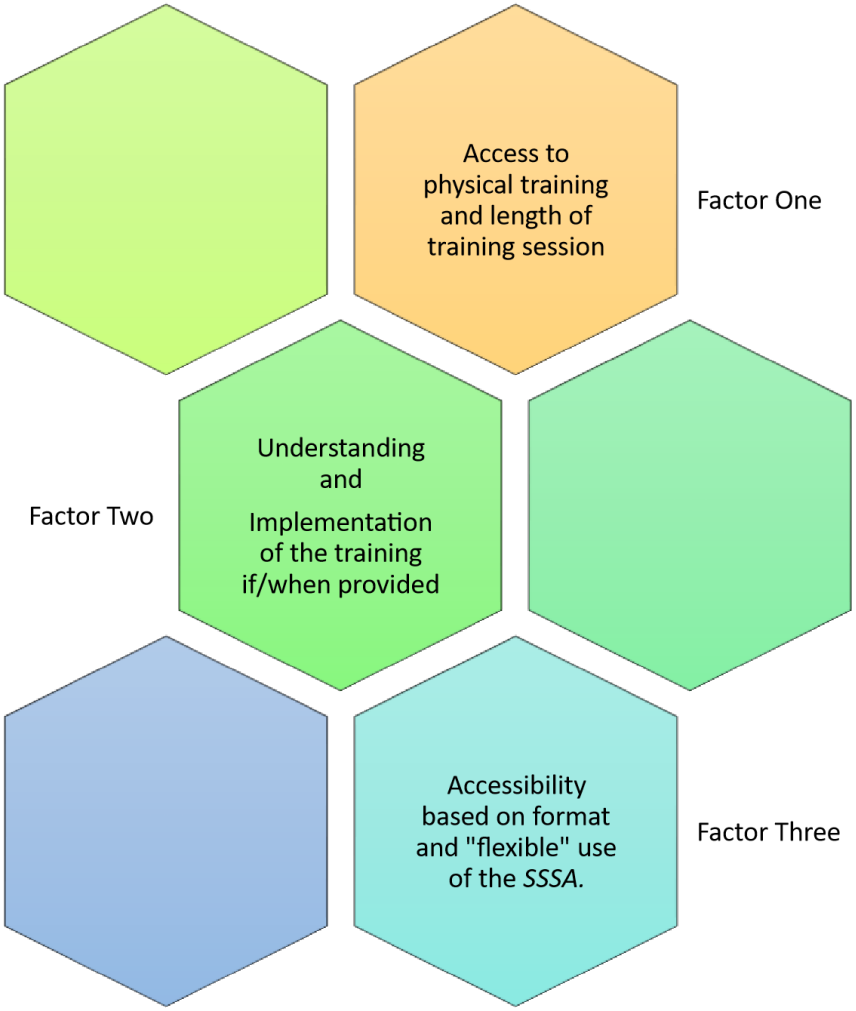
Quote from Participant 4 Interview Transcript:

Participant 4, PIC site 3:

"…the Practice/ placement Support team: they used to come out to the students, visit them: walk the wards, chat to them, have a look at their document and that was a service that we run pre, pre- pandemic, so it wasn't stopped because of the pandemic: it was stopped because of a number of reasons at [Annonymised] – Some of the staff didn't like coming out: it was, that was completely obvious, erm some of the staff didn't feel comfortable coming into the clinical area and there wasn't enough of the staff that really wanted to come in, so it was about managing that element with coming into the clinical area….."

From the participants' perspective, the reintroduction of the placement support tutor role would also help to form a physical point of collaboration so that miscommunication between AEIs and PLPs is reduced, but it also allows for greater availability of registrants who are informed to work with pre-registration students and registrants alike. In turn, this would help improve understanding and awareness of the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d). Finally, from a wider perspective, this could also help to address the cumulative factors, as summatively shown in Figure 5 below:

Figure 5 - Summary of Factors that influence awareness and understanding so far.



From an impact perspective, failure to address these factors could, in the long term, undermine the "team approach" to pre-registration supervision and assessment fostered within the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d), Although it could be suggested that this is primarily based on attempts to increase placement capacity and greater potential to ensure objective assessment of pre-registration students, the standards may well remain aspirational unless these factors are addressed. Additionally, without addressing these factors, particularly from an understanding and awareness perspective, individuals may not only fear change but revert to what is known or familiar to them. This may include a 1:1 ratio of pre-

registration student to mentor or sign-off mentor and a lack of supervision for a wider body of pre-registration students.

To some degree, this has already occurred, as Participant 3 has already explained, as shown in Table Fourteen (see p.166), and has impacted on pre-registration student experience and had the potential to affect a student's progression to the next part of their training:

Quote from Participant 3 interview transcript.

Participant 3, PIC site 2:

"….I had a student only last week who went on an action plan with late feedback who's only got two weeks of their placement left, so students aren't getting timely feedback because one person sees it as her job to do everything, then I, I think that's quite a big problem. So at the moment, I think long term when the education standards are embedded, and Coronavirus has made that more difficult to imbed it…."

Conclusive discussion for Sub-category one and why this links with language and terminology.

The multitude of factors that inhibited wider awareness, understanding, and useability of the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) presented significant concerns for participants and the study. This is due to experiences that highlighted a natural link between no or limited training, awareness of the *Future Nurse* standards, and the subsequent difficulty existing registrants have reported having when trying to apply them with pre-registration students in "real-time". As suggested, this is an area in which AEIS and PLPS may be able to collaborate further, particularly as extracts within Group Two's transcripts allude to pre-existing systems that were mentioned in the original study's brief. This includes adapting pre-existing models that AEIs used to adhere to the SLAiP standards (NMC,2008; RCN,2015) due to the use of academic staff visiting practice learning environments (see preface) and having a consistent interpretation of the academic assessor role which aligns with the role of the practice assessor (Hodgetts,2023 – see Appendix 11). In some institutions, prior the use of the *SSSA*, AEIs utilised a role commonly known as a "Placement Support Tutor" which was explicitly discussed. In contrast to the benefits of utilising a PST role, due to the size of some preregistration nursing cohorts that are present in some AEIs, finding

a balance that could work for both stakeholders is a key consideration, as an extract from Participant 3 indicates:

Quote from Participant 3 interview transcript:

Participant 3, PCI site 2:

"..we couldn't have a 100 different academic assessors or personal tutors coming out to us because we couldn't keep track of that, and they, and they would also would have to, well, I don't know if it would change, but they used to have to come and do an induction, cooperate induction and have an honorary contract to be able to be in the trust: I don't know if that would still be required or not, but I don't want 50 or 100 different members of university staff, what we need is one or two key people that can liaise with the different academic assessors or PST's as required.."

However, irrespective of how an academic assessor role is utilised to be a successful aspect of the student experience and support training, awareness, and understanding of the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) and its links with language, and terminology must be considered. To encourage this, relaunching the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) within Trusts using collaborative resources may not only encourage an agreed-upon approach to pre-registration training but could also provide a consistent method that can be used amongst existing registrants as members of the interdisciplinary team. This would include the use of consistent language and terminology, which can help to form a collective understanding and help to ensure that students are also prepared for their experiences in practice learning environments. As there is also an acknowledged need to adapt the support to suit varying needs, accompanying and collective resources, which also could support pre-registration students and existing registrants, it may be useful to construct an accompanying clinical glossary. This may include examples of how to apply the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d), allowing registrants to gain insight into how the roles, responsibilities, and use of the *SSSA* (NMC,2018) may be adapted to suit a range of preregistration students' needs. It may also help existing registrants objectively consider prior learning or experience and avoid assumptions that aspects have been sufficiently covered in other practice learning environments.

When compared to other themes, it also became clear that sporadic awareness and understanding of the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) became a significant trend that required exploration. This was observed especially in participants that were in group one, as only one in four of this group participants referred to the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) during their interview and offered limited insight into their interpretation and understanding of the *SSSA* (NMC,2018). This is particularly significant as Group One, who identify as "full-time or dual role practitioners that work or have access to an Acute Trust in a nursing capacity", have the most frequent contact with pre-registration students and, therefore, are responsible for fulfilling the daily practices of pre-registration supervision and assessment. This finding was corroborated when additional analysis of interview transcripts and their significant codes indicated that only senior members of the nursing community who have been part of discussions with AEIs or representatives of the NMC were able to explicitly demonstrate an accurate or detailed awareness and understanding of the Standards of Proficiency for Registered Nurses (NMC,2018a) and the *SSSA* (NMC,2018). This undoubtedly creates a barrier to implementing the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) as the people with sufficient knowledge cannot deliver training, which in turn limits access and potentially creates a challenge for those who need to understand how numbers of pre-registration students should now be supervised and assessed.

As a cumulative series of extracts and considerations, language and terminology are symbiotically linked with training, awareness, and understanding. It also made it possible to suggest that collective efforts have the potential to span beyond the agreement of how AEIs and PLPs have interpreted the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d). However, without addressing the factors alluded to in this sub-category, it would not only make it difficult to manage student expectations but would also challenge the ability to foster a consistent understanding of the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) generally. This would, by proxy, make it difficult to ensure that all registrants could now meet the expected level of proficiency outlined in the standards of proficiency amongst the entire nursing workforce.

Furthermore, a lack of collective awareness and understanding of the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) could lead to inconsistent approaches and could partially explain why participants had developed resistance and reluctance to use the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) in clinical practice or other practice learning environments, which will now be discussed.

The link between a lack of understanding, awareness and inability to sense check understanding of training consistently contributed to a resistance to adopting a new way of working or fear of changes made to the practice education and pre-registration student training. From this study's specific and participant's perspective, fear of change, without all of the needed information, led to resistance and a reluctance to follow the *SSSA* (NMC,2018) as it was intended. This was somewhat captured in Participant 6's perspective, where a registrant was reluctant to progress a pre-registration student (see p.178) because they had not worked with this particular student. This was somewhat related to Participant 9's thoughts surrounding the *SSSA* (NMC,2018) and their reluctance to adopt the "team approach". This reluctance seemingly stemmed from the achievement of continuity and is demonstrated in the following quote:

Quote from Participant 9 Interview Transcript:

Participant 9, PIC site 3:

"…I don't think student should be coming to work every day and just be "put with her, put with him put with her" I don't… to me personally, I don't like it. Some of the students might love it. I just think you need that continuity, so you know what that student's capable of and what you need to teach them or what they need to improve on…"

While it may be suggested that this is at the discretion of the practice supervisor overseeing a pre-registration student, there are cases where students have faced unnecessary challenges at the progression stage due to the availability of staff who have continued to use the outdated model of pre-registration supervision and assessment (see p.188). Furthermore, resistance to change based on limited understanding may also occur because understanding and interpretation of the *SSSA*

(NMC,2018), in particular, has led to apparent confusion despite attending training on the *SSSA* (NMC,2018) as the next quote indicates:

Quote from Participant 9 Interview Transcript:

Participant 9, PIC site 3:

"…you need to be able to do everything: I'm not signing off somebody that thinks they can give two minute care to a patient and then sit and go and have a coffee or go and talk to their mates… nah. Its, I can't… I can't help the way that I feel and I'm not gonna change it so I'm not signing them off. And I think that's why I don't like it, you need to be able to tell: maybe say if you've got close say 4people, 4 nurses working and we all do a bit maybe that, but I'm not a fan. Nah. [short pause] I think continuity of care so continuity of support…"

However, if language and terminology could be addressed, in Participant 10's experience, having a "team approach" could enhance learning opportunities for pre-registration students to ensure that if they do require a skill, proficiency or exposure to a procedure, suitably trained individuals can facilitate or support the consolidation of learning and knowledge; as demonstrated in the following quote:

Quote from Participant 10 Interview Transcript:

Participant 10, PIC site 7

".. Erm the best people to teach female catheterisation is a midwife: doesn't matter who you're teaching, midwives can get that catheter where the sun doesn't shine without much problem. To teach that skill and supervise that skill previously they weren't allowed to do it, they weren't allowed to sign off that competency because that person was a midwife and that person was a nurse: one was a student nurse. … Same with chest physio, physios are better at doing chest physio then any blinking nurse I've come across: they're the people to teach the skill, they're the people to do the skill with and they're the people to support…."

Furthermore, a fear of change also featured in Participant 8's interview transcript, who indicated that fear of change influences people's perception of the change, as shown in the following quote:

Quote from Participant 8 interview transcript:

Participant 8, PIC site 6:

".. how can I supervise these students when im not allowed/ don't know how to do these things? So for me it was not about whether the standard was a good or a bad thing: this was about managing change and it's still about managing change, so you know, some people are vociferous about why we should do certain things but you know nothing happened in isolation….. So it was all of those, you it's all about changing culture, this is about the ambition for the profession, this is about what people need and it's about managing change…"

The data, therefore, suggests that change can be unsettling for individuals. From Participant 8's perspective, the comparison between SLAiP and the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) is not about the differences between the standards, but rather actioning the change put forward and adapting culture to suit. However, without suitable training, awareness and understanding of the *SSSA* (NMC,2018), which includes using the appropriate language and terminology to explain or define aspects of the current standards generally, changes to pre-registration student supervision and assessment are not proactive would be somewhat detached from the current vision for preregistration nurse education. The findings also allude to an acknowledgement of change, but there was no suggestion for how individual, existing registrants may manage the change personally.

The discussion also did not elaborate on how existing registrants were going to be able to meet the re-envisioned role of a nurse, as this quote below indicates:

Quote from Participant 8, PIC site 6 Interview Transcript:

Participant 8, PIC site 6:

"…But I remember presenting at a conference when we were consulting on the Future Nurse standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d). Standards and all of the skills within the skills annexe was there, and what you had was the mentors and the sign-off mentors saying, "Who's going to invest in me? – so I can learn those things as well?" or "how can I supervise these student s when I'm not allowed/ don't know how to do these things? So for me it was not about whether the standard was a good or a bad thing.."

In addition, reasons, why people dislike the *Future Nurse standards* (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) and implementation of the *SSSA* (NMC,2018), appear complex.

Without further exploration of its use, it cannot be said if this was an initial reaction to change or if it is something that is more deep-rooted due to chronic issues such as skills mix, staffing and the "theory-practice gap" (Greenway et al.,2019; Shoghi et al., 2019). This may also extend to having time to address concerns about providing pre-registration students with adequate supervision for pre-registration students and if existing registrants have understood the *SSSA* (NMC,2018) to a sufficient level. Having said that, based on Kantian theory and literature within the introduction to the thesis, a great deal of what is learnt and practised is based on experiences that registrants were exposed to when they were students themselves and had reflected on.

This proved to be unanimously considered practice and links to the next category of reflection, which will now be discussed.

6.3 Research Findings - Analytical Category Two: Looking back to pay it forward.

Exploration of Analytical Category Two: ***Looking back to pay it forward*** was based on two of the five significant themes that emerged after focus coding and synthesis of analytical categories. The themes most relevant to this chapter have been demonstrated in Table Fifteen, which reintroduces the theme name, individual participants these themes were significant for, and which PICs they aligned to.

Table 15 - Tentative theme and meanings that specifically related to this category

Analytical Category and its Content	Participant Number	PIC site that participants align to:
Daily roles and responsibilities of a registered nurse: i) Individual Participant Characteristics and Clinical Expertise ii) Exposure within the practice learning environment	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11	1, 2, 3, 4, 5, 6, 7
Reflecting to affect learning culture: i) Reflection ii) Willingness to work with preregistration students iii) Encouragement of student development iv) Recognition of student's prior learning	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11	1, 2, 3, 4, 5, 6, 7

This analytical category houses “Roles and responsibilities of a registered nurse” and “Reflection,” the only two unanimously significant codes for all parties across PIC sites in the study. This may not be surprising for the reader as the regulator advocates for continual reflection and specifies that a registered nurses conduct should be in keeping with “The Code” (NMC,2018b). In addition, reflection represents one aspect of the formal revalidation process that registered nurses and midwives undertake as part of a three-year cycle (NMC,2021b).

In congruence with Category One, these have been broken down into sub-categories so that findings and discussion that will now be presented.

6.3.1 Sub-category One: Daily roles and responsibilities of a registered nurse:

Pre, during, and immediately post Coronavirus pandemic, registrants who took part in the study have discussed their roles, or the roles of less senior staff, and their impact on preregistration student experiences. Some relate to using the *SSSA* (NMC,2018) and the Standards of Proficiency for Registered Nurses (NMC, 2018a). However, other nuances within the transcripts referred to prior duties as a mentor or sign-off mentor and how individuals have performed their roles and responsibilities during their tenure. As such, registered nurses often develop knowledge experientially and have, in preceding models, applied a “see one, do, one, teach one” approach, which is often a staple of practical learning practitioners, particularly as nurses often rely on the experiences of others throughout their career (Albert and Burns,2018). This not only enhances the subjective nature of pre-registration supervision and assessment, as alluded to in Literary Objectives One and Two in the thesis (see pp:36-64) but also relies on a registrant to be able to “look back in order to pay it forward.”

Sub-category Two: **Reflecting to affect learning culture:** All registrants reflected on their experiences throughout the interviews. In turn, their experiences have informed support offered to pre-registration students while on placement. For many participants, this included reflecting on their own experiences as a student nurse or as a new mentor and signoff mentor. The lived experiences of the participants also tended to describe or identify different approaches that either worked or did not work for them as pre-registration students or when they became registrants themselves. In turn, this has shaped what registrants have incorporated in their approach or avoided when working with pre-registration students’ long term. When this is linked to existing literature, reflection generates numerous benefits; the practice of reflection means different things to different people and can be multifaceted as well as non-formal or dynamic. This is not dissimilar to how registrants and pre-registration students associate with their roles and responsibilities. This may stem from the recognition that the roles and responsibilities of individual registrants instil niche knowledge and experiences and inform a practitioner's scope or limitations of practice. In this instance, experience of the registrant who is supervising or assessing the pre-registration student will also be linked to the attainment of skills, nursing procedures and levels of proficiencies that

may lead to dissonance between the existing workforce and what newly registered nurses are expected to demonstrate at the point of registration.

From *'The Code'* (NMC,2018b), it is also possible to recognise that roles and responsibilities also shape and guide the process of appropriate delegation and a registrant's duty to follow up on an action to ensure it is completed to a sufficient standard.

However, the guise of reflection and being able to look back and instill evidence-based practice in the future generation of registered nurses rely on addressing the existing and often "toxic learning culture" (Feeney and Everett, 2020:43) that pre-registration students can be exposed to within practice learning environments daily. This will now be discussed in Subcategory One.

6.3.2 Sub-category One: Daily roles and responsibilities of a registered nurse.

An initial and overall interpretation of lived experiences relevant to Analytical Category One was demonstrated through several factors which emerged from the data. Although there were many nuances within the data, the primary link between these themes and all participants centred on the recognition that a registered nurse typically linked their ability to make everyday decisions with their clinical expertise, sense of autonomy, and response to constructed environmental culture(s). However, learning culture was intrinsically linked with a registrant's general willingness to support preregistration students when related to pre-registration supervision and assessment. Furthermore, in line with the interviews and the literature, role modelling and culture set by registrants was, and remains, the pinnacle of pre-registration students' learning experience. The transcripts mainly captured how existing registrants used reflection to justify clinical decisions and act as a guide for opportunities offered to pre-registration nurses within the practice learning environment.

For some participants, the decision-making process in accordance with their role and responsibilities as a registrant also linked with themes previously introduced in Analytical Category One, such as adapting to the individual needs of the pre-registration student and using a variety of approaches to support learning in the

practice learning environment consistently. However, in some cases, this was more directly aligned with helping the student nurse achieve outstanding or new proficiencies and/or construct self-directed goals that may lead to other models being utilised. Some of these referred to in interviews included Group Teaching, Peer Assisted Learning (PAL), Coaching, and Peer Assisted Learning (CPAL) or a Collaborative Learning in Practice (CLiP) approach.

Although this concept links placement opportunities with clinical decision-making in ways that are now formalised in the *SSSA* (NMC,2018), prior to its implementation, this process was largely an optional aspect of the registrant's duties while a student nurse was on placement. It, therefore, partly relied on a registrant's expertise or understanding of other specialities as effective signposting to alternative environments or experiences. This has several benefits for the pre-registration student's development and recognition of transferable skills and knowledge, but again does not guarantee optimal exposure and highlights the potential for pathway selection to be significantly influenced by an individual registrant. However, with the knowledge of these influencers, and using their own experiences to guide them, a registrant can make a more informed choice as to how they fulfil their new role as an educator, assessor, or supervisor. This can include role modelling optimal conditions and behaviours attributed to forming a positive learning culture or actively avoid putting pre-registration students in the circumstances that do not. This somewhat links the roles and responsibilities if a registered nurse to reflection and 'Looking back to pay it forward.'

Some of the most common things that undermine pre-registration nursing learning are perhaps noted in quotes taken from Participant 2's interview transcript:

Quote from Participant 2 Interview Transcript:

Participant 2, PIC site 2:

"but it's funny it's the negative things that stand out…. I can't remember something positive she taught me but I can very much remember those negative, humiliating experiences that I had. I also erm, had mentors on other placements, which made me want to leave nursing: so I was ignored, or I was the one put in with the confused patients as an "extra pair of hands", rather than as a student: to learn how to manage"

Quote from Participant 2 Interview Transcript:

Participant 2, PIC site 2:

"I've just seen nurses that appear to me to not… to come to work for a job… is vocational the right word? Im trying to think what vocational means "when somethings more than just a job, isn't it?"

As such creating a balanced but positive learning culture can also be linked to the expertise of the existing registrant is a dominant factor that influences pre-registration supervision and assessment within the practice learning environment. This can also inform how many transferable learning opportunities were previously afforded to the pre-registration student when pathway experiences were an optional entity within nurse training, as Participant Five recalls in the following quote:

Quote from Participant 5 Interview Transcript:

Participant 5, PIC site 2:

"Yeah definitely… I didn't have a respiratory placement erm, while I was training but I did get a good, varied placements and, and they were all equally important, erm and I got to, you get to appreciate what all the different specialities have to do, so when you're in your own little respiratory bubble erm Im aware of that, of how other wards erm manage and work … erm but with our pathways for our students they erm, so once you're qualified you won't get the opportunity to go and see any procedures or anything so, because you don't have time, so when you're a student: I can go " do you want to go and watch that ?" erm once you're qualified you not gonna go " ok, Im just gonna pop off the ward now to go and erm watch a bronchoscopy or anything", so it's nice just to be able to offer that …."

Quote from Participant 5 Interview Transcript:

Participant 5, PIC site 2:

"So when I was in my cardiology placement, and they bang on about "had a CABBAGE" blah, blah blah, seeing how intricate that surgery is and the recovery process for the patients after erm, It did help and the care before they go for their surgery, it was just nice to be able to follow through the whole way and then working with the heart failure nurses as well to look after those patients who unfortunately aren't doing so well but erm, yeah it did really help to improve my practice."

However, in accordance with Participants 6, 8, and 9's experiences below, individual and collective placement areas' ethoses can alter the approach taken to offering pre-registration support through a student's part of their training, which heavily relies on subjective elements that exist within individual workspaces. It also suggests that alongside individual conduct, role modelling, and accommodation of pre-registration, student experiences are influenced by overarching team dynamics. This is particularly significant as the ability to meet the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) hinges on the ability to utilise a "team-approach" to pre-registration or assessment, and how this can be used to address pre-existing attitudes that they have been exposed to:

Quote from Participant 6 Interview Transcript:

Participant 6, PIC site 4

"…Why are some people excellent at it? We've all trained the same way, we've all got the same code of practice and then other, I've just literally got two wards next to each another: one ward – no staffing issues, no recruitment issues, they have up to 10 learners at any one time, all years so levels 1 to 3: have anyone, happy to have anyone, follow the assessment process, contact me if there are any problems. Same, more or less same specialty to the one next door, they have 4 students at any one time, only second or third years: so they're more self-sufficient: not as dependent [laughter] as a first year, horrendous staffing issues, loads of vacancies, …They don't engage in training and development: they don't encourage the students to come to teaching sessions and forums, so why, why does that happen? We're meant to be doing things the same way [pause] very interesting..."

The findings of the study also suggested that while some practitioners are aware of broadly interpreted sources of evidence that underpins care, the nature of practice learning environments and poor dissemination of research outcomes in some cases, and the complexity of nursing culture, make it challenging to identify what guidance is related to isolated aspects of care, and is largely down to what the individual has learned from peers and the patients. However, Participant 6's shared experiences indicated that due to specific circumstances in a practice learning environment, they had had to support pre-registration students who were otherwise being poorly supervised, as the following quote indicates:

Quote from Participant 6 Interview Transcript:

Participant 6, PIC site 4:

"..We did have a couple of students feedback just before my annual leave last week …. Was a couple of weeks before that they didn't feel like they were being supervised erm in that environment and actually they weren't in all fairness because the, the ward was too short staffed, the team was fragmented erm high levels of sickness, you know COVID has impacted everything everywhere at the moment and there were only: looking at the team, there were only three established team members on shift at any one time. And the students were kind of exposed to this: for a shortened period of time… it was only just two weeks but actually they did the right thing to come and speak to me because they weren't being supervised as we would expect them to normally within a normal kind of experience…."

From this, it may be suggested that a lack of understanding, and to a degree, acceptance of the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) may come from poor interpretation, awareness and understanding of the *SSSA* and 'team-approach' to pre- registration supervision and assessment from a historical context of not accessing a SLAiP or formal mentoring course, as Participant 8 suggests in the following quote:

Quote from Participant 8 Interview Transcript:

Participant 8, PIC site 6:

"..and you'll know it in your own career is when you've got nurses and midwives who just kind of hold their hand up and go "I don't do students, I haven't done my Mentorship" and it's a get out of jail card [laughter] so we, we were able to flip that narrative very very quickly and say actually it is every nurse, it is every midwives responsibility to support new and junior and student colleagues: it's in the code and that opportunity to say I don't do students, I haven't got my mentorship, just disappears if you do that…"

If the principle is then transferred to the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d), it is difficult to say how many registrants who work flexibly, such as those who work for nursing agencies or are registered with local

nursing banks, have sufficient knowledge of the changes to pre-registration supervision and who will take responsibility for their training, as all registrants can now contribute to the supervision and subsequent assessment of pre-registration students. It also makes it possible to suggest that although everyone had the same "Code" (NMC,2018b) everyone interprets their role and therefore their responsibilities differently. This creates subjectivity in practice, as well as the experience that pre-registration students gain while they are in the practice learning environments. This not only builds on from some of Participant 2's experiences, but also extends to the discussion, that although all registrants should support the 'Future Nurse', not all registrants are willing to. This may then lead to an insufficient, fundamental skills which enable pre-registration students to be effectively supervised and assessed with compassion or by registrants creating a positive learning culture; as Participant 9 explains in the following extract:

Quote From Participant 1 Interview Transcript:

Participant 9, PIC site 4:

", because she was nervous, a very, very nervous nurse because of the ways this ward manager treat her: we got on really well. I thought her when she didn't want to do anything, this ward manager called me three meetings on me, the first one she called a meeting on me, she said " you know I don't know about this lark, that you can't spell" sat at the nurses ones day and one day she was going " come on… Come on,…. A, B" my spelling, I just looked at her and carried on…"

To some degree, therefore, culture from an individual and collective perspective also shapes the registrant's ability to justify their decisions, which again, in line with themes in Category One, can also be shaped by access to training, awareness, and understanding that impact on a preregistration's progress up to the point of registration. For example, in Participant 1's experiences, the following quote demonstrates the need to find a balance between the time limited opportunity that pre-registration students can have access to, and how this may benefit their wider exposure in relation to their "future" career prospects, and is reflexive of how they are trained, as the following quotes state:

Quote from Participant 1 Interview Transcript:

Participant 1, PIC site 1:

"I think, because the students are only in for a week at a time…erm, you try to get them to be exposed to lots of different things, and depending on their background, it might be that they are moved from one theatre to another to get a better exposure that will benefit their needs for the future on the wards"

Quote from Participant 1 Interview Transcript:

Participant 1, PIC site 1:

the training of the students erm has changed from there, their like university training… We've gone from students being in the clinical area for significant portions of time to having their working hours restricted, more time in academic settings, erm limited days of the week they can be requested to work. Erm, we tend to get erm different settings now with student nurses than we used to erm so many years ago student nurses would get like a block booking within theatre and would perhaps spend up to six weeks at a time in that area, now with the hubs and spokes, they typically only get put with us for a week, so erm it's more of a whistle stop tour .. Just as an overview rather than an expectation that will be up and running with erm a theatre background. We get a lot more ODP students come through who are set and based with us for a prolonged periods of time erm because of them being specialised in the Operating Department practice as opposed to erm the nurses which are often training is often ward based and are just coming in for an overview of what's happening in theatres"

However, the pre-existing course, which, too, had mixed results, linked confidence and ability to meet the pre-registration nurse's needs and expectations through the accrual, consolidation, and reflection of anecdotal, experiential, or empirical stimuli. This results in Priori Knowledge and cumulative expertise, which informs the care of patients and directly impacts how practitioners develop their sense of clinical identity, and how they role model other nursing or healthcare fraternity members.

This posed an interesting point within the research as it has been recognised in the literature (Gopee,2023) that there is limited evidence to substantiate the changes to pre-registration nurse education in the form of the *Future Nurse* standards (NMC,2018;

NMC,2018a; NMC,2018c; NMC,2018d) and what they advocate for. This was somewhat mirrored in the literature searches, which showed that aside from the optional practice guides (2018e) and the *Future Nurse* standards (NMC,2018;NMC,2018a;NMC,2018c;NMC,2018d) documents, very little was available in the public domain when searched for in CINAHL in PUBMED between 2018 and 2021. However, extracts within Participant 8's interview stated that the scope of change was not initially envisaged to be as substantive as they are, as demonstrated in the quote below:

Quote from Participant 8 interview transcript:

Participant 8, PIC site 6:

"…So it was all of those, you it's all about changing culture, this is about the ambition for the profession, this is about what people need and it's about managing change. So it was like the Italian job, we didn't mean to blow the doors off but we did [mutual laughter] in a way [mutual laughter] erm because it was the right thing to do for people, you know and it is where care is going. You know we weren't trying to do things that weren't happening already, this was about people living with complex needs, comorbidities and where's the application of that evidence based knowledge and skill practice and so the skills needed to be upped really…"

The discrepancy between the SLAiP standards (NMC,2008; RCN,2015) and the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) highlights the need to find a balance between the facilitation of exposures for student nurses to various placement areas and creating the right atmosphere or attitude to learning. However, because different subcultures influence practice learning environments and individual staff, there is great potential for these aspects to create subjectivity in the supervision and assessment process. This is reasoned as exposure, and learning culture is shaped by how much a registrant, or now a collective team, may be willing to invest in the development of a student's understanding and negotiate how each of them fulfils their role, responsibilities, and to some extent, defines their role in the student nurse's journey towards registration, as Participant 10 highlights in their transcript:

Quote from Participant 10 Interview Transcript:

Participant 10, PIC site 7:

"…My question is do we supervise students in practice or if we should be teaching them in practice. Why do I have a student in my clinical area? Are they in the clinical area to learn or do I have a student in my clinical area to do? Students are in my clinical area to learn, they're not in my clinical areas to do. Part of that learning will be done by doing, part of that consolidation of learning is done by doing. How can I correct their practice if I am not observing them? Now observation can come in one of many ways: It can come in being stood right next to you, it can come in being arm's length, it can be "well actually you've done this when I've been stood right next to you, Im gonna let you crack on and we will have a discussion later" I can only do that with what is in the standards and the skills that they need to achieve..."

However, when connecting language and terminology to the adoption of a "Team Approach" and an underpinning ethos of professionalism, Participant 8 offered the following insight:

Quote from Participant 8 Interview Transcript:

Participant 8, PIC site 6:

"And then if you extend that outside the NMC register, language takes on a whole different meaning and the one example that I constantly think about, because it's come up again recently is clinical supervision. So for nursing, midwifery colleagues clinical supervision means one thing but it doesn't necessarily mean supervision and assessment of students who are learning to become something. Whereas clinical supervision in medicine does mean that. That you're supporting someone's practice learning environments and attainment".

It was also mentioned in this interview that individuals who have oversight of nurses do not fully understand the daily duties of a registered nurse, as captured in the following quote:

Quote from Participant 8 Interview Transcript:

Participant 8, PIC site 6:

"…What also isn't a surprise is that members of the public are the people that know least about the standards and yet there is that element about members well if the public know what a midwife can do, that can bring confidence and trust. Erm but the group who knew the least, the second group who knew least about the standard were employers of nurses and midwives and so you would get this conundrum where an employer says, "when these newly qualified people join me, they don't know how to do this this, this and that" but they didn't know what these standards were preparing those nursing and midwives to be able to do and you get this,.."

These challenges are further compounded by the recent COVID-19 pandemic. Although it remains the case that the full extent pandemic and "Long Covid" remains unknown. It can therefore be questioned if the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) remain fit for purpose, or reflective of complex needs that now exist within the UK population. As such, this may present the regulator, AEIs, and PLPs with an opportunity to revisit the Standards of Proficiency for Registered Nurses (NMC,2018a) and *SSSA* (NMC,2018) to ensure that these remain appropriate to meet the needs of the patient. This may include a clinical audit of how many areas within Trusts utilise the formerly labelled "advanced skills" as part of their daily roles and responsibilities. This may then extend to audit what opportunities participants are given to maintain these skills once a practitioner has attained them, and if they are aware of changes to the remit of a registered nurse since the pandemic has transitioned into a different phase. It may also establish an evidence base and help combat factors identified in Analytical Category One, including awareness and understanding of the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) and subsequent resistance to change.

Furthermore, the daily roles and responsibilities not only rely on pinpointing what a role entails but also prompt discussion surrounding the skills annexes and differences between the SLAiP standards (NMC,2008; RCN,2015) and the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d).

This extended to further explanation from Participant 10 but also from several other participants, as the following extracts demonstrate:

Quote from Participant 10 Interview Transcript:

Participant 10, PIC site 7:

".. There's other skills within them, so if you look at the skills annexe for mental health training, there's some expectations in their: that's not my skills set of what they are but I know that a lot of my colleagues who are in the mental health fraternity will turn round and say that that's not routine practice for them, that there's things in there that they do not do on a regular basis…"

This links to transcripts from Participants 3 and 4 below, which highlight that achievement of specific skills is not only not immediately possible but may not be maintained once a preregistration student has attained them in the practice learning environment, as participants 3 and 4 discuss in the extracts that follow:

Quote from Participant 3 Interview Transcript:

Participant 3, PIC site 2:

"… none of them do PR examinations, none of them do manual evacuations because that's against policy: so they're not going to be able to do achieve the PR skills…"

Quote from Participant 4 Interview Transcript:

Participant 4, PIC site 3:

"…actually somebody in the mental health field is not going to get a cannulation. I don't understand the rationale behind it … I understand the brief reasoning why the NMC thought to have you know, all fields doing the same but to fail a mental health student because they didn't cannulate is the most bizzarest thing I've ever seen and that's what could happen. So you get universities or skills teams such as myself paying lip service to a simulation skill: just so a student can pass and they'll never do it again…"

This was reflected in Participant 8's discussions who discussed the potential to change policy so that skills may be achieved, as shown in the quote below:

Quote from Participant 8 Interview Transcript:

Participant 8, PIC site 6:

"…And then employers would go "ooooo, don't know about that, our policy doesn't allow students to do this stuff .and you say well change your policy, so we were really shaking it up erm, really shaking it up but there was a defining moment and so lots of people say, you know we've gone a step too far: prescribing practice was a good example of this: you've gone a step too far: others where people say no this is right: this is what people need…"

However, while it is possible to change a policy or a standard operating procedure in an organisation to enable the attainment of skills or procedures, evidence in relation to the placement of NG tubes, in particular, highlighted patient safety issues. A key example of this includes an NHS Improvement patient safety alert issued surrounding the placement of NG tubed and mortality associated with incorrect placement and complications that ensued (NHS England,2016; NHS Improvement,2016) This was also raised as a point of particular concern in Participant 4s interview as indicated in the extract below:

Quote from Participant 4 Interview Transcript:

Participant 4, PIC site 3:

"… but I'm also worried about the Naso- gastric feeding element as well. I don't actually know who was sitting round that policy table at the time, but it weren't people that I respected… Yeah I'm a bit angry about that… I just think it's going to cause a lot of problems, plus the pandemic, I know I'm going back to that but because students were pulled, particularly in their first year and moving into second a lot of them have not had the opportunity to get these skills, so we are going to end up being in a position where students are moving through the system and not getting them signed off…."

Incidentally this continued to be a concern in 2023 as well as a source of innovation (Bowie, 2023). From this, it may be said that although the last extract is emotive, interpretation of this correlates with the pandemic's after-effects and a lack of opportunity to practice skills or proficiency prior to the point of sign-off for any year a pre-registration student comes to. In context with the preceding quotes included, it also makes it possible to link these concerns with the likelihood that these skills are not necessarily suitable for all pre-registration students to undertake, particularly if

their field of practice does not warrant regular use of this skill, as Participant 10 highlighted in the transcript extracts below:

Quote from Participant 10 Interview Transcript:

Participant 10, PIC Site 7

".. The last time my patients came in, they have a specific reason for coming in. It wasn't just because "you know what Im just not feeling well" There was a specific reason why they just didn't feel well. If we were able to survive being a jack of all trades and a master of none, we wouldn't have respiratory specialists, we wouldn't have cardiology specialists, we wouldn't have critical care specialists, we wouldn't have paediatric specialists, mental health specialists, learning disability specialists. We wouldn't be having a whole different conversation around frailty and that actually we need to start looking at having an older adult's specialty. … We need to have a broad knowledge, but we don't need to be a jack of everything…"

Quote from Participant 10 Interview Transcript:

Participant 10, PIC site 7:

".. 80% of the patients and 80% of the skills. So 80% of patients require 80% of the skills, we should know about it. If only 20% of the patients will require 1% of the skills: it's a specialist skill: it's not a jack of all trades skill.…"

However, where it is possible, as in 80% of patients requiring a skill, use of the "team approach" to pre-registration supervision and attainment of competencies does increase placement capacity, as participants 3,4 and 6 alluded to in their transcripts, but also promotes an opportunity for pre-registration students to be taught by individuals who are "expert" or proficient in their own area of practice, as stated by Participant 10 in the extract below:

Quote from Participant 10 Interview Transcript:

Participant 10, PIC site 7:

".. Erm the best people to teach female catheterisation is a midwife: doesn't matter who you're teaching, midwives can get that catheter where the sun doesn't shine without much problem. To teach that skill and supervise that skill previously they weren't allowed to do it, they weren't allowed to sign off that competency because that person was a midwife and that person was a nurse: one was a student nurse. … Same with chest physio, physios are better at doing chest physio then any blinking nurse I've come across: they're the people to teach the skill, they're the people to do the skill with and they're the people to support…."

This has prompted part of the study's considerations to include further concerns for embedding the *SSSA* (NMC, 2018) if every registered professional is expected to contribute to the supervision of pre-registration students and remain up to date with the Trust so they can practise effectively. An account from Participant 2's interview transcript speaks of some of the challenges faced when familiarising themselves with seminal aspects of nursing care in an Acute Trust. As they explain, is it not just the culture and the team that people go to work with, but practical issues that create a barrier to acting as a registrant in a bank capacity.

This may include reading and understanding new policies and procedures, ensuring access to appropriate systems, and allowing them to work fully within "The Code" (2018b), which governs Nursing, Midwifery, and Nursing Associate practice. As there wasn't a specific process that this participant alluded to, there is a suggestion to consider that without a process, this largely depends on the individual's good will and diligence to be self-sufficient as the following quote attests to:

Quote from Participant 2 Interview Transcript:

Participant 2, PIC site 2:

" I feel like I shouldn't be going in as a registered nurse, because every time I go into practice ….. Every time I go into practice I have to spend, I have to go in early to make sure I can access all the online systems, that if I haven't done a shift for a while I have time to take the training or retake the assessment before I use the systems, that you know I spend a lot of time unpaid at the beginning of the shift to make sure I do this and the changes are coming in so thick and fast: every time I go: the assessments changes, every time I go the paperwork has changed and so I can't go in and nurse and take care of my patients…"

To have this diligence, however, takes significant insight, investment and time that people may not have and act as a deterrent to continue working clinically and relying more on what they had been exposed to as pre-registration students or experiences gained as a newly qualified nurse, and 'mentor' in styles that align to methods used before implementation of the *Future Nurse* standards. This may therefore influence how they supervise based and follows more of an experiential approach, such what they did, or did not, respond to. In other words, without considering how people are updated, existing registrants have will rely on 'looking back to pay forward' and links to subcategory two which focuses on reflecting to affect learning culture.

6.3.3. Sub-category Two: Reflecting to affect learning culture.

Clarke describes reflection in the following way:

> *The process of reflection requires immersion within our experiences, being fully present with our thoughts and feelings, how we responded to others and our environment, and how we perceive how others respond to us. Reflection doesn't require a critical incident to have the experience to learn from; it makes no assumption that we have done something wrong or need to improve. Reflection assumes a neutral position. We create a non-judgemental framework within which to empathically understand ourselves, in the context of professional practice and our many personal identities, which influence our behaviour in the clinical setting.*
>
> (Clarke,2022)

From this, reflection can be a tool accessed at any point which can instill confidence in individual actions, inform future actions, or prompt introspection of how to adapt to exposure or a situation should it arise again. Reflection is also shaped by external factors that impact unique responses or reactions to people, stimuli, or situations. For pre-registration students, past experiences with former mentors, prior learning, and their stage of training heavily inform what they require from existing registrants and what they hope to gain from individual practice learning environments. It, therefore, promotes an opportunity to set boundaries for the need to introduce a new skill or

proficiency, delegate one or multiple tasks, and jointly review or, if there is a point, observe and provide feedback.

This represents a parallel between pre-registration students' experiences and existing registrants as both change and development, based on their accrued knowledge and cumulative exposures, as participant two reflects in the quote below:

Quote from Participant Two interview transcript:

Participant 2, PIC site 2:

"I think when I started mentoring, I wanted to be liked and so my boundaries were probably a lot…wider than they would be today erm, and then that came, so this wanting to be liked and wanting to be that support and doing that, from the best possible place, for wanting to support them and to be aware of those anxieties and treat them like a person not like a student who needs to be taught, it, it did lead to some situations where their practice was not up to the standard that it needed to be, it was more difficult than to challenge and to help them realise that they needed to up their standard…., , so I was able then to develop the skill to still develop that rapport but have it more as a team player rapport then "let's be friends" and it was really important to distinguish between being friendly and being friends.. in order to ensure that you could challenge students at any time".

Experience and exposures then help to develop transferability of skills to perform and fulfil roles or specific duties, as well as consolidate and disseminate knowledge through varying means to others. If this is a commonplace action for an individual, it also helps to build confidence and competence within this process. Although this was typically spoken about in relation to the preceding mentorship course, the removal of the mandatory, theoretical component in favour of optional practice guides (NMC,2018e) leaves Priori knowledge and experience as a primary source of knowledge to act and fulfil the roles of practice supervisor and/or practice assessor in the practice learning environment. For Participant 1, this process stemmed from having an effective mentor who assisted them as they formed their understanding of the mentor, or sign-off mentor role, in congruence with a mandated course, as shown in the quote below:

Quote from Participant 1 interview transcript:

Participant 1, PIC 1:

"I think I was quite lucky because years ago there were a lot more staff, so I erm was lucky enough to have a good mentor when I started and I saw how things were documented, what sort of processes they did, what sort of expectations there were, erm and then I went on a mentor assessor course and I had senior staff that if I had any queries I could have like and discuss with them and now we've got the practice placement managers so you never felt alone to deal with a student…"

In some ways, this was emulated in Participant 2's experience, as they recognised the importance of having "good" staff to support their practice. Furthermore, there was a link between being a "good ward manager" or a "good sister" with the experience they had accumulated in the practice learning environment and drawing from their experiences to inform their actions and decisions. On the other hand, as the following quote states, being able to reflect on their own time as a pre-registration student was also a key factor that influenced their ability to meet the role requirements of being a mentor:

Quote from Participant 2 interview transcript:

Participant 2; PIC site 2:

"…I didn't really have any support with how to be a mentor at ward level, or at clinical level. What I did have was, if I was having problems, you know sort of…. what do I do? – I had a really, really good ward manager, and a couple of really good sisters on the ward so I would talk to them: so I used to go to more experienced colleagues. Erm, but really it wasn't anything formal that helped me in developing that mentoring ability or in the ability to mentor students erm, so I don't really feel I had guidance on how to be a mentor, apart from, I would say the main learning guidance was actually my experience was having being mentored and what worked and what didn't work for me: so nothing really official I don't think……"

Quote from Participant 1 Interview Transcript:

Participant 1, PIC 1:

"..I think it's got to be somebody who's understanding of the students' needs but also understanding of them as an individual. I think it's got to be somebody who's got experience and exposure into what they're actually trying to teach. In an ideal world, it would be someone who had a good mentor in the first place, because I think you can pick up a lot of good attributes from that. I think it's having support and a good group of colleagues that are all mentors who you can actually discuss things whilst not taking preconceived ideas from someone else…"

From the cumulative interpretation of quotes thus far, it is possible to state that emerging concepts within the data suggest that individual attitudes to pre-registration supervision and assessment rely on Priori knowledge, but due to its individualised nature, it has indefinite potential to shape what current and future registrants feel is important to embody as a practitioner, or as the future healthcare workforce. From a decision-making perspective, both approaches to learning culture and a registrant's clinical expertise can also influence how preregistration students are encouraged to link their exposure to different specialisms and facets of nursing knowledge throughout their care. This then shapes their ability to adapt care based on the patient's conditions (Lawton and Turner,2020), comorbidity, age, or acuity. From a national perspective, this, in turn, shapes how ready the current pre-registration nurses are supported to meet the requirements of the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) and are prepared to help others do the same.

For some, such as participants 2 and 9, the ability to mentor was accompanied by their ability to reconcile with suboptimal learning experiences or self-described trauma. This was perhaps most poignantly shown in the following quotes:

Quote from Participant 2 Interview Transcript:

Participant 2, PIC site 2:

"so I had some negative experiences in my first ever placement as a student nurse that I swore I would never do to somebody else. At the same time, I also learnt a lot from that placement and I enjoyed it so, but it's funny it's the negative things that stand out…. I can't remember something positive she taught me but I can very much remember those negative, humiliating experiences that I had. I also erm, had mentors on other placements, which made me want to leave nursing"

Quote from Participant 2 Interview Transcripts:

Participant 2, PIC site 2:

"From my perspective, I had very mixed experiences of being mentored when I was a, a student nurse, erm, so I had, My first ever placement I had a, erm, quite a strong character of a care, looking after me, or I should say mentoring me: who really didn't understand that I had no healthcare background whatsoever and who got very angry with me when I didn't know how to empty a catheter: which was very humiliating given that it was done in front of the patient. She also erm, humiliated me in front of the patient …,"

Subsequent parts of the interviews have led to detailed descriptions that demonstrate a wish to empower others in ways they had not experienced, and, therefore, improve existing learning cultures in the future. Some of these, in participant's 2 and 9's perspective, include the formation of feedback, appropriation of prior knowledge or experience, and how learning can be improved in an appropriate place to avoid embarrassment or actions that could lead to a lessening of a patient's confidence:

Quote from Participant 2 Interview Transcript:

Participant 2, PIC site 2

"…I was sort of laughed at by the staff, and so the negative experiences are what have really shaped my practice as a mentor for student nurses that "you don't need to teach that way, and that is not the way to teach" that… the positive reinforcement, the praise and identifying what they're doing well actually works because they're the mentors that I had that I remember the most: The ones that would say you know…

"You've done this part really well, this is the bit we need to learn a bit more of"…"

This correlates with existing literature in the sense that former mentors held a position of significant influence (Ball,2017; Rooke,2014), but that this influence can have a positive and negative connotation for peers and pre-registration students in the surrounding practice learning environment. As an overview, it also explains how parts of the literature drawn from at the beginning of the thesis recognise the disparity in the learner experience and accounts for varying amounts of pre-registration student satisfaction in their placement environments (Gale et al.,2016). From several points within Participant 6's interview, individual attitudes displayed as part of former mentorship process not only creates a rippling effect in how other people will be supervised and assessed in the future, but also how they have tried individually to remind existing members of staff to consider their own progression to the point of registration and how it related to "The Code" (NMC,2018b) in the quotes that follow:

Quote from Participant 6 Interview Transcript:

Participant 6, PIC site 4

"…and equally reminding sometimes that the colleagues that they're working with that you're actually their role models, you know they're aspiring to be like you and having that balance will, well actually if… if they're see you acting like this: how, you need to reflect and making them aware that their behaviours will impart and have that impact on the student learners experience just as much as the clinical stuff they are teaching them…. [pause]"

Quote from Participant 6 Interview Transcript:

Participant 6, PIC site 4

" If you haven't got that, philosophy or ethos within the team, its, which you can physically see, almost physically feel it can't you, when you walk into an area erm, the students will know that and make their minds up within 10 minutes what kind of placement experience they're going to have because the response their getting "oh I haven't got time to show you today, can you go and work with the HCA's….. can you escort, can you go and do this….." – anything to avoid a student asking them a question or working or showing them something, because perhaps that's how they were treated, I don't know, or that's the culture within that, that department…"

Quote from Participant 6 Interview Transcript:

Participant 6, PIC site 4

"Erm I've had assessors who have actually said to me "I don't want to work with students anymore because they you know …. And just one experience: a negative experience with a student has caused them to feel unwell and have time off work: it's been too, too overwhelming for them because of that decision making process that's, that's so important and taken on board all of that stress and anxiety erm…."

Quote from Participant 11 Interview Transcript:

Participant 11, PIC site 6:

"and again I would remind them of 9.4 of the code hasn't changed. Back to everything's changed really…. You know we have always had a responsibility to our students at the point of registration under the code…being their supervisor: yeah, you know that is an added responsibility but also….. you know it's, it's not, it's not hard line saying this is what we expect of a supervisor, yeah there are things we expect of a supervisor… actually you're a registered nurse, you are talking to another registered nurse about how they… or a student registered nurse about your practice and what you're learning"

It also has the potential to underpin a longstanding attitude that can span across different clinical team members and makes supervision an entirely subjective process that relies on a balance between technical and non-technical characteristics, as informed by Participants 4 and 11's transcripts, who advocate for equal weighting in a person's repertoire of skills or proficiencies:

Quote from Participant 11 Interview Transcript:

Participant 11, PIC site 6

".. : Erm as well as they've ever been as I feel is my answer erm because erm, they're very focused on the erm, on those practical skills… really interesting because everyone used to get really freaked out about Annexe B skills: I used to freak out about Annexe A skills; Never have I met a preceptees whose said "I can't get my cannulation signed off Okay, not once….. They've all been very motivated "yeah, it's cool… I can do this" Erm every time I met a preceptee they see "a clinical support worker won't go for coffee when I ask them" those, those levels of erm, or skills, learning of erm managing, working within teams are the ones that preceptees have and possibly always will erm, will struggle with. Erm I think annexe A recognises that, and that's one of the good things that the erm, the erm, the new proficiencies are recognising those as actual skills. Erm and certainly reflecting back on my ward manager erm those are the skills I valued more so than the ability to cannulate or not…. In all honesty [Short pause] …"

Quote from Participant 4 interview transcript:

Participant 4, PIC site 3

"I think it's being approachable, having really good communication skills in order to get down to a student's level and unpick exactly what's going on: because sometimes a failing student's got that much going on at home and other things: it's not just the assessment that's the issue. So having some empathy towards the student's plights: some staff have forgotten that. I've seen a lot of students come and go and become supervisors themselves and had to remind them that they were a student once: I don't know where that period is where: we used to call it "Staffnurseitis" when I was younger…"

However, these should be proportionate to professional characteristics and supported by suitable amounts of clinical expertise and accrued experience to either understand the preregistration student or meaningfully reflect on their experiences to enhance pre-registration student experiences:

Quote from Participant 2 Interview Transcript:

Participant 2, PIC site 2:

"…. All of these things as a student nurse yourself, you would have experienced, so I think you've got to, it's not necessarily empathy but it's being able to reflect back and remember what that experience was like for you and it's not about putting yourself saying "this was my experience, therefore it's yours", but it's about acknowledging that they will have a wide range of issues going on in their lives and that their not a student automaton, they are living, breathing people that need our support and need our help and they're working in a very challenging, stressful and emotive area….and we need to reflect back on what that felt like when we were new to it…. So I think that's, that's the one, the key things is being able to reflect back and remember…"

This led to discussions surrounding the time it takes to feel prepared or ready to fulfil a role such as the preceding mentor role. Again, in line with the literature and participants' 2 and 7 experienced this - it took about a year to feel fully embedded in their role and then feel confident enough to teach, each of them has reflected on this in extracts below:

Quote from Participant 2 Interview Transcript:

Participant 2, PIC site 2:

"…it took me a year, after qualification to feel that I was now a nurse, I knew I was a nurse but, it took me a year after qualifying to really feel that I could, not that I could do it, because I was doing it, it.. to really feel settled in the role, to feel that I was definitely settled, that I definitely felt secure in my understanding what that particular ward needed me to do because you know, you train in different areas, and I was lucky that the ward that I got a job in took me off my final placement early and moved me to them and I'd worked with them in my first, second year as well, so I did know that ward, but even knowing the area and the team it still took me a year to really feel confident I what I was doing and knowing that I was doing things the way that they should be done in that environment… …"

Quote from Participant 7 Interview Transcript:

Participant 7, PIC site 5:

"I think it varies, I probably felt confident to be I suppose a mentor, a sign off mentor originally when I was more established in my own role erm, I think perhaps after I had a year of having my role and developing, I mean Im going back about 40 years now [laughter] perhaps [more laughter],it's a long, long time ago so erm, I think perhaps, after id been qualified at least a year, then I felt more able to support students, but the mechanisms of supporting then it was very different to what it is now…."

It was also noted by Participant 7 that since the removal of the SLAiP course, and subsequent removal of the mandated course to become a practice supervisor and/or assessor, registrants were worried about the accreditation of their skills, as demonstrated in the quote below:

Quote from Participant 7 Interview Transcript:

Participant 7, PIC site 5:

"…I have or that has been picked up from practice erm and by ourselves is that the previous programme, the SLAiP programme was an accredited programme and so you had to take, I think 12 weeks erm preparation and then you had an assessment at the end and then you had either 10 or, it varied depending on the various universities but it was either 10 or 20 credit module, so that's something that staff could actually use erm for their personal development. With the new SSSA standards, the erm transfer from Practice Assessor, sorry the Practice Supervisor to the Practice Assessor isn't accredited so I think now staff are now having to identify another way of getting those accredited, accreditation really…"

However, based on the literature, a bridge between the preceding SLAiP course and the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) could be reached through the desire to mandate formal preceptorship, as recognised in a survey partially funded by the Nightingale Foundation (Mitchell,2022a), and is referenced on page 20 of the thesis. This is suggested as it would give registrants time to imbed themselves within a role, become established in core aspects of their role, and informally offer additional support beyond the "hour" or "two hours" that is offered by Trusts as formal training for the role.

6.4 Conclusive discussion for sub-categories and why this links with language and terminology.

The multitude of factors that shape an ability to reflect on prior experiences as a preregistration student and how this has shaped their decision-making and ability to act as a former mentor or sign-off mentor. Experiential knowledge is a significant source of knowledge that pre-registrations have exposure to during their training. However, the transition from student progressions to the point of registration prompts significant introspection so that individuals can meet the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) in their current format. However, addressing the preidentified lack of training and awareness of the *Future Nurse* standards may undermine what existing registrants can support as part of the new processes. As suggested, an automatic transition from mentor to practice supervisor or practice assessor does not necessarily reflect the need to use appropriate language and terminology to empower individuals, explain how evidence-based decisions have been made, and how pre-registration students can benefit from constructive advice.

Furthermore, feedback and exploration of prior learning also advocate for being accessible, transparent, and, in time, resolving the “toxic” learning culture that has been alluded to in some of the participants’ experiences. In congruence with the literature, this has included attitudes and perceptions to learning, failing to make the student feel empowered or orientated in their environment (Al-Niarat et al.,2019). Given the impact and potential effect this has on preregistration students being ready at the point of registration to practice, this is an area that AEIs and PLPs may be able to collaborate on further, as practice learning environments and use of taught content rely on individual awareness and emotional intelligence, which would either perpetuate or change existing cultures, encourage student self-empowerment, and create a consistent sense of quality. For some participants, this extended to further interpretation of their clinical role and corresponding responsibilities during the ‘sign-off’ process and how robust the decision-making process is of registrant nurses during the supervision and assessment process.

These additional findings prompt the research to highlight Category Two's key findings, which are:

1. Managers of registered nursing staff do not necessarily understand the nurse's role before the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c;NMC,2018d) were implemented. Still, they have altered the daily responsibilities of a registrant without a body of evidence readily available within the public domain.

2. This research confirms that the most valued form of knowledge amongst nurses is experiential and heavily informs pre-registration supervision and assessment, as there was existing precedence within the SLAiP standards for this to occur. While this may promote the removal of a mandated course, there is reason to believe that a preceptorship period, of up to 12 months, could be needed for registrants to imbed in their role and then fulfil the role of practice supervisor and/or practice assessor.

3. There is no evidence or stated time period which explains how much time or experience a practitioner needs to gain between becoming a practice supervisor and practice assessor – this may prove detrimental to the sign-off process and may be worth consideration and review.

4. There may be a need to review adherence to the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d), with a view to explore if they are fit for purpose in various settings and encourage the entire lifespan working in practice learning environments.

5. There may also be a need to audit the use of formerly "advanced skills" (Brown,2017; Peate,2018; Welyczko,2020) used in practice learning environments, including the maintenance of a skill once it has been achieved, and how confident individuals feel to use these skills in practice learning environments once they are registered.

6. The research reveals that AEIs and practice learning partners may wish to explore how newly registered nurses have been trained using the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) and if their format sufficiently prepares them for fulfilling the roles of practice supervisor and/or practice assessor at the point of registration.

From this final category, the following figure indicates some of the keywords that have emerged from the analysis of the transcripts and the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) documents.

Figure 6 - Keywords generated from interpretation of the transcripts and the Future Nurse standard documents (NMC,2018, 2018a; 2018c; NMC,2018d)

Consideration of literature, the Standards of Proficiency for Registered Nurses (NMC,2018a), the *SSSA* (NMC,2018), and most importantly, the interview transcripts, have influenced the theories accessed and adapted to underpin the conceptual framework. These have included the ability to become proficient and able to work at a realigned level of skill from the point of registration, to lead effectively, and to manage change as a pre-registration student education embeds the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) in parallel with existing registrant's efforts to adapt and fulfil the new vision for nursing practice.

Chapter Seven:

Justification and presentation of the conceptual framework.

The theoretical and conceptual basis for this study places great emphasis on legitimizing the voices of all participants in relation to existing theories that help to underpin preregistration nursing education and training. Based on an adapted application of Cons. GT theory (Charmaz, 2014), and what I have discovered from emerging themes from the data, there is also a need to demonstrate how a conceptual framework has been justified, has remained grounded in the lived experience but was authentically styled so it represents an original contribution to knowledge. This extends to the acknowledgement that although the structure of the thesis (see Chapter 1) is unconventional, the stylisation of the thesis not only justifies the methodological approach to the study but links to how the conceptual framework has been developed in conjunction with the management of my own positionality as a continual process. In some cases, this includes how I have appraised to overall nursing context in post post-Coronavirus pandemic age and how this directly impacts the provision of pre-registration nurse education.

Initial justification as to how the thesis and findings have followed the participants' narrative and its interpretation is demonstrated as the findings have been introduced throughout the key findings and how the formation of consolidated, focused codes have subsequently informed the analytical categories presented in the thesis.

The immersion and interpretation of participant experience extended unanticipated themes and concepts also challenged my ability, as a fairly new registrant and researcher to orchestrate and continue to interview from a neutral position. Some of this included using active listening skills without interruption at potentially contentious points that the participants put forward. It was also a gradual process to develop my role as a researcher and the curiosity it fostered without being intimidated or changing the interview's nature in the face of more senior officials. A more explicit example of this was when participants stated that they felt that AEIs had allowed partnership working to partly dissolve, which had perceived impacts on the pre-registration student and PLP working and relationship management.

While I do not believe that this was intentional, it is possible that due to the emergency standards (NMC,2020a), subsequent revisions (NMC,2021a) and arrangements regarding redeployment during the peaks of the pandemic, communication could be broken with some pre-registration students. This could then lead to lead to frayed ends

from the pre-registration student's perspective and breaks in the continuity with PLP and AEI information and, therefore, their overall practice learning experience, as is strongly featured in the participant's lived experiences shared in Chapter 6. The competing factors also tie into considerations of the literature and findings from the study have been drawn from the preface (see p.14), elements in chapter one that compare and contrast literature between the SLAiP standards (NMC,2008; RCN,2015) and the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c;

NMC,2018d) which link changes to continuity to the factors as mentioned above between more pre-registration pathways requiring placement opportunities, closure of placement opportunities and additional stressors that were both initiated and exacerbated due to the pandemic, chronic short staffing and readiness to act as a former "mentor", "sign-off mentor" and now as a Practice Supervisor or Practice Assessor. Although I acknowledges that changes to pre-registration nursing education at a national and strategic have tried to address this in line with government targets by removing the cap of students that could be allotted to a cohort of pre-registration students, have increased the amount of simulated learning hours that can be used to supplement learning experiences in the practice learning environment and diversify opportunity and exposure to skills and procedural elements required in their training (West and Bender 2023; Department of Health and Social Care and Health Education England,2022), there is a still an obligation to provide opportunity for pre-registration students to work in the practice learning environment, care for patients in real-time and have a practical understanding of nursing in a social, political, historical context and respond appropriately. It may be suggested that that while remuneration, introducing simulated exposures and removing the cap on how many nurses can be trained at any one time may look like effective measures and theoretically increase numbers, ensuring pre-registration students gain effective learning experiences within the practice learning environment while being supported by suitably trained professionals who understand the assessment methods remains problematic. By extension, this also problematises the effective use of the *Future Nurse* Standards, and their usability and moves beyond them being something to be realised instead of aspired to, as recognised in the following quote from Participant 8:

Quote from Participant 8 interview transcript:

Participant 8, PIC site 6:

"see them as an opportunity, don't fear them. You know don't see them as a stick to beat people up with. See them as an opportunity to grow with… you know again it's this perception of the NMC: you know if you do something wrong OH MY GOSH! You know the world will fall in and you'll find yourself in front of FTP: its more that changing the narrative, see them as something to be proud of and what you want everyone to aspire to…"

Based on the findings of the literature review and the findings chapter, at the point that the literature reviews were conducted, there was a limited amount of formal literature available which discusses the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) beyond the introduction of the Practice Supervisor, Practice Assessor and Academic Assessor Roles and that these standards replace the 2010 Nursing Standards for education (NMC,2010) and accompanying SLAiP standards (NMC,2008; RCN,2015). This not only alters the wider public awareness of changes made to pre-registration nursing education but gives existing registrants a limited choice but to go to the standard documents and the optional practice guides (NMC,2018e). While this helps to reduce informal discussions and use of information from selectively written sources, as the participants have alluded to, many nurses did not understand, have an awareness, or have the training to translate their prior experience as a mentor or a sign of mentor to the fulfilment of the current roles and duties listed in the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d). This then created a tangible disconnect between the regulator's vision for pre-registration nursing, what they should be able to demonstrate at the point of registration and what the role of a registrant entails. If unaddressed, this mismatch has the potential to create dissonance and undermine utilise the current standards based on the language and terminology used and a lack of familiarity with how the *SSSA* (NMC,2018) and Standards of Proficiency for Registered Nurses (NMC,2018a). By extension, this could, therefore, lead to a lack of accessibility for all and impact on the pre-registration nursing students' experience. This, too, comes from analysis of the

data and individual participant transcripts as the segregation of participant groups, as demonstrated in Figure 3 (see p.153), led to the comparison and formation of 34 initial themes which were classified as significant (10 entries or more in a singular interview), but only two that were unanimously generated for all participants when comparison of generated themes took place as a partial example is shown in Appendix 10 (see p.319-322). As demonstrated, there is a noticeable amount of agreement between the participants. This was not the case when other groups were compared, which could indicate that the lived experience of supporting, supervising and assessing pre-registration students creates greater subjectivity as recognised within the literature, methodological underpinnings of the study and is disclosed experiences and acknowledgement of positionality throughout Chapter 3. As noted in the literature and lived experiences that this thesis draws from, subjectivity in the practice learning environment can also create varying levels of quality experience that pre-registration students are exposed to (see Chapter 1). As mentioned in the literature, this also can be measured by the learning culture present, or if it is considered “Toxic” (Feeney and Everett,2020:43) and why participants themselves acknowledge its impact on them as registered professionals, their conduct with preregistration and the observations made on others (see Chapter 6).

Other aspects recognised within the analytical categories indicated that for other participants, it was important to match an understanding of the role with the ability to provide realistic and appropriate opportunities for the individual student's study stage. However, some felt that they needed to further develop some of their own skills in recognition of the fluid and changing environment of placement areas, as advocated for in the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d). Although government targets are to increase the nursing workforce and there is some discussion around financial investment in the NHS (Lateef, 2023), until a review beyond the Harlow Consulting LTD and Transverse report (2021) and Transverse (2021), the effects of implementing the Standards of Proficiency for Registered Nurses (NMC,2018a) and associated annexes (NMC,2018:pp 27-37) cannot be fully known and if the changes to a baseline level of skill or procedural knowledge are truly justified, is utilised in the way that NMC envisioned and if the skills or procedures within the annexes are commonly offered in all fields of practice and to

all ages as desired. It is also unknown at this point; in practice, learning environments have “changed policy” or if they intend so that skills and procedures can be achieved and maintained once a person is deemed proficient. To some degree, this too featured in the theoretical elements of the thesis, particularly when the role of the mental health practitioner is considered and global evidence captured on page 25, which considers the implications when generic practitioners deliver specialist care, treatment and advice and the experiences of participants who discuss the benefits of cross-professional working (see Chapter 6) in comparison to limitations that preregistration students may exist. As an additional consideration, as recognised within the thesis, the AEI can set the nature of proficiency and knowledge, and PLP can be determined through local arrangements. However, this may not be the same as where the preregistration gains employment once they have joined the register. Based on this, I have troubled over how new registrants will be prepared to meet “Article 15(1) of the Nursing and Midwifery Order 2001 (‘the Order’) requires the Council to establish standards for education and training which are necessary to achieve the standards of proficiency for admission to the register” (NMC,2001 in NMC,2018b:4).

An unanswered question featured in Participant 8’s interview (p.188), which discusses investment in existing registrants, the same can be asked of international nurses, nurses that work using a flexible working/nursing bank or agency provision, as it is unclear who is responsible for ensuring they too can access training and opportunity to develop and therefore meet the standard expected of all registrants.

The development of the conceptual framework also considered that although circumstances like short staffing represent a chronic issue, the potential for incomplete understanding and awareness may lead to registrants assuming supervision is taking place with one member of staff or another. As it also removes the potential to observe using the 1:1 pre-registration supervision model more strictly, the change initially prompted dislike and resistance to change, which may be partially due to the lack of understanding. However, dislike of the *Future Nurse* standards and concerns about adequate supervision for pre-registration students, time to train existing staff, and, in some instances, the inclusion of specific skills or proficiencies were transferable amongst three of four participant groups and therefore warranted investigation.

These key elements of the study's findings have informed the development of the conceptual framework. However, to support this, it is necessary to draw from existing theories that focus on initiating and sustaining change and consider the steps individuals should take as they gain exposure and experience in the practice learning environment.

The first of these theories is the ADKAR model (Hiatt, 2006), so named as it focuses on five key areas, which have been broken down into:

1. Awareness of the need for change;
2. Desire to support and participate in the change;
3. Knowledge of how to change;
4. Ability to implement required skills and behaviours;
5. Reinforcement to sustain the change.

(Hiatt,2006:2)

This theory was chosen as a model for theory as it links to different stages within the change process and surrounding factors that can influence the success of embedding a new way of working into practice learning environments. It has been trialled in areas linked to business, the American Department of Defence, and has an established course accessed by hundreds of businesses (Hiatt,2006). The ADKAR model also has established precedent in education as it has been used to amalgamate courses offered by different AEIs that have subsequently merged and had to establish a shared identity instead of working as silo institutions (Pawl and Anderson,2017). It, therefore, seemed a good fit to initiate the change as outlined in the conceptual framework.

The need to sustain these changes post-implementation is also a key aspect of introducing a new way of working. This requires leadership to encourage, reinforce, and be a source of knowledge for others regarding change. It may be argued that this stage of the process is just as important as the change itself, as adapting long-standing practices, in particular, is not often a freely considered aspect of practice but is instead implemented and enforced (Hiatt,2006; Pawl and Anderson,2017). As such, there is a

need to not only introduce a change that makes sense to those affected by it but also to continue using a new model and evaluate its performance to ensure efficacy. This, in turn, allows individuals to note the benefits and limitations of a newly proposed way of working. However, for this too, to be effective and relational to the wider process, there is also a need for individuals to have sufficient levels of self-awareness to understand their interpretation and their reaction to change. They also need the necessary desire to embrace a new way of working and to have the ability to carry out what is being asked.

When more specifically related to nursing, practitioners who formerly mentored and assessed pre-registration students in practice learning environments were required to develop technical and non-technical skills in equal measure, particularly as both have value to service users and help to shape care (Straughair,2019). This also influences the ability to lead and develop personal characteristics and autonomy, which shape a professional role as recognised and inspired by Patton's four principles of leadership (Williamson,1982). This is reasoned as the four principles which are featured as part of this leadership model encourage the development of an individual through Command and Management, Good Health, Making decisions, and Success (Williamson,1982), which underpin some of the actions clinicians may undertake to fulfil the ADKAR model (Hiatt,2006). It also complements parts of "The Code" (2018b) and the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d), which emphasise the need for a practitioner to be aware and escalate concerns about their, or someone else's, safety (NMC,2018b) as well as "be emotionally intelligent and resilient individuals, who can manage their health and wellbeing, and know when and how to access support" (NMC,2018a:3). It further extends to the regulator's stipulations that if there is a need to delegate work or responsibility, this should be rechecked for completion and ensure that the task given to someone else is appropriate for them to do (NMC,2018b).

It may also be suggested that the participants' lived experiences have often referred to a change in how they practiced, once established, and made conscious decisions to avoid repetition of suboptimal support or Mentorship of students while adapting to the student's needs. This would suggest that there is a clear sense of growth, development, and progression that defines milestones in a practitioner's career, which

naturally lends itself to Benner's Novice to Expert theory (Benner,2001), which describes the stages of learning and point of proficiency that practitioners may aspire to get to.

In summary, the combined use of these principles and theories will be individually discussed in more detail but then adapted for use in this study, and their relation to the conceptual framework and recommendations that have shaped it.

7.1 The ADKAR model

Although Hiatt (2006) has identified five key pillars that form the model, more can be said for what each of these involves from a theoretical perspective and then be interpreted for use within practice learning environments, given what has been discovered and subsequently recommended.

The first five pillars on which this model is based surround the need for awareness and why something needs to change, what drives or motivates a change in practice, and how this is justified to a wider audience. Developing this awareness also prompts practitioners to acknowledge and develop their understanding of nuances and complications associated with change or new practice.

7.1.1 How has this theory been adapted and remains relevant to this study, Practice Learning partners, and AEIs?

As alluded to in the introductory literature (see Chapter 1) and literary objectives (see pp.3054), there was little evidence in the public domain which substantiated the need to change or move away from the Mentorship (NMC,2008; RCN,2015) model of student support and assessment. Furthermore, the participants' lived experiences did not provide any greater strategic insight that justified changes to the nursing curriculum or practice supervision and assessment.

This somewhat contradicts the limited available evidence, which warns practitioners about the automatic transition from mentor to practice assessor (Hunt,2019), as it does

not address the existing failing-to-fail culture (Black,2014; Duffy,2013; Hunt,2014) that still exists in nursing.

However, none of these sufficiently answer the model's questions:

- **Why is this change necessary?** There is no significant evidence base that justifies the nature of the changes made under the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d). In some cases, the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) are not seen to enhance the profession actively but do increase placement capacity and several bodies available to supervise and contribute to pre-registration supervision and assessment.

- **Why is this change happening now?** Firstly, it is unclear why separating the former mentor, sign-off mentor, and upskilling the existing workforce before changing the nursing curriculum would not achieve the same results. In addition, aside from increasing placement capacity, rolling out the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) without sufficiently preparing the existing workforce for the standard realignments may have resulted in confusion and additional resistance to their implementation.

- **What is wrong with what we are doing today?** As the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) have been referred to as something to aspire to by a person associated with the regulatory body, it is important to explicitly understand how "everything has changed, and nothing has changed." Practice Learning Partners use PAL, CLIP, and similar models, which suit their ward areas, to facilitate the *SSSA* (NMC,2018), so the pre-registration students may meet the new prerequisites for practice. This is useful as it highlights that placement areas are sometimes unique in what they offer and alter what students are exposed to. However, this only formalises what has been done within the confines of mentorship (Heath,2019) and does not necessarily lend itself to redesigning placement provisions. This also places additional responsibility on newly qualified registrants without upskilling the existing workforce by first embedding these skills and nursing procedures.

This links to the five factors that influence the recognition of change and some barriers that inhibit practice change (Hiatt,2006)

Factor One: A person's view of the current state

Adapted to: A registrant's understanding of the current Nursing Curriculum and Future Nurse standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d)

Justification for this adaptation: Hiatt (2006) recognises that a lack of understanding exacerbates fear of the unknown, or the untested, and a perceived loss of autonomy and power, or personal position or status due to an invested interest. This can also include individuals feeling like change is happening instead of feeling part of a transition and, therefore, losing part of their pre-existing identity (Hiatt,2006; Pawl and Anderson,2017). As such, understanding why a change is needed and "what's in it for me" (Hiatt,2006:9) or for the organisation if this change is fully embedded. However, as the five original pillars in the ADKAR model consider Desire, Knowledge, and Ability as key parts of implementing a change, a great deal of onus is placed on the individual registrant to have the necessary personal and professional or technical skills to adapt and seek understanding, so that that awareness may be optimised and change the nursing culture in the long term.

Factor Two: How the Person Perceives Problems.

Adapted to: Why did AEIs and PLP work together in the formats they did to address challenges that have been presented since the publication of the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d)

Factor Three: The credibility of the Sender

Adapted to: The degree of transparency shown by the regulator and reasons for why a change is needed, or how it promoted the professional image of Nursing, Midwifery, and Nursing Associates?

Factor Four: Circulation of misinformation or rumours

Adapted to: How accessibility of information encourages people to use language or terminology that all stakeholders understand and have agreed upon definitions for the reduction of misinformation or perpetuation of 'myths.'

Factor Five: Contestability of the reasons for change

Adapted to: How does the regulator work with AEIs and PLPs post consultation and publishing the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) to reduce perceived harm to patients and negative perceptions?

These factors could form the basis of a checklist that can be employed in the practice learning environment once they have considered the adaptation of Benner's Novice to Expert (Benner, 2001) and Patton's principles of leadership, which follow the conceptual framework, which, after the checklist has been completed, can help to structure preparation of pre-registration student nurses in the future to meet the needs of the public.

Conceptual framework:

Checklist and model

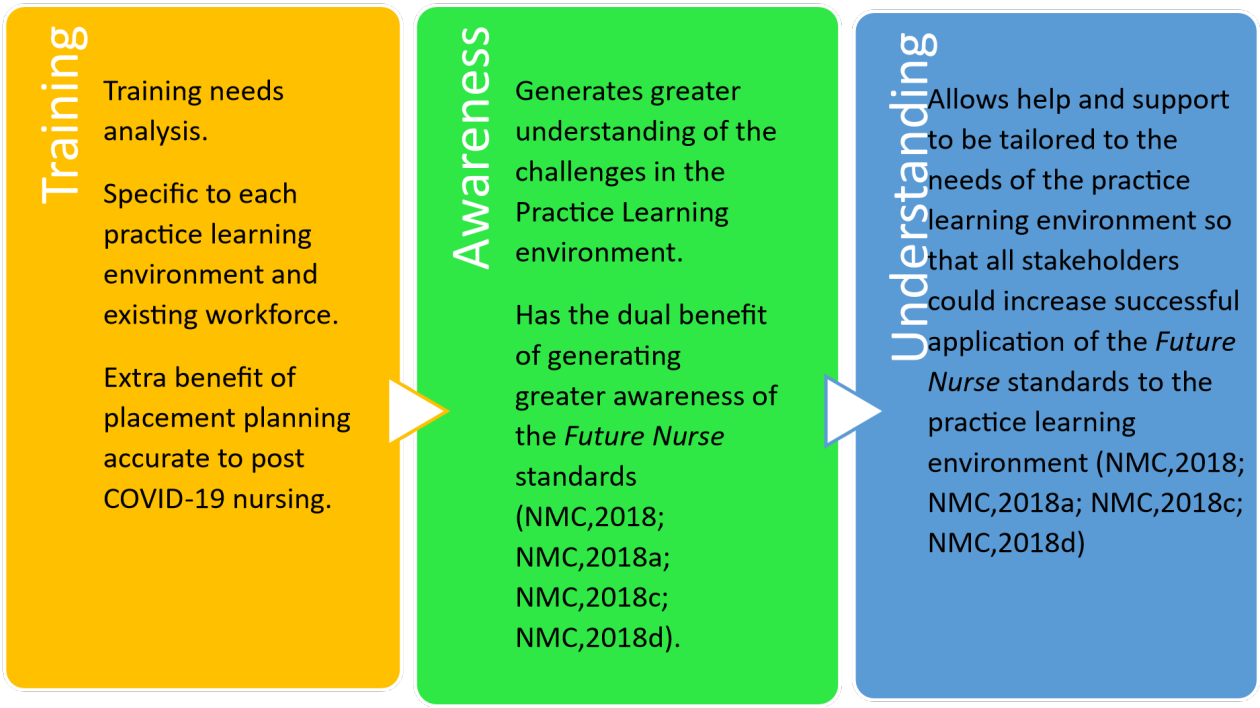
Table 16- Conceptual Model Checklist

Name of Practice Learning Environment	
Date of Initial Review	
Next Review to be completed	
Q1. How many registered staff work in this area? How many of these are permanent staff How many of these are agencies?	
Q2. How many registered staff within this area have completed: Practice Supervisor Training: Practice Assessor Training: Received an update within the last 12 months:	
Q3. Is your area able to fully meet the Future Nurse standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) in line with the following documents: The Standards of Proficiency for Registered Nurses? The Standards for Student Supervision and Assessment (*SSSA*)	**If yes, please provide evidence for both** **If not, please state why**
Q4. Based on the Standards of proficiency for registered nurses, how many of the registered staff in this area can do the following tasks: • Venepuncture and Cannulation • Obtain and Interpret an Arterial Blood gas • Interpret ECG readings • Perform Chest Auscultation • Perform PR exams	**If so, how many** **If not, why?**

Q5. Are there any of these skills or nursing procedures that you feel the University or other members of the nursing team could help your area achieve:	
Q6. Are there any skills listed above that you do not use or would not benefit your practice learning environment?	**If so, why?**
Q7. Based on the last cycle of appraisals, are any of the newly registered staff working in your area ready to undertake a prescribing course?	**If yes, how many:** **If not, why?**
Q8. Is there any current method that you use to train new registrants or existing staff about the use of the *SSSA?*	**Please explain:**
Q9. Is there any particular method you think would work in your area to help existing registrants, new registrants, or bank work colleagues understand the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) in a clear and accessible way?	
Q10. Is there anything else that you would like to say or suggest that could help prepare existing staff and new registrants for using the *SSSA* or achieve the skills and nursing procedures to the level deemed appropriate for your practice learning environment?	

From this checklist, as shown, Figure Seven below draws from identified deficits in the analysis of literature and extracts from the participant's lived experiences to consider how Training in Awareness and Understanding can optimise the use of the *Future Nurse Standards* (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) within AEIs as well as PLPs so that partnership working, as advocated for by the regulator also benefits:

Figure 7 - Training, Understanding and Awareness



To consider how this was informed, the "training, understanding and awareness" the conceptual model and checklist has also been drawn into an adapted version of Novice to Expert (Benner,2001) and Patton's Principles of Leadership (Williamson, 1972) alongside extracts from the participants and how it could be applied to each Part of a pre-registration nurses training. This can be seen below in Figures 8 - 10:

Figure 8: How can Patton's principles of leadership translate to nursing using an adaption of Benner's novice-to-expert theory and themes generated from the data? - Part One

Adaptation of Patricia Benner's 'Novice to Expert' Scale – Benner, P. (2001)

Understand the curriculum and *Future Nurse standards* (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) *in order to adequately assess* Student competency and support development as a suitable Practice Supervisor or Practice Assessor in the practice learning environment.

Adapting Patton's principles of command and management:

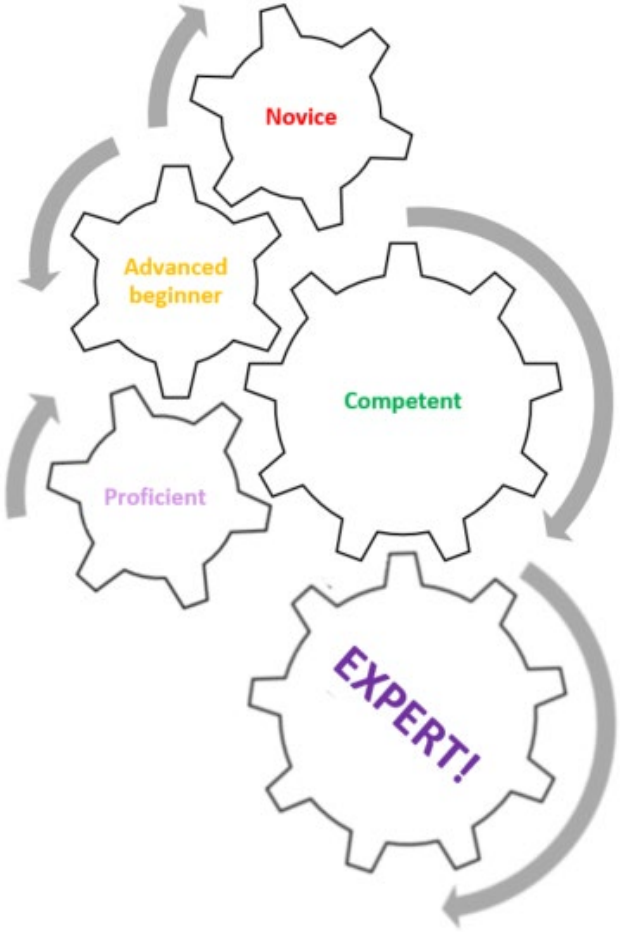
NOVICE: Ask clear questions in order to develop an understanding between you and the pre-registration student.

Advanced Beginner: Only go on to become a Practice Assessor when you are confident in your own abilities and have gained sufficient exposure to your area of practice. If unsure, gain feedback from other sources to evaluate your performance.

Proficient: Be willing to stand by your own convictions and standards of practice in order to assess without fear of recrimination and justify your own assessment of an individual students 'development in relation to their part of the training

Competent: Supervise in order to let them gain exposure to the lived experience of being a nurse within the realms of safety and be willing to offer advice about how something could be Improved/ consolidated or avoided. This can be transferred to other areas.

Expert: Repurposing the Academic Assessor role- to work partly in practice, partly in university and act as a liaison between the dedicated Clinical Units in practice, key individuals in the practice partner's institution and the AEI itself and provide exposure for individuals in practice with an opportunity to teach clinically – great for revalidation purposes and consolidation for existing workforce



How does this contribute Learning Culture?

Under the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d), there is now no set way of supervising pre-registration students and registrants are expected to use their discretion. However, in accordance with the participants lived experience and the literature this can only be really achieved:

- Once registrants feel they are ready to provide this support and what they have to share is of value.
- Registrants also need time to be confident and build their own rationale for practice.
- A failure to do this makes people feel "thrown in at the deep end and contributes to resistance, increase attrition rates, and contributes to a "toxic" learning culture.

".. I think we can overcomplicate things, but just as I said before everything has changed but also nothing has changed, nurses… it's about nursing learning how to be nurses..." **(Participant 11, PIC 6)**

So, the first step is really about,

"...Learn how to be a nurse, consolidate that, do the basics brilliantly and then start enhancing because if you do the basics brilliantly, you'll always be safe, you'll always deliver safe care. That would be my bit..." **(Participant 10, PIC 7)**

And avoid situations where:

"…Some staff don't necessarily recognise, their, their value in supporting students…" **(Participant 7, PIC 5)**

Adaptation of Patricia Benner's 'Novice to Expert' Scale – Benner, P. (2001)

Figure 9: How can Patton's principles of leadership translate to nursing using an adaption of Benner's novice-to-expert theory and themes generated from the data? - Part Two

Be confident in your adoption of the role to make specific decisions with suitable awareness and use your clinical expertise to rationalise the process.

Adapting Patton's principles of good health and decision making:

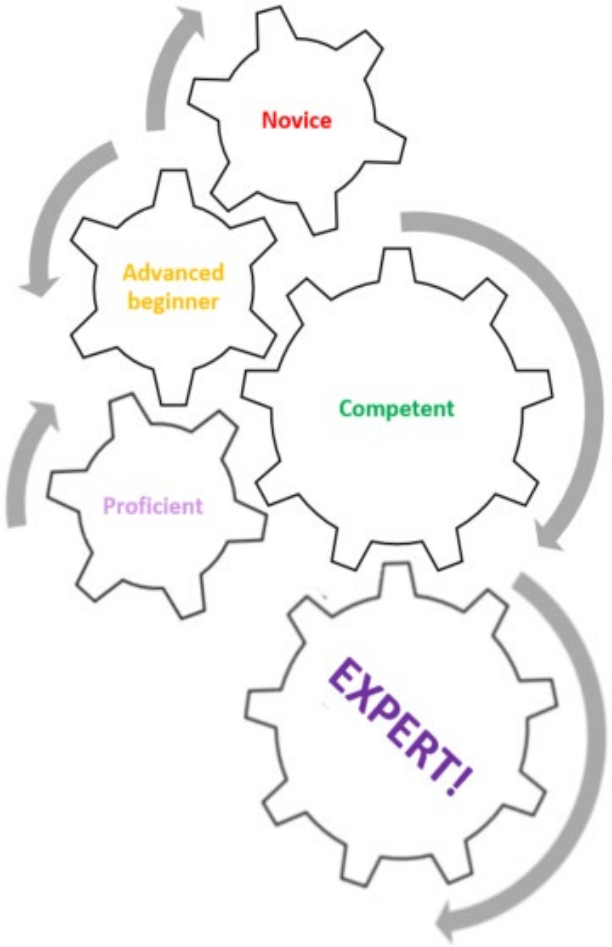
NOVICE: Be critical of your own knowledge base: Just because you are qualified doesn't mean you know all there is to know about nursing- and nor are you expected to.

Advanced Beginner: Use the appraisal of your knowledge and its limits and strengths to make a realistic plan for development.

Proficient: Be aware of your own health and well-being and know your limits of what you can provide as a registrant emotionally, physically, psychologically. Be careful to maintain the professional boundaries of the role(s) you fulfil as a team of supervisors or practice assessors. Understand the escalation processes as the Clinical Educators/ Practice Placement Managers are there to support you- not to penalize your decisions.

Competent: Use this information to inform what you share with others and how you could explain fundamental principles with practice – such as more junior students or peers of a similar level of competency. Take the opportunity to gain feedback and consolidate before you become a registrant and undertake the role of a Practice Assessor.

Expert: Repurposing the Academic Assessor role- to work partly in practice, partly in university and act as a liaison between the dedicated Clinical Units in practice, key individuals in the practice partner's institution and the AEI itself and provide exposure for individuals in practice with an opportunity to teach clinically – great for revalidation purposes and support the wider organisation. May also help to triage points of help with increased student capacity and reduced/ same number of senior support staff in clinical environment.



How does this contribute to Learning Culture?

- Understanding the support around you makes you feel more confident is asking for support.

"…I'm really honest about bringing my experience to the table when Im talking to students, you know I've been supporting my own colleagues, and students at coroners court, those sorts of erm investigation and inquiries you know just the other side of and the reality of working within healthcare…erm it's not always as rosy as, as we'd like to think, but actually most of the stuff we do in terms of training and education and, and experiences: It is very positive but it's at those times where you need that additional support students or sometimes colleagues feel like they haven't got the experience to, to deal with this and manage this on my own. So, I hope that the students can come to me, or even qualified staff can come to me and ask for my help and support with that: I see that as my role and how I can share my knowledge in practice with them as well as clinical skills and knowledge…" **(Participant 6, PIC 3)**

And avoids:

"…well, erm, I always thought that calling on them was a negative thing, but it's not like, the support that they offered the ward and student is really important so it's made me, like I've got quite a good relationship with the one at [Annonymised] and we do check in quite regularly when she's on the ward and seeing how the students are doing erm, so I see her role as a positive role not a negative "she's coming to fail the students" kind of role, which a lot of the student's kind of get a little freaked out about when they see the PPM arrive on the ward, buts she's just checking in on them normally, and making sure that they're happy that they are getting the experience that they need for their placement and that we're offering it…" **(Participant 5, PIC 2)**

Figure 10: How can Patton's principles of leadership translate to nursing using an adaption of Benner's novice-to-expert theory and themes generated from the data? - Part Three

Adapted version of Patricia Benner's 'Novice to Expert' Scale – Benner, P. (2001)

Use and appraise your own experience, perceptions of self and reflect to enhance the student experience in practice and Teaching: including provision of simulation and offering feedback and suggest or facilitate alternative models or ways of training/learning.

Adapting Patton's principles for success:

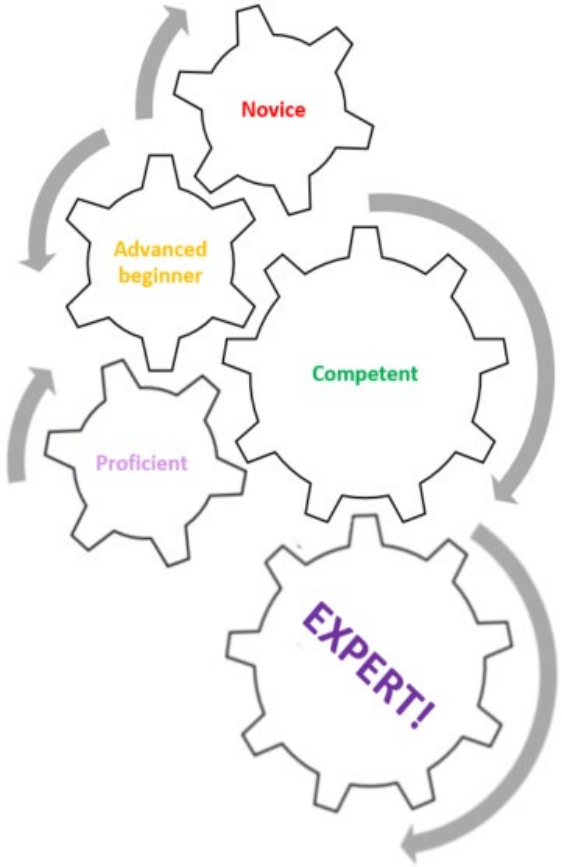
NOVICE: Take advantage of hub and spoke placements to expand your knowledge: don't be discouraged in there are one or two experiences that don't suit you- that's normal!

Advanced Beginner: Use the positive and negative experiences to consolidate and reflect on what you think creates a positive or negative learning experience? How does this relate to your development of skills and what do you think would be useful to share?

Proficient: be approachable and use the code to support your work ethic. Take the opportunity as a supervisor to look at different ways of offering support and facilitating supervised practice. This will allow you to adapt to individual students needs and potentially optimise the placement experience for them or give them critical points to consolidate on in the next "part of their training."

Competent: Use this information to inform what you share with others: What do you wish you would have known as a student earlier? What would have helped to ease a challenging area of study? How could you explain this part of clinical practice to peers or someone of a similar set of skill to you? Take the opportunity to gain and construct feedback to consolidate before you become a registrant and undertake the role of a Practice Assessor and know when this step is for you: don't be pressured or compare yourself to other people's pathways or pace of progression.

Expert: Repurposing the Academic Assessor role- to work partly in practice, partly in university and act as a liaison between the dedicated Clinical Units in practice, key individuals in the practice partner's institution and the AEI itself and provide exposure for individuals in practice with an opportunity to teach clinically – great for revalidation purposes and support the wider organisation. May also help to triage points of help with increased student capacity and reduced/ same number of senior support staff in clinical environment.



How does this contribute to Learning Culture?

- Maximising placement exposure optimises your experience and all- round knowledge and adapt to the student.

"*…I will also ask them to share with me if they've been on placements before what they enjoyed about the placement and what worked well for them, what their experience was of being mentored by somebody else…. And whether they got on with that approach or not…*" (Participant 2, PIC 2)

***"…..get exposed to the surgeries they are likely to be caring for before and after and then have a better understanding of what the patient may be experiencing on the ward and also if the patient has any questions to ask about surgeries it might give them a little more familiarity and understanding of what they're going through to be able to allow them erm, provide a little more information to the patients and their parents…"* (Participant 1, PIC 1)**

And encourage more of:

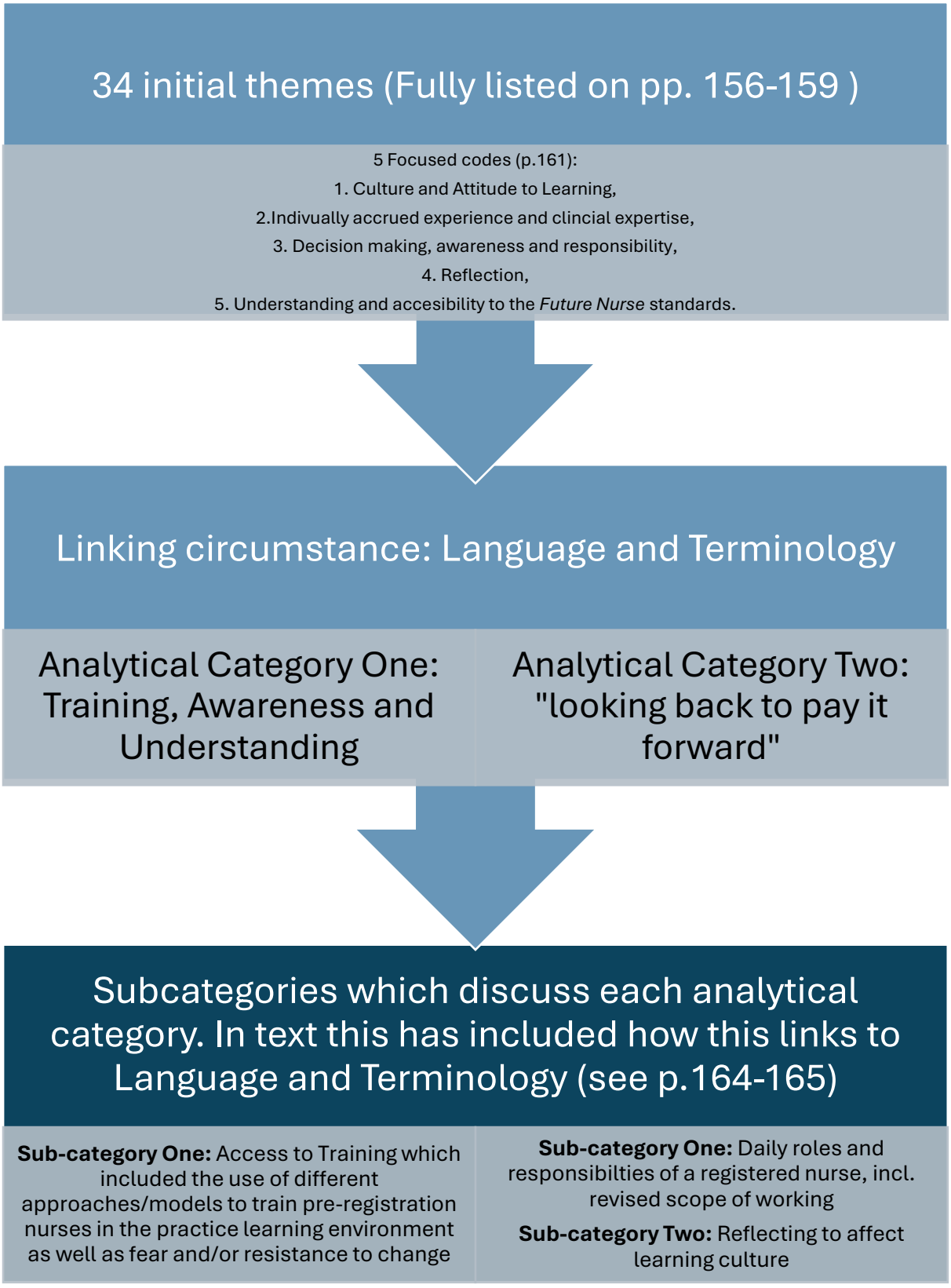
"*…I did that really well, but how could I have done it better?" you know " you did that really well, but maybe you want to think about these things " you know, always have this in your repertoire, rather than seeing it as a you know: we have lots of stories about practice assessment where the mentor would say " alright you fill in your bit, and then give it to me and I'll do it on my day off and then I'll give it back to you" you know that relationship wasn't there and that was a frequent message we got…. Erm so it's everything, everything's connected [laughter] definitely…*" (Participant 8, PIC 6)

Chapter Eight:

Recommendations and future work

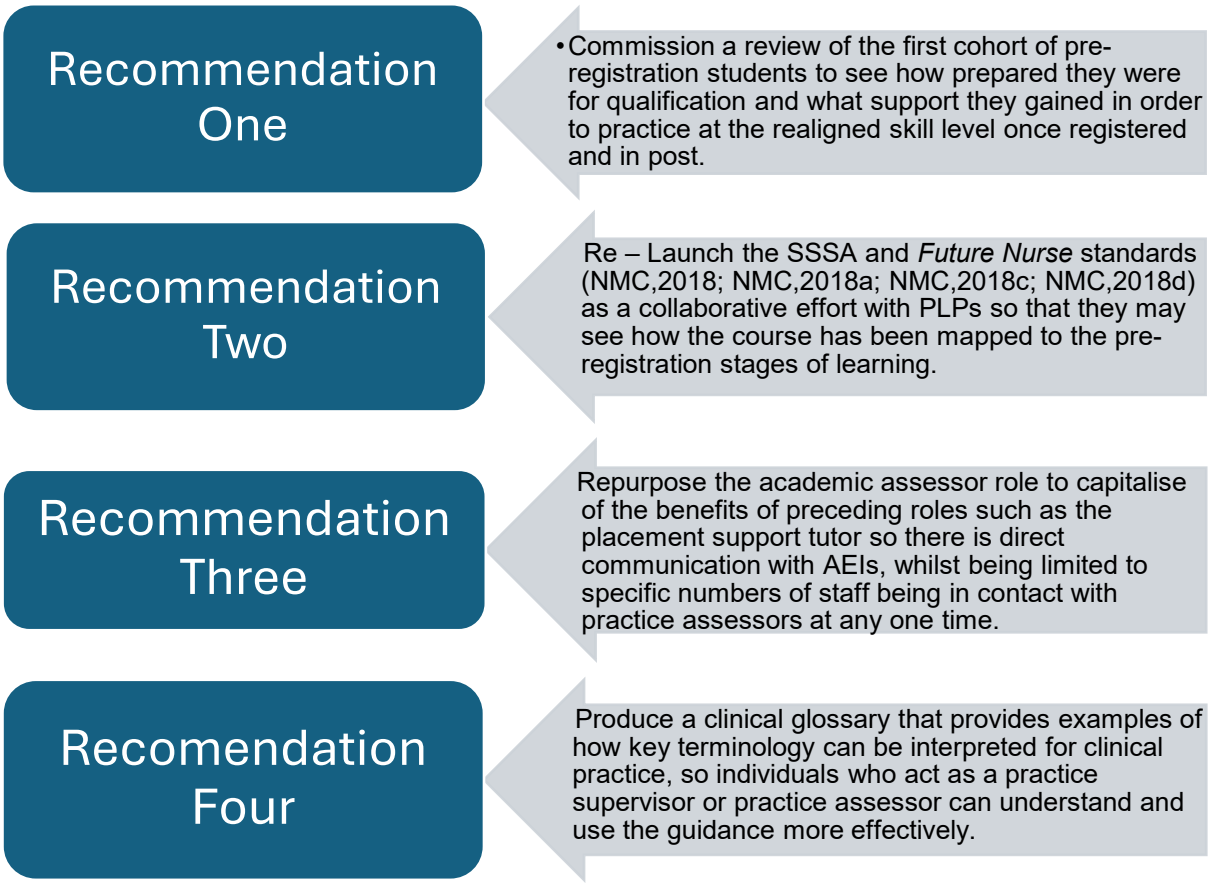
From the participants' lived experience and how this can be related to underpinning concepts that can be aligned to theoretical development in nursing, managing change and developing effective leadership, it was possible to identify almost tangible, emerging categories that were important to consider when attempting to answer the main research question of how AEIs may support pre-registration students in clinical practice using the *Future Nurse* standards. This chapter, therefore, discusses each recommendation that has stemmed from the study's findings and conclusions reached at the end of each category, sub-category, or literature review. Therefore, the recommendations are underpinned by two analytical categories and sub-categories distilled from 34 initial codes. The process of getting from 34 initial themes to two analytical categories and their sub-categories is shown in Figure Eleven below:

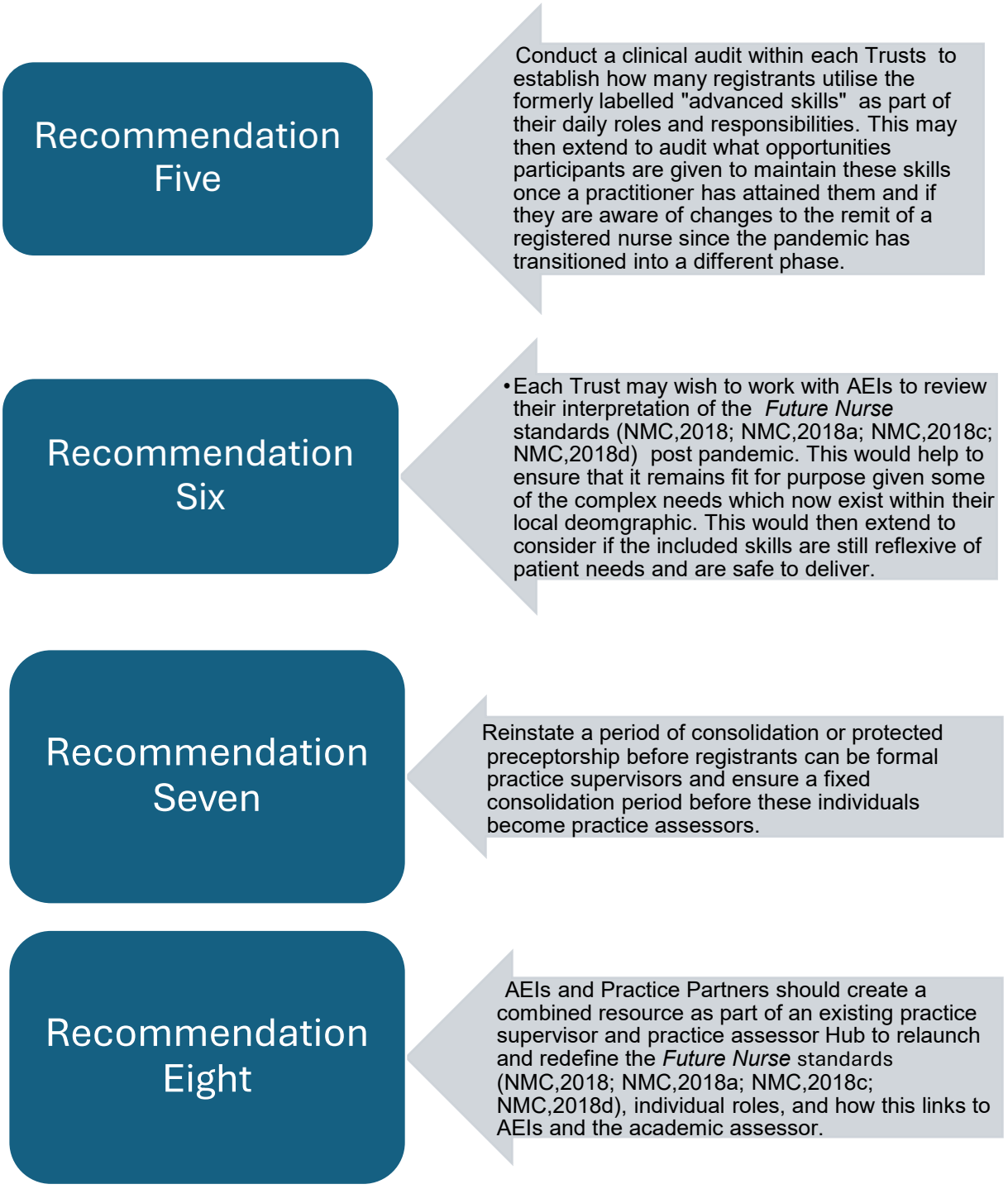
Figure 11: Where have the recommendations come from in the study?



From this process, several findings were summarised within each analytical category and lent themselves to nine recommendations for future work. These recommendations are shown in Figure Twelve below:

Figure 12: Recommendations drawn from the study





This is likely also to be altered by recent guidance by the NMC to alter the number of simulated practice hours in a pre-registration nurse's training (NMC,2023; West and Bender,2023), and this stands to also impact collaborative working between the PLPs and AEIs. A final recommendation is included below:

Recommendation Nine

Initiate a review into the impact on increased simulation hours offered by AEIs as supplementation for Practice Learning exposures (NMC,2023) to assess its impact and compare with preceding pre-registration students' learning experiences, as well as their readiness to work in the practice learning environment.

These recommendations will now be discussed in turn to demonstrate why they are appropriate and justified. It will also consider how the current evidence base supports the use of clinical audits, where appropriate recommendations have highlighted opportunities for future work.

8.1 Recommendation One: Commission a review of the first cohort of pre-registration students to see how prepared they were for qualification and what support they gained to practise at the realigned skill level once registered and in a post.

Based on the literature reviews conducted in 2019 and 2021 (see p.73-82), pre-and post-pandemic searches indicate that there is limited literature available within the public domain which discusses the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d). As these standards were implemented into the curriculum from 2019 onwards, there was a pressing need for AEIs to interpret and implement the *Future Nurse* standards within a short time frame. The start of a global pandemic understandably and significantly affected the ability of educational programmes to

continue in the planned format. This was replicated in the rescindment of placement opportunities during the initial pandemic when the redeployment of registered nurses and partial deployment of students occurred. The Emergency Standards for Nursing and Midwifery Education (2020a) were implemented and fully removed in September 2022, when normal programmes and access to placement facilities could continue if they had not taken place already. However, during this period, while research has started to look into the experiences of pre-registration nurses who worked alongside existing registrants during the pandemic (Godbold et al.;2021), it is unclear if studies have taken place which review the preparedness of pre-registration nurse students to act as a registrant under the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d), particularly as 2019 students would be the first cohorts of nursing students to qualify using these standards alone. As such, their first twelve months as practitioners who fulfil the Standards of Proficiency (NMC,2018a) and the *SSSA* (NMC,2018) will be vital to understanding the differences made between the preceding SLAiP standards (NMC,2008; RCN,2015) and most importantly, if they can shed any further insight into how AEIs may support pre-registration nurses in practice using the current, *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d).

This is particularly important as there is much emphasis on the standard documents (NMC, 2018;2018a; NMC,2018c;2018d), which not only discuss the need for a “team-approach” to pre-registration supervision and assessment but that pre-registration students must be able to demonstrate all of Annexe A: Communication and Relationship Management Skills (NMC,2018a) and Annexe B: Nursing Procedures (NMC,2018a) at the point of registration.

Without formally reviewing how prepared pre-registration students felt to become practice supervisors at the point of registration and to practice using the formerly labelled “advanced skills” (Brown,2017; Peate,2018; Welyczko,2020), it cannot be known if Participant 10’s perceptions and experiences reflect individual circumstances or could represent the norm amongst pre-registration students.

Together, these points substantiate several of the other recommendations, which are reiterated in Table Seventeen below:

Table 17- Recommendation number and detail of the recommendation

Recommendation Number	Recommendation Detail
Recommendation Two	Re-launch the *SSSA* and *Future Nurse* framework with practice assessors so that they may see how the course has been mapped to the pre-registration stages of learning. This may include wider dissemination to the interdisciplinary teams, including medical tutors/ educators.
Recommendation Four	Produce a clinical glossary that provides examples of how key terminology can be interpreted for clinical practice so individuals who act as a practice supervisors or practice assessors can understand and use the guidance more effectively.
Recommendation Five	Conduct a clinical audit within each Trust to establish how many registrants utilise the formerly labelled "advanced skills" in their daily roles and responsibilities. This may then extend to audit what opportunities participants are given to maintain these skills once a practitioner has attained them and if they are aware of changes to the remit of a registered nurse since the pandemic has transitioned into a different phase.
Recommendation Six	Each Trust may wish to work with AEIs to review their interpretation of the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) post-pandemic to ensure that it remains fit for purpose or reflective of complex needs within their local demographic and that included skills are still reflexive of patient needs and are safe to deliver.
Recommendation Seven	Reinstate a period of consolidation or protected preceptorship before registrants can be formal practice supervisors and ensure a fixed consolidation period before these individuals become practice assessors.

Recommendation Eight.	AEIs and Practice Partners should create a combined resource as part of an existing practice supervisor and practice assessor Hub to relaunch and redefine the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d), its corresponding individual roles, and how this links to AEIs and the academic assessor.
Recommendation Nine	Initiate a review into the impact of increased simulation hours offered by AEIs as supplementation for Practice Learning exposures (NMC,2023; Harlow Consulting and Transverse,2021; Transverse,2021) to assess its impact and compare with preceding pre-registration students' learning experiences as well as their readiness to work in the practice learning environment.

It is now possible to consider the third recommendation, which is linked to the question but not in such an intrinsic way, as it looks at repurposing the newly formed academic assessor role.

8.2 Recommendation Three: Repurpose the academic assessor role to capitalise on the benefits of preceding roles, such as the placement support tutor, so there is direct communication with AEIs while being limited to specific numbers of staff in contact with practice assessors at any one time.

Participants in this study clearly articulated several challenges they foresaw when introduced to the *SSSA* (NMC, 2018) and encountered when they initially attempted to use it. Included extracts also showed that even registrants with experience disseminating new guidance or updates meant they needed time to understand the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d).

From a recommendation perspective, the rationale behind repurposing the academic assessor role comes from the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d), which state that *"a nominated Practice Assessor works in partnership with the nominated academic assessor to evaluate and recommend the student for progression for each part of the programme, in line with programme standards and local and national policies"* (NMC,2018g). For AEIs, this is different from the personal tutor's role, but under some local arrangements, Academic Assessors do not have specific contact with practice assessors. However, as a potential compromise, having a dedicated team of academic assessors who do not fulfil any personal tutor role but are still associated with the university not only allows these benefits to be instilled in common practice but also enables AEIs and PLPs to more closely work to NMC guidance as illustrated above, instead of trying to fulfil a personal tutor role and an academic assessor role for other pre-registration students. Furthermore, by having dedicated staff directly involved with the Trust, better communication can occur between AEIs and practice assessors. This can also help to disseminate the combined interpretation of the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d), which can help stabilise learning cultures, lessen the fear of change, and promote awareness and understanding of a wider population.

In summary, the identification and selection of these key extracts suggest that while a change to local or national policy would remove a "risk adverse" barrier to the

performance of a skill, it does not necessarily mean that there will be enough existing registered staff to support the attainment of skill, or proficiency, with sufficient knowledge. There may also not be sufficient demand for some of the skills in an area that allows many pre-registration students to gain exposure to a skill, let alone practice and develop a degree of confidence or proficiency. It also relies on several factors, which include registrants having sufficient training, understanding, and awareness of the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) to note the differences in approach to supervision and what is now expected of a registered nurse at the point of registration.

- Registrants have the confidence, competence, and exposure to the skill themselves, particularly in light of the evidence which suggests that nurses rely on more experienced colleagues to help them form their practices and look to them for guidance, support, and advice (Ball,2017; Devlin and Duggan,2020; Rooke,2014). This is particularly relevant to areas such as PR examinations and non-medical prescribing, which was alluded to in the introduction of the thesis.

- That there is a need for the skill or proficiency in the first place – such as the "80% of the patients, 80% of the time," to warrant the change remaining part of pre-registration student nurse education and remain part of a nurse's role, that they must be able to demonstrate at the point of registration.

- Social demographics and patient needs have changed due to members of the public and NHS staff presenting with "Long Covid" symptoms. Without exploration, it is unclear if possessing all these skills is now relevant and meets patient needs.

8.3 Summary of Recommendations

This study has taken two Analytical Categories drawn from the interpretative analysis of eleven semi-structured interviews and constructed nine recommendations, eight of which were based on the lived experiences of registrants who self-identified as one of four participant groups, which included insights from representatives of the regulator. With the exception of one recommendation, all others link together and rely on completing each one in turn to satisfy them all.

The ninth recommendation is the exception to this and has been constructed to reflect an awareness of changes that the NMC approved in 2023, which also stands to significantly affect pre-registration nursing curriculums and education. This is reasoned as the changes in 2023 alter how many simulated learning hours may be used in pre-registration nurse curriculums. As this will inevitably inform how pre-registration students respond to stimuli in the practice learning environment, this amendment to training could impact AEI and PLP working relationships. An example of this is where to place pre-registration students so they get adequate exposure to skills and procedures rather than developing a dependency on simulated practice before registration. However, this may be problematic if there is a failure to address previous points made in the thesis around skill or procedure gaps between what existing registrants can do in comparison to newly registered counterparts.

Conclusion

This study has contributed to the evidence base around the implementation of the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) and has considered several barriers to their implementation. In congruence with a search of related literature pre and post-Coronavirus pandemic, I have grappled with the concept of their suitability for practice and whether they remain suitable for practice given the ever-changing landscape of the practice learning environment. It is important to note that until it is explored, the exacerbating factors which have hindered the *Future Nurse* standards implementation due to the COVID-19 pandemic cannot be fully realised, and resulted in difficult decisions which have shaped how

AEIs could have supported the practice learning environment and pre-registration students that were studying in this period.

With this in mind, the conceptual framework has suggested a way to scope the extent to which the 'Future Nurse' vision has been achieved beyond being "aspirational", which in turn could inform how Approved Educational Institutions (AEIs) may continue to adapt support given to pre-registration students in the practice learning environment using the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) published in 2018.

To conclude, from a more personal perspective, the inclusion of the author's provenance and subsequent reflective extracts, there are several perspectives I, as the author, would like to share.

Firstly, the ability to gain a diagnosis and a better understanding of self, which would inform undertaking doctoral research and studying for a PhD as an overall process. This is because I had particular difficulty at points articulating myself in ways that other people could easily understand. While this may have always been a feature in my life, this hasn't before been articulated as a difficulty verbally as well as in the written word. There were points when I felt truly inept and really doubted my ability to perform and finish this work. Therefore, to commit to a consistent process and trust the Director Of Studies and academic supervisors' advice and judgement instead of being able to go on prior experience to research and marshalling of thoughts and expression of ideas is designed to be critical, made working towards doctoral research extremely difficult at times, as it exposed flaws that I knew existed but not to this degree with no safety net or familiar knowledge to draw on. Relearning how to become explicit, rephrase questions and develop language and terminology to communicate what I have learned in an appropriate way as a researcher, as a newly registered nurse and as a budding Practice Supervisor and Practice Assessor was therefore integral to learning how to relate to the academic world as well as the clinical one that I am still firmly planted in and work in regularly.

Working in both places and valuing both equally within my perception as a nurse and educator was particularly difficult during the pandemic, as demonstrated in some of

the extracts I have shared and are marked as being taken in the midst of the pandemic. At several points, certainly, throughout the initial wave of the pandemic, I did question if this was the right course of action to take or whether to postpone the study. However, so much of what I have learned during this process has relied on understanding the pandemic and being there with friends and colleagues so that what was said could be listened to, heard and empathised with. It also highlighted that although AEIs and PLPs both represent the public and the learner's interests, it is still a choice to be one or the other, and it is not easily governed to allow people to do both and for both to be equally valued in the practice learning environment. On reflection, the ability to do both actually helped my mental health during the pandemic and allowed me to protect my routine. It afforded me stability and the ability to regularly support my colleagues exposed to the ramifications of the pandemic as part of their full-time occupation. It feels like we have shared a moment in history in the practice learning environment which has shaped the course of pre-registration nursing education, but with more insight could show how both stakeholders can inform processes so that the *Future Nurse* Standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) to not be aspirational in perpetuity.

Finding a balance between the different roles that I fulfil also requires careful management of my own positionality and being mindful not to be biased toward one role or another. This was particularly relevant when extracts that discussed the University's role in the pandemic proved to be quite emotive and, therefore, could have easily been taken personally. However, the need to protect the integrity of the interviewing process and the participants and ensure their autonomy was not diminished in any way. It was important to listen and ensure they felt heard but also to keep my own counsel and reflect on the comments in my own time and space. Failing to do this may have led to power imbalances on my part, which is not ethical and may discourage the participant from saying more or continuing the interview and participating in the study at all. To my surprise, I feel this led to me feeling overcautious and experiencing a reverse of the Hawthorne effect and I felt underprepared to deal with this kind of dynamic in parts of the study. In hindsight, this could have been pre-empted as I was already aware of power dynamics within nursing and healthcare through the literature but have rarely been directly exposed

to it professionally. I think it was unexpected in a research context as I was approaching the research as a new registrant but also someone who was looking to understand the perspectives of others.

From a research perspective, the conceptual framework, which his rooted in the lived experience of 11 Participants from four distinct participant groups and spans across the West Midlands, has been developed which can inform how Approved Educational Institutions (AEIs) may adapt support given to pre-registration students in the practice learning environment using the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) published in 2018. As this considers the current standards for pre-registration nursing education instead of the preceding 2010 and SLAiP standards (NMC,2010;2008; RCN,2015), and there is limited literature which has discussed the nationally implemented *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) in relation to how AEIs can use them to support pre-registration nursing education, this forms new knowledge which could be considered nationally.

As a conclusion to the study, several last points based on the study's recommendations (see pp. 244-246) have been established for final consideration:

- There is currently insufficient literature within the public domain that justifies the degree of change to pre-registration nurse education beyond the need to increase placement capacity. This makes them appear baseless.

- There are no agreed-upon methods for upskilling existing registrants beyond training, which they may not have any or inconsistent access to, particularly from a flexible or nursing bank perspective.

- There are concerns that some of the skills are not representative of all patient's needs and that maintenance of skills will not improve competency and what patients can access at the point of delivery. This is not likely to be quantifiable unless there is an audit of skills and their use so that accruement of skills is based on patient needs as intended by the regulator.

- In order to meet the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d), relevant healthcare professionals must establish awareness, understanding, and the ability to transfer this knowledge across all students in different fields of practice and in each part of pre-registration nurse training. It also does not promote the intended and improved learning culture, as individuals may be unnecessarily reticent about the change.
- As a consequence of the pandemic, until they have been properly audited, it is not known if the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) and the "team approach" in its current is entirely fit for purpose, particularly in light of the high attrition rates amongst existing registrants, unsafe staffing levels and closure of wards and clinical areas.

- There may be significant benefits to be had if the role of the Academic Assessor were repurposed, as there is already an identifiable need to further the work of PPMs in trust and build on this to expand links between AEIs and PLPs in the practice learning environment.

Limitations of the study

As the research focuses on existing registered nurses and their lived experiences, it discounted the voice of the pre-registration student. The study did not include those delivering nursing programmes in AEIs. To include these participants was beyond the scope of this study but is being considered for future projects.

As previously acknowledged, the Coronavirus pandemic has undoubtedly impacted the study in several ways. It was impossible to access some of the participants identified, and they may have had a different perspective than those presented in this work. It is also unclear how much impact the changes in practice affected the ability to embed the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d) as they are currently written into the practice learning environment. It is also not known how significantly the pandemic affected individual practitioners' ability to engage with the *Future Nurse* standards and their ability to understand and implement them.

A further point is that the pandemic would undoubtedly have disrupted research into the implementation of the *Future Nurse* standards (NMC,2018; NMC,2018a; NMC,2018c; NMC,2018d), and therefore, limited literature was available to inform this study.

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Appendices

Appendix 1: SWOT Analysis mentioned in the Appraisal of Phase 1 (The Spidergram)

Strengths

- Good event to pilot the Spidergram, considering the theme of CSPACE with lots of space to exhibit in
- Able to communicate ideas clearly.
- Didn't require any guidance or interaction from me to get responses.
- Results were similar to other contributions made to answer the question and all were relevant.
- Face Validity showed some common language developed.
- At least one response from every category was made.
- Participants that did feed back to me personally provided positive feedback.
- Organised and well thought through in terms of materials and resources.
- Area had high visibility when door was open.
- Generalisability of question meant that anyone could contribute i.e. non field specific participation

Weaknesses

- Only the people at CSPACE knew about it.
- There was a disproportionate amount of undergraduate student exposure.
- person on consent form stated that they had no opportunity for questions.
- Lunch was offered in a place that wasn't necessarily around other pieces of artwork and slightly out the way.

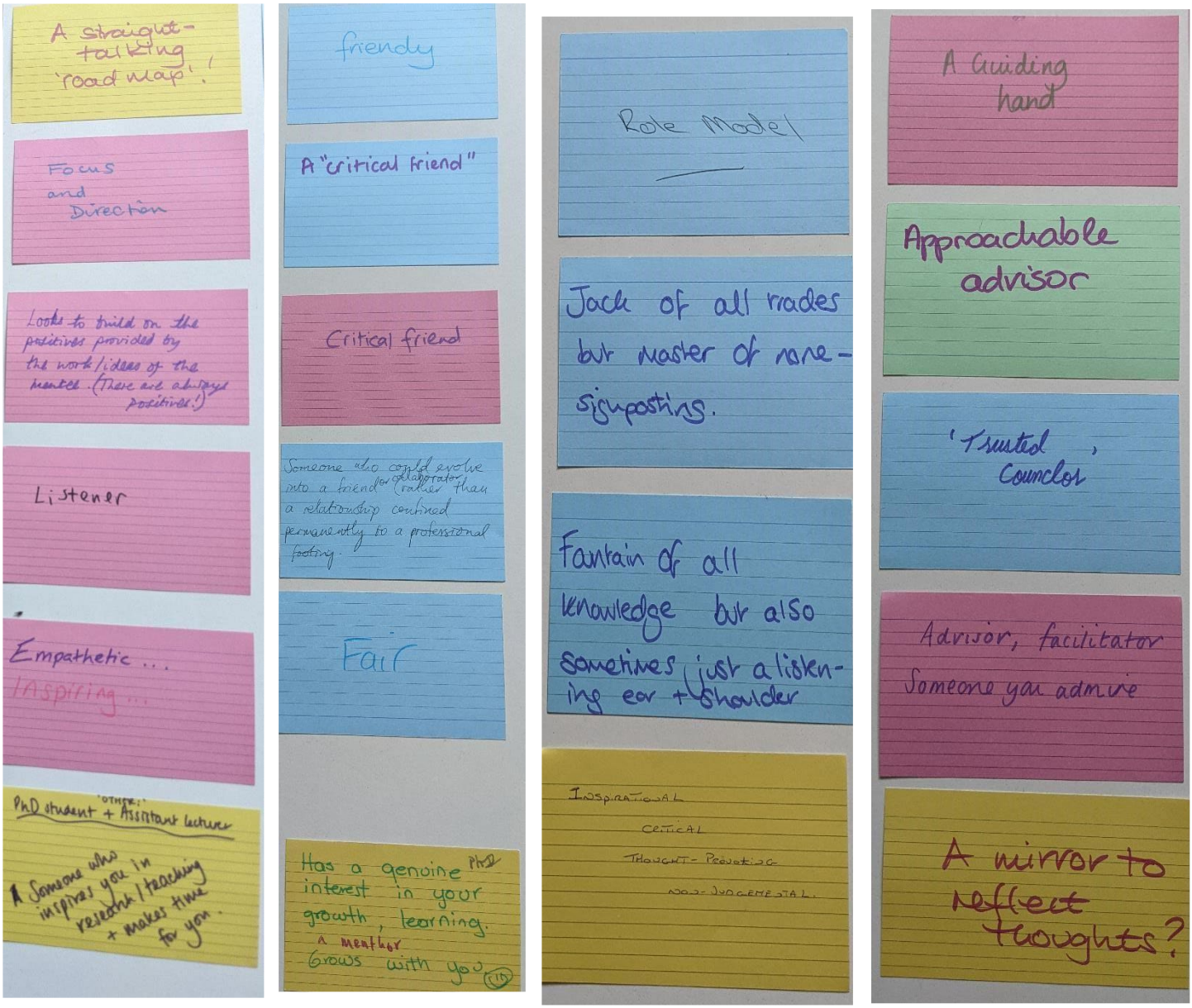
Opportunities

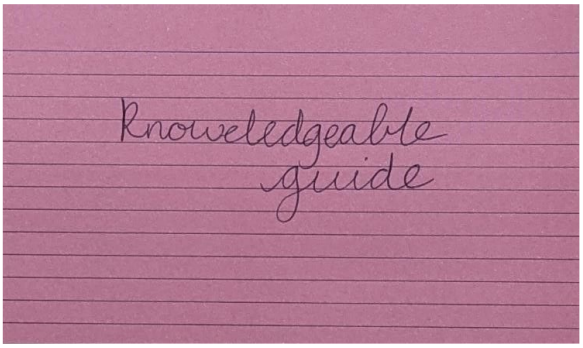
- Further opportunities could now take place now that the pilot has taken place and showed potential.
- It's given me an opportunity to look for different locations in order to gain more varied opinions.
- I can now form the definition based on the common language generated and now look at forming my next question.
- Opportunities to ask questions could occur by having different integrations with the Spidergram - however a questions box and pad were offered so I could answer any

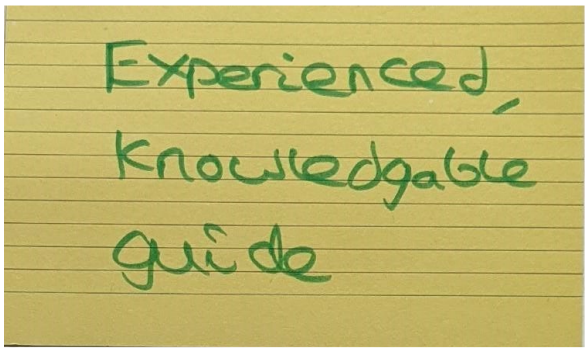
Threats

- Time it would take to generate responses.
- Transporting the Spidergram to and from the University using public transport.
- Greater integration may change how people interact with the Spidergram.
- Change of location may not change the number of responses and data saturation could be achieved too quickly.

Appendix 2 –Visual results of Phase 1: The Spidergram.







Appendix 3 – Example of Interview Schedule used in the initial stages of Data Collection

Interview Schedule for How might registered nurses adapt their practice, in relation to student nurses supervision and assessment in order to meet the New Standards for Proficiency and Standards for Student Supervision and Assessment (*SSSA* (NMC, 2018B)) in Nursing (NMC,2018; NMC, 2018a; NMC, 2018b, NMC, 2018C)?

Introduction

Introduce myself as a researcher, and professional identity as nurse, academic and researcher. Thank the participant for volunteering to take part in the study and confirm that they meet the inclusion criteria to participate before going further.

Ensure that they have read through the corresponding information for interviewing, signed the consent form, and indicated if they wish to receive an electronic copy for their own records.

Explain to the research participant that their personal data and any data that is collected in relation to the study will be handled, stored, and kept in line with BCU policy, along with the length of retention as per GDPR regulations.

Highlight the pathways to gaining post interview support if required or escalation of concerns or complaints (as stated In the Participant information Sheet)

Provide an overview of the studies aims, objectives and what I hopes to achieve as the outcome of the study.

State the interview process.

Areas to be explored through the semi structured interview process.

How long the member of staff has been qualified and then become a mentor or sign off mentor.

Ask them to explain what kinds of students they have in practice learning environments and if their approach changes depending on the student? – does this include the clinical scopes of practice and proficiency

If they are able to, can they state if their own experiences have consciously contributed to the way that they offer supervision/ mentorship to the students that they work with now qualified

If so have these standards modified the way in which they currently facilitate support or the experiences that they expose students to in practice learning environments.

Ask them to describe their experience of supervision or being mentored as a student

Can they articulate the type of support offered to them becoming mentors or sign off mentors? Prompts – what kind of support has been given, was this sufficient? What would have changed/ enhanced or better prepared

you? Can the registrant explain how they select what they choose to focus on in supervision? – if so what influences their choice ?

Have you mentored more than one student at any one time?- If so does this change the ability or quality of supervision offered to students?

Prompts – How does the mentor manage this in practice learning environments and what do they feel about it? Are there any benefits or limitations of offering support to more than one student at any given time?

Do the mentors/ sign off mentors know of any theories or models that have informed the way they support students?

Prompts- In what ways have these been helpful?

If you modify your practice when working with different students, how do you do this and why? Can you provide an example in practice, can you tell me about how confident you felt in doing this?

What are the most significant challenges to facilitating student support in practice placements?

Prompts – How might these be overcome? How is this tailored to supervision? How have you come to reach this opinion or adopt this in practice?

Can the mentor or sign off mentor state any specific qualities that they feel enhance their ability to offer a better quality of supervision?

Prompts –what has led them to this conclusion?

Is there anything else you would like to tell me about in relation to supervising students?

Have they got any knowledge of the NMC *Future Nurse* standards (NMC,2018;NMC,2018a;NMC,2018c;NMC,2018d). Standards – If so has this influenced their approach to mentoring?

Appendix 4: Letter sent to Research and Development Teams based on Access Letter Approved through HRA.

Dear Sir or Madam

My name is Laura Hodgetts. I am a PhD student at Birmingham City University. I am writing to you in order to advertise my doctoral study entitled:

How might existing registrants adapt to meet the revised Standards for Proficiency and Standards for Student Supervision and Assessment (*SSSA* (NMC, 2018B)) issued by the Nursing and Midwifery Council in 2018?

Premise of the study:

The study's focus is to capture and interpret the lived experience of other registered nurses and the way(s) in which 'mentorship' was fulfilled in practice, up until the reshaping of pre-registration student nursing supervision and assessment in practice. The reshaping is a direct consequence of the Nursing and Midwifery Council (NMC) publishing the Standards for Proficiency and Standards for Student Supervision and Assessment (*SSSA*) in 2018 and their implementation in early 2019 (NMC, 2018; NMC, 2018a; NMC, 2018b; NMC, 2018c). Although there are quite a few subtle differences in the practice of supervision when compared to the preceding model of mentorship, the standards of proficiency and *SSSA* (NMC, 2018; NMC, 2018a) also represent more significant alterations for pre-registration students and registrants alike. Some of these include the revised level of skill and proficiency now required of experienced and newly qualified registrants, as well as a new division of supervision and assessment duties undertaken by clinical staff. So far, the theoretical underpinning of the study has shown that a combination of these factors highlight a gap between the contemporary literature, current NMC expectations and practice learning environments. On initial consideration of the literature, this originates from the existing registrants' generic skills remit and how this compares with the new

requirements stated in the standards of proficiency and *SSSA* (NMC, 2018; NMC, 2018a).

Intended outcome of the study:

To develop a conceptual framework which will inform Practice Learning Partners and Approved Educational Institutions, as to how existing registrants may better be supported to meet the new standards of profiency and *SSSA* (NMC,2018; NMC,2018a) An additional consideration will be to explore how this framework could then be adapted to meet the clinical provision and need of patients within “hot” and “cold” sites associated with Coronavirus presentation as well as peaks and troughs that may be presented in the coming months.

The Research Participants:

In order to achieve this I am looking to recruit 10-15 research participants, who are adult branch nurses and are registered mentors and sign off mentors. They must also have at least 12 months experience fulfilling one or both of these roles. The expectation of participants is to participate in a singular and individual interview lasting no more than 1 hour in duration via Microsoft teams (MST) or another online platform of the participants choice (recommended MST, Skype or Zoom).

BCU ethical approval and insurance and indemnity cover has been provided in full. The ethics number is :

Hodgetts /#3296 /sub1 /Am /2020 /Sep /HELS FAEC - How might student supervision and assessment adapt to meet the New Standards for Nursing? This allows me to do the interviews online.

In order to meet the aim of the study, the following objectives have been set.

To explore a “mentor” or “sign off mentor’s” lived experience of facilitating supervision and assessment of pre-registration students.

To investigate ‘mentors and sign of mentors’ understanding of the new NMC Standards for practice and proficiency.

To examine any potential barriers that may impact on the ability of ‘mentors and sign off mentors’ to deliver the new standards of practice and proficiency – if they have awareness of the new standards and are able to share insight.

If there is any interest, I would be more than happy to supply further information to the individuals who contact me directly via email

Best wishes and thank you for your support,

Laura Hodgetts

PhD Candidate, Birmingham City University.

Appendix 5: Copy of Consent Form issued to each participant.

Version. 1 19/07/2019

Dear Participant,

Thankyou for taking time to read the participant Information Sheet. In doing so, you will have received specific information that relates to the conduct of the study entitled:

How might registered nurses adapt their practice, in relation to student nurses' supervision and assessment in order to meet the New Standards for Proficiency and Standards for Student Supervision and Assessment (*SSSA*) in Nursing (NMC,2018; NMC, 2018a; NMC, 2018b, NMC, 2018C)?

Before the interview commences, please initial the appropriate questions and sign at the bottom of the page if you still wish to continue. You will be offered to keep a copy of the consent form if you want to which may be provided in either hard or electronic format.

Questions:

☐ I have read and understood the participant information sheet that is related to this study,

More specifically I, The research participant is informed in giving consent in the knowledge that;

☐ I understand the level of contribution that the study requires and meet the inclusion criteria for the study,

☐ I acknowledge that my participation within the study in entirely voluntary. I am also aware that I am able to terminate the interview at any time without reason and may also ask for a transcription of the interview if I would like one,

☐ I have had the opportunity to ask questions; as well as received information surrounding the escalation of concerns or how to raise complaints that are relevant to the study,

☐ I am also aware that the interview will be audio recorded for the purposes of transcription,

☐ I am aware that the Primary Investigator of this study is a Registered Nurse and governed The Nursing and Midwifery Council's (NMC) *Code of Professional Standards and Behaviour for Nurses, Midwives and Nursing Associates* (2018). This includes the practitioners Duty of Care and Duty of Candour. This may result in a breach of confidentiality by I, if there is disclosed information which relate to concerns surrounding safeguarding and whistleblowing procedures.

Name of participant …….

Signature: …….

Email Address: (If a copy of consent form would be required:

…….

Name: …….

Laura J. Hodgetts.

Signed: …….

Laura J. Hodgetts. PhD Candidate

Appendix 6: Participant Information Sheet issued to all participants.

Participant Information Sheet Version 5. 12/05/2020

IRAS Number: 263032

How might registered nurses adapt their practice, in relation to student nurse's supervision and assessment in order to meet the New Standards for Proficiency and Standards for Student Supervision and Assessment in Nursing (2018)?

Study:

Aims of the study:

The aim of the study is to develop a conceptual framework to inform the education and training of 'mentors and sign off mentors' so that they are equipped to fulfil their roles in line with the requirements of the new NMC Standards.

Inclusion Criteria and Freedom to Participate:

The Primary Investigator (PI) (Laura Hodgetts) invites you to take part in the above study, by means of an audio recorded interview that will last for a maximum of one hour. This interview aims to gain insight into your experiences and perceptions of mentoring students within a clinical environment. The inclusion criteria of the study is that you must be a registered practitioner who has achieved the Supporting Learning and Assessment in Practice (SLAiP) qualification; with the option of the additional Sign off Criteria and has gained at least 12 months experience in this role.

All participation within the study is entirely voluntary. In extension to this, there will be no repercussions or penalty imposed upon you, should you choose not to participate. This extends to your ability to access services, education or care. There will also be no recompense or financial incentive for participating in the study.

Expectations of the Participants:

In order to conduct the study, you are asked to participate in a singular interview. This will take place at a time and location that is convenient for you. Once audio recording has been completed, these will be transcribed verbatim. I may also take field notes relating to points of particular interest throughout the interview which will form private memos for future reference. The transcriptions will be available for you to view, however they will not be able to be amended post recording, and you will not be reinterviewed,

Potential risks of participation:

It is not anticipated that taking part in this study will involve any significant risk to you. However, there is the potential that some of the questions asked could revoke memories that may result in you feeling anxious, angry or saddened. It is important to note that you have the right to not answer questions, as well as to terminate the interview without giving a reason. At this point audio recording will cease and if required I can signpost you to appropriate support via Occupational health and their counselling services. You will also have the opportunity to express any concerns or complaints to the person overseeing this study, Dr Barbara Howard-Hunt. Her contact details are listed on the bottom of this sheet as well as on the consent form for the study.

Confidentiality:

What is patient data?

When you go to your GP or hospital, the doctors and others looking after you will record information about your health. This will include your health problems, and the tests and treatment you have had. They might want to know about family history, if you smoke or what work you do. All this information that is recorded about you is called patient data or patient information.

When information about your health care joins together with information that can show who you are (like your name or NHS number) it is called identifiable patient information. It’s important to all of us that this identifiable patient information is kept

confidential to the patient and the people who need to know relevant bits of that information to look after the patient. There are special rules to keep confidential patient information safe and secure.

What sort of patient data does health and care research use?

There are lots of different types of health and care research.

If you take part in a clinical trial, researchers will be testing a medicine or other treatment. Or you may take part in a research study where you have some health tests or answer some questions. When you have agreed to take part in the study, the research team may look at your medical history and ask you questions to see if you are suitable for the study. During the study you may have blood tests or other health checks, and you may complete questionnaires. The research team will record this data in special forms and combine it with the information from everyone else in the study. This recorded information is research data.

In other types of research, you won't need to do anything different, but the research team will be looking at some of your health records. This sort of research may use some data from your GP, hospital or central NHS records. Some research will combine these records with information from other places, like schools or social care. The information that I collects from the health records is research data.

Why does health and care research use information from patients?

In clinical trials, Is are collecting data that will tell them whether one treatment is better or worse than other. The information they collect will show how safe a treatment is, or whether it is making a difference to your health. Different people can respond differently to a treatment. By collecting information from lots of people, researchers can use statistics to work out what effect a treatment is having.

Other types of research will collect data from lots of health records to look for patterns. It might be looking to see if any problems happen more in patients taking a medicine. Or to see if people who have screening tests are more likely to stay healthier.

Some research will use blood tests or samples along with information about the patient's health.

Researchers may be looking at changes in cells or chemicals due to a disease.

All research should only use the patient data that it really needs to do the research. You can ask what parts of your health records will be looked at.

How does research use patient data?

If you take part in some types of research, like clinical trials, some of the research team will need to know your name and contact details so they can contact you about your research appointments, or to send you questionnaires. Researchers must always make sure that as few people as possible can see this sort of information that can show who you are.

In lots of research, most of the research team will not need to know your name. In these cases, someone will remove your name from the research data and replace it with a code number. This is called coded data, or the technical term is pseudonymised data. For example, your blood test might be labelled with your code number instead of your name. It can be matched up with the rest of the data relating to you by the code number.

In other research, only the doctor copying the data from your health records will know your name. They will replace your name with a code number. They will also make sure that any other information that could show who you are is removed. For example, instead of using your date of birth they will give the research team your age. When there is no information that could show who you are, this is called anonymous data.

Where will my data go?

Sometimes your own doctor or care team will be involved in doing a research study. Often, they will be part of a bigger research team. This may involve other hospitals, or universities or companies developing new treatments. Sometimes parts of the research team will be in other countries. You can ask about where your data will go. You can also check whether the data they get will include information that could show who you are. Research teams in other countries must stick to the rules that the UK uses.

All the computers storing patient data must meet special security arrangements.

If you want to find out more about how companies develop and sell new medicines, the Association of the British Pharmaceutical Industry has information on its website.

What are my choices about my patient data?

You can stop being part of a research study at any time, without giving a reason, but the research team will keep the research data about you that they already have. You can find out what would happen with your data before you agree to take part in a study.

In some studies, once you have finished treatment the research team will continue to collect some information from your doctor or from central NHS records over a few months or years so the research team can track your health. If you do not want this to happen, you can say you want to stop any more information being collected.

Researchers need to manage your records in specific ways for the research to be reliable. This means that they won't be able to let you see or change the data they hold about you. Research could go wrong if data is removed or changed.

What happens to my research data after the study?

Researchers must make sure they write the reports about the study in a way that no-one can work out that you took part in the study.

Once they have finished the study, the research team will keep the research data for several years, in case they need to check it. You can ask about who will keep it, whether it includes your name, and how long they will keep it.

Usually, your hospital or GP where you are taking part in the study will keep a copy of the research data along with your name. The organisation running the research will usually only keep a coded copy of your research data, without your name included. This is kept so the results can be checked.

If you agree to take part in a research study, you may get the choice to give your research data from this study for future research. Sometimes this future research may use research data that has had your name and NHS number removed. Or it may use research data that could show who you are. You will be told what options there are. You will get details if your research data will be joined up with other information about you or your health, such as from your GP or social services.

Once your details like your name or NHS number have been removed, other researchers won't be able to contact you to ask you about future research.

Any information that could show who you are will be held safely with strict limits on who can access it.

You may also have the choice for the hospital or researchers to keep your contact details and some of your health information, so they can invite you to take part in future clinical trials or other studies. Your data will not be used to sell you anything. It will not be given to other organisations or companies except for research.

Will the use of my data meet GDPR rules?

GDPR stands for the General Data Protection Regulations. In the UK we follow the GDPR rules and have a law called the Data Protection Act. All research using patient data must follow UK laws and rules.

Universities, NHS organisations and companies may use patient data to do research to make health and care better.

When companies do research to develop new treatments, they need to be able to prove that they need to use patient data for the research, and that they need to do the research to develop new treatments. In legal terms, they have a 'legitimate interest' in using patient data.

Universities and the NHS are funded from taxes and they are expected to do research as part of their job. They still need to be able to prove that they need to use patient data for the research. In legal terms this means that they use patient data as part of 'a task in the public interest.

If they could do the research without using patient data, they would not be allowed to get your data.

Researchers must show that their research takes account of the views of patients and ordinary members of the public. They must also show how they protect the privacy of the people who take part. An NHS research ethics committee checks this before the research starts.

What if I don't want my patient data used for research?

You will have a choice about taking part in a clinical trial testing a treatment. If you choose not to take part, that is fine.

In most cases, you will also have a choice about your patient data being used for other types of research. There are two cases where this might not happen:

When the research is using anonymous information. Because it's anonymous, the research team don't know whose data it is and can't ask you.

When it would not be possible for the research team to ask everyone. This would usually be because of the number of people who would have to be contacted. Sometimes it will be because the research

could be biased if some people choose not to agree. In this case, a special NHS group will check that the reasons are valid. You can opt out of your data being used for this sort of research. You can ask your GP about opting out or find out more.

Who can I contact if I have a complaint?

If you want to complain about how researchers have handled your information, you should contact the research team. If you are not happy after that, you can contact the Data Protection Officer. The research team can give you details of the right Data Protection Officer.

In this study, complaints may be addressed to the Patient Advice and Liaison Service (PALS), whose details are as follows:

Telephone: 0121 421 3280

Email: PALS@uhb.nhs.uk

If you are not happy with their response or believe they are processing your data in a way that is not right or lawful, you can complain to the Information Commissioner's Office (ICO) (www.ico.org.uk or 0303 123 1113).

Storage and Deletion of Audio recordings

Once the data is collected, the audio recording and subsequent transcriptions will be password protected and stored in individual folders on BCU One drive so that the participant's confidentiality and privacy are maintained throughout the course of the study. No hard copies of the participant's personal information will be created or

stored on the premises but will be stored separately in individual, password-protected folders within the PI'S BCU Staff Email emailed account and labelled correspondence. Audio recordings will be also be coded to match the participant with the consent form and transcription to ensure that anonymity is preserved. All information will be kept in this way for the duration of the study and for a period of 3 years. After this period, all data will be permanently deleted under the supervision of BCU IT services, and any hard copies of the transcriptions will be sensitively disposed of via shredding methods on a hospital site and then placed into a confidential waste bag.

However, due to the nature of the study as the Primary Investigator, I reserve the right to breach confidentiality on the grounds of unsafe practice or matters that may apply to safeguarding or whistleblowing protocol. If sensitive material needed to be disclosed, the participant would be made aware of this prior to immediate reporting to the participant's line manager or another responsible person within the Trust, such as the safeguarding lead, in line with the Trust policy. This is due to the PI also working within their own Code of Professional Conduct and Behaviours for Nurses, Midwives and Nursing Associates (NMC, 2018d) as well as applying the duty of Candour (Care Quality Commission, 2015, Regulation 20) and Duty of Care within their role as a Registered Nurse (NMC, 2018d) and Researcher.

Consent:

You will have the opportunity to ask questions prior to giving informed consent before the date of the interview. Immediately prior to the interview commencing, you will also be asked to verbally confirm that you are still happy to participate in an interview.

Funders and Persons Involved in the Research

There are no external funders of the research. However, the study is being supervised by an experienced supervisory team. Should you have any questions or concerns relating to the study, please do not hesitate to contact myself or Dr Barbara Howard-Hunt using the contact details below:

Dr Barbara Howard-Hunt: Barbara.HowardHunt@bcu.ac.uk Phone: 0121 331 7184

Dr Abbie Fordham Barnes: Abbie.Fordhambarnes@bcu.ac.uk Phone: 0121 331 5000

Alternatively you may also contact the Faculty of Health, Education and Life Sciences Ethics Department via the following email address: HELS_Ethics@bcu.ac.uk,

At this point, I would like to Thank you for to reading this participant information sheet and considering participating in this study.

Yours Faithfully,

Laura Hodgetts

Laura.Hodgetts@bcu.ac.uk

Primary Investigator:

How might registered nurses adapt their practice, in relation to student nurse's supervision and assessment in order to meet the New Standards for Proficiency and Standards for Student Supervision and Assessment in Nursing (2018)?

Appendix 7: Letter from Sponsor to approve study

Faculty of Health, Education & Life Sciences Research Office

Seacole Building, Westbourne Road

Birmingham B15

3TN

HELS_Ethics@bcu.ac.uk

29/Oct/2019

Miss Laura Hodgetts laura.hodgetts@bcu.ac.uk

Dear Laura,

Re: Hodgetts /3296 /R(C) /2019 /Oct /HELS FAEC - How might student supervision and assessment adapt to meet the New Standards for Nursing?

Thank you for your application and documentation regarding the above study. I am pleased to confirm that Birmingham City University has agreed to take on the role of Sponsor.

Birmingham City University can confirm that our insurance indemnity cover includes the actions of researchers working in suitable premises and under appropriate supervision. Our policy cover will not apply to liability that is more specifically insured under any policy covering medical negligence, malpractice or indemnity, professional errors, omissions or negligence.

A copy of BCU's insurance details is available at: https://icity.bcu.ac.uk/Legal-Services-andhttps://icity.bcu.ac.uk/Legal-Services-and-Compliance/Insurance/IndexCompliance/Insurance/Index.

If you wish to make any changes to your proposed study (by request or otherwise), then you must submit an Amendment application to us. Examples of changes include (but are not limited to) adding a new study site, a new method of participant recruitment, adding a new method of data collection and/or a change of Project Lead.

Please also note that the Committee should be notified of any serious adverse effects arising as a result of this activity.

Keep a copy of this letter along with the corresponding application for your records as evidence of approval.

If you have any queries, please contact HELS_Ethics@bcu.ac.uk

I wish you every success with your study.

Yours Sincerely,

Ms Julie Quick

On behalf of the Health, Education and Life Sciences Faculty Academic Ethics Committee

Appendix 8: First Page of HRA Approval Letter

Dr Barbara Howard Hunt

Birmingham City University Email: approvals@hra.nhs.uk

HCRW.approvals@wales.nhs.uk Westbourne Road

Edgebaston

B15 3TN

06 July 2020

Dear Dr Howard Hunt HRA and Heath and Care Research Wales (HCRW) Approval Letter

Study title:	How might registered nurses adapt their practice, in relation to student nurses supervision and assessment in order to meet the New Standards for Proficiency and Standards for Student Supervision and Assessment in Nursing (2018)?
IRAS project ID:	263032
Protocol number:	Hodgetts /3296 /R(C) /2
REC reference:	
Sponsor	

20/NW/0227

Birmingham City University

I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the “Information to support study set up” section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland? HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

Appendix 9: Example of a frequency table used to plot comparisons of individuals and participant groups in the next stage.

Participant 1, PIC site 1.

Theme and Colour	Frequency
Individual Characteristics and expertise	13
Time in one speciality or practised in many	1
Transferable knowledge or skills	9
Skill Mix/Staffing/Teamwork	12
Nursing Culture or Climate/ change over time	1
Alterations in normal working patterns	6
Financial or organisational pressures	6
Exposure or lived experience in placement – student	27
University role, relationship with trust and associated factors, including student placement and capacity	7
Time or Time Management	16
Nursing, Education or Theory to practice gap	7
Alternative models or ways of training	8

Summary:

36 themes,

Less than 10 entries: 24

Substantive themes: 12

Student Focused: (3)

Exposure or lived experience in placement – student

Student competency and or development (clinical or education)

Student experience in practice and Teaching (including simulation and feedback)

Registrant Focused: (6)

Adapting Practice or placement opportunities – learner's needs Skill Mix/Staffing/Teamwork

Individual Characteristic and expertise

Role specific decision making/awareness/ responsibilities

Optimising placements/ pathway opportunity and exposure

Personal opinions/ Perceptions of self or drawing on past experiences (Including Reflection)

Collective Circumstance (3):

Student/ mentor personalities, relationship and/or conduct

Physical/ Clinical environment and associated factors (Human)

Physical/ Clinical environment and associated factors (Human)	11
Optimising placements/ pathway opportunities and exposure	14
Adapting Practice or placement opportunities – learners need	18
Student competency and or development (clinical or education)	17
Patient or person-centred care	7
Role-specific decision making/awareness/ responsibilities	18
Personal opinions/ Perceptions of self or drawing on past experiences (Including Reflection)	24
Student experience in practice and Teaching (including simulation and feedback)	12
Hospital procedures/ guidance and policy (including Risk assessment and investigations)	3
Balance of supporting role with rank or additional responsibility	7
Student-directed learning/ opportunities (including peer assisted learning)	4

SLAiP, mentor role and or updates	4
Student/ mentor personalities, relationships and/or conduct	13
Code/scope of practice	6
Boundary of pass or fail/ Failing to fail or fitness for practice – Escalating/ Managing concerns (staff or student).	5
Documentation	7
Role modelling and development of competency - registrants	2
Job role remit, skills and competency –realignment and/or adjustment.	6
Clinical Identity, role responsibilities and Role presence/ visibility in area (PPM)	1
Non-technical skills to prevent harm or injury- Registrant (such as burnout, compassion fatigue etc.)	6
Coronavirus	3
Redeployment of students and staff or the Emergency Standards	1

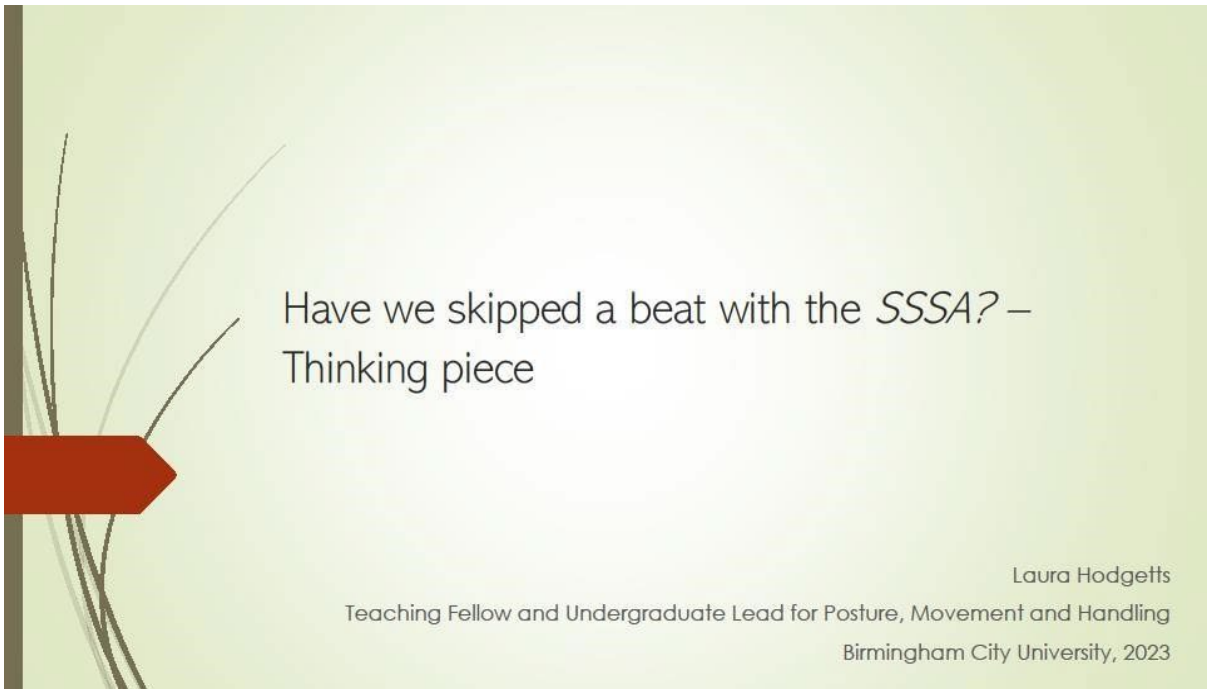
Support, Pastoral needs & health and wellbeing (staff and students)	8
Lived experience or background of students or staff (non-healthcare related)	2

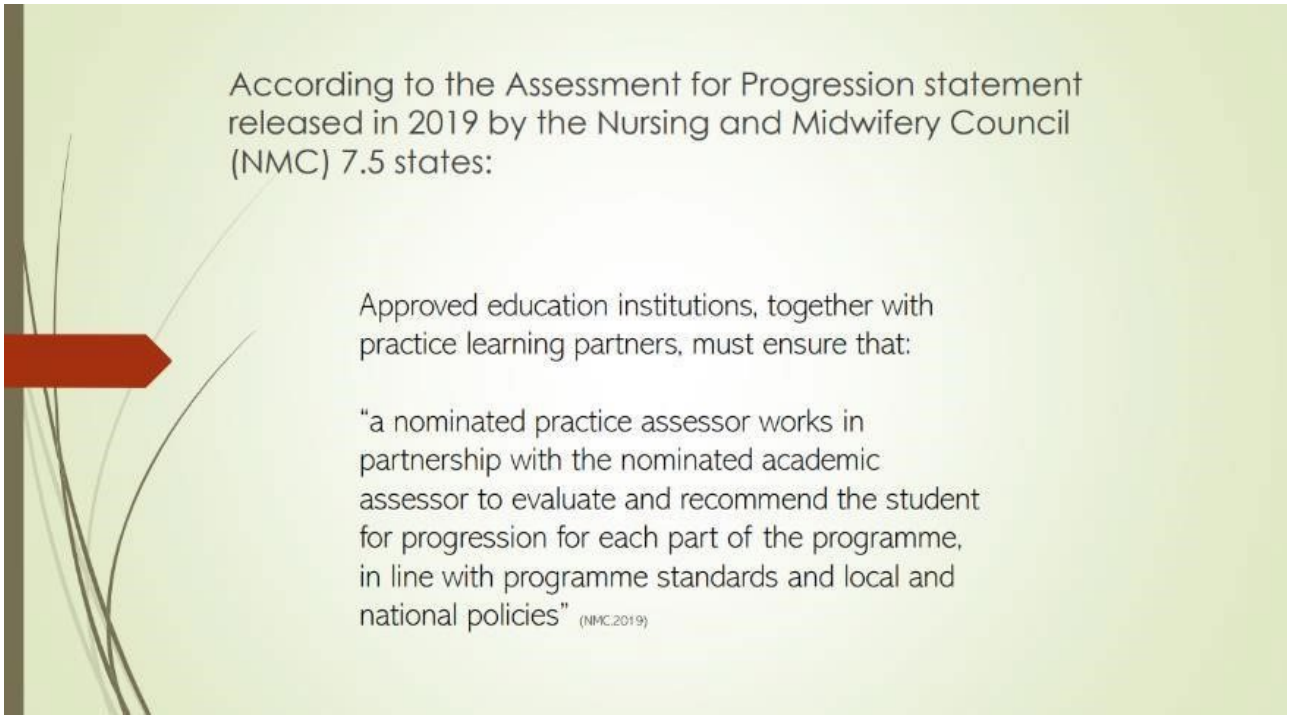
Appendix 10: Example of how data was compared across participants in the same PIC site after refinement of codes took place

	A	B	C
1	Group 4	Participant 8	Participant 11
2	Substantive Theme (greater than 10 entries)		
3	Student experience in practice and Teaching (including simulation and feedback)		
4	Exposure or lived experience in placement – student		
5	Adapting Practice or placement opportunities – learners needs		
6	Student competency and or development (clinical or education)		
7	Individual Characteristic and expertise		
8	Optimising placements/ pathway opportunity and exposure		
9	Role specific decision making/awareness/ responsibilities		
10	Time, duration or Time Management		
11	Support, Pastoral needs & health and wellbeing (staff or student)		
12	Boundary of pass or fail/ Failing to fail or fitness for practice – Escalating concerns (staff or student).		
13	SLAiP, mentor role and or updates		
14	Job role remit, skills and competency –realignment and/or adjustment.		
15	Student/ mentor personalities and conduct		
16	Personal opinions/ Perceptions of self or drawing on past experiences (Including Reflection)		
17	Non-technical skills to prevent harm or injury- Registrant (such as burnout, compassion fatigue etc.)		
18	University role and associated roles/ factors including student placement and capacity		
19	Duality of Job role- change of role, change of perception and adaptions to these responsibilities		
20	Skill Mix/Staffing/Teamwork		
21	Supervision, Assessment NMC (2018) standards and or staff updates.		
22	Training of staff incl. clinical skills and education: clinically based or formalised		
23	Alternative models or ways of training		
24	Physical/ Clinical environment and associated factors (Human)		
25	Documentation		
26	Perception of staff or student shared with participant and feedback		
27	Technical communication with staff and/ or students		
28	Alterations in normal working patterns		
29	Coronavirus		
30	NMC: Role as a regulator, the register or specific remits.		
31	Nursing, Education and/or theory to practice gap		
32	Transferable knowledge or skills (including interprofessional learning and support)		
33	Nursing Culture or Climate/ change over time (incl. attitudes of student and staff)		
34	Patient or person centred care (incl. patient assessment and care interventions)		
35	Imbedding, implementing, interpreting and / or acceptance of the new standards		

Appendix 11. Related work to thesis I have published and referred to within the thesis.

Hodgetts, L.J. (2023). Have we skipped a beat with the *SSSA*? [PowerPoint Presentation]– CSPACE Conference: Rhythm of Learning and Living, Birmingham City University, 5th July.





Thinking piece Question:

If the NMC have issued guidance under "What do Academic Assessors do?" and it is stipulated that there will be joint working with a nominated practice assessor to form a recommendation for a pre-registration students progression:

Have we skipped a beat with the current interpretation of the NMC guidance and the role of the Academic Assessor? – is it significantly different from what a Personal Tutor used to do under the 2010 standards for nursing education, and is there potential to use it differently?

There is additional criteria that discusses what the role of the Academic Assessor which is broken down into a number of subcategories:

- Collation and Confirmation of Academic Learning
- Assessment for Progression
- Upholding Public Protection
- Managing a Student not meeting the progress expected
- Handing over to the next assessor (if relevant)

Detail within the collation and Confirmation of Academic Learning guidance stipulates that part of an Academic Assessors role is responsible for reviewing, collating and confirming that the pre – registration student has achieved all proficiencies and programme outcomes in their academic learning. This guidance then states:

" In order to make a recommendation for progression the academic assessor must make a judgment about student achievement in the academic environment based on the collation and confirmation of their academic learning. The academic assessor should take into account the student's history of achievement throughout the programme and across theory and practice". (NMC,2019a)

The thinking piece -

There could be perceived discrepancy when interpreting the role of the Academic Assessor due to the detail within these two parts.

- In 7.5 the guidance about working in partnership with a practice assessor, which lends itself to evaluating the pre- registration students progress and recommend progression to the next part of their training.

Critical points:

- No mention about the referral process or if there is discrepancy in opinion between the parties.
- There is also no discussion which considers how this may be negotiated beyond what is documented in an EPAD or similar.

However, in the guidance for collation and confirmation of academic learning there is no mention about this being a joint decision between the practice assessor and themselves.

Instead, the Academic Assessor should consider the pre-registration students history of achievement through the programme and across theory and practice – this is not dissimilar to the use of the previous Ongoing Achievement Record which was reviewed by the Personal Tutor.

There is no mention of marking of a students portfolio or similar - ? Potential biases if marking personal students work

Thankyou for listening and allowing me to introduce this thinking piece ☺

References

Nursing and Midwifery Council (2010) *Standards for competence for registered Nurses.* Available at: nmc-standards-for-competence-for-registered-nurses.pdf [Accessed 21/03/2018]

Nursing and Midwifery Council (2019) *What do academic assessor do?* [online] Available at: What do academic assessors do? - The Nursing and Midwifery Council (nmc.org.uk) [Accessed 11/08/2022]

Nursing and Midwifery Council (2019a) *Collection and confirmation of academic learning.* [online] Available at: Collation and confirmation of academic learning - The Nursing and Midwifery Council (nmc.org.uk) [Accessed 15/06/23]