

**Pre-Registration MSc Project Preliminary Report**

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This research project was funded by Health Education England, North Central and East London to evaluate a programme of study commissioned at the University of Hertfordshire during the time March 2014-September 2016.

This project was preceded by scoping work which examined MSc pre-registration nursing programmes in England (Appendix A). It is also complemented by an additional research study with a service improvement element, examining our BSc Nursing programme for Adult students. Since both contribute useful contextual information to pre-registration MSc Nursing, the findings from them are occasionally referred to within this report. Our report to HENCEL refers to the BSc Nursing “Learning to Care” Study as a parallel or “sister” project, which was funded by quality uplift monies from other educational commissioners.

Phase 1 of the HENCEL commissioned study was an examination of practice assessment documentation, which at the time, included a large amount of textual data from students and mentors, as well as signed competencies (Appendix B). Our sister project has additional elements, which included a wider range of focus groups with link lecturers, practice mentors, and educational facilitators in our placement areas and a workshop day (collated results shown in Appendix C), but with no career’s follow up. The data extracted from the MSc pre-registration student’s practice assessment documents is shown in Appendix D. The career’s follow up survey (Appendix E) is reported for 12 month’s outcomes for those already qualified, with more to follow in Sept/October 2016.

We are extremely grateful to all those who completed interviews and surveys to help inform our studies. The work of the research team has worked hard together to ensure that the findings are trustworthy, and that your important opinions are heard.

Our thanks are also extended to HENCEL for funding this project. We hope that you find this report useful.

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**Chapter One: Project Specification.**

**Pre-Registration MSc Nursing Project.**

**Health Education North and Central East London.**

The University of Hertfordshire began Pre-registration MSc Nursing in September 2012 and is one of only 10 institutions commissioned to offer these programmes in England (UKPASS,2013). Entry criteria to the programme requires students to hold an undergraduate degree in a related subject, with students expected to meet academic criteria and acquire professional competencies in a 2 year timeframe. Scoping work at UH indicates that across the country minimum timeframes, prior health care work and entry requirements vary considerably (Young, Godbold and Wood, 2014). There has been no research investigating student experience or outcomes of these UK pre-registration programmes, although Dawley (2003) found that employment amongst nurses with masters qualifications in the US at registration was different from their graduate peers (despite their state final results being similar) and Drennan (2008) showed different UK employment opportunities for nurses (RNs) with post- registration MScs.

Care and compassion are embedded in pre-registration nursing’s essential skills cluster (NMC, 2010) and the CNOs Vision for Nursing (DH/ NHS Commissioning Board,2012). Yet a systematic review shows a research evidence gap about holistic competence in pre-registration training (Yanhua and Watson, 2011). Assessing theoretical and practice competencies in master’s RNs is found to be problematic (Gerrish, Ashworth & McManus, 2000), and it is important to evaluate this aspect of the pre-registration MSc curriculum.

Maas Burhans and Alligood (2010) showed students learn from lecturers who model and teach intrinsic qualities of caring and empathy (emphasising nursing aesthetics, not simply technical skill acquisition), but also that they place most value on situated learning in practice. Achieving consistency in placement quality is problematic (Skaalvik, Norman and Henriksen, 2012), and evidence from Francis and Keogh Reports (2013) recognises the extent of these problems. The inextricable link to nurse education, (based on 50% theory, 50% practice) has been noted (Council of Deans of Health, 2013; Darbyshire & McKenna, 2013). Furthermore, Berwick (DH, 2013) argues that student nurses can be instrumental in promoting change in practice.

The philosophical stance of the project is designed to develop educational expertise and enhance student experience beyond the lifetime of the project, which has local and national significance.

The new pre-registration MSc nursing programme at UH is a result of contracting with NHS London, and is currently planned to continue until at least 2017. The move to a graduate nursing workforce and technological advance increases the likelihood that programmes like these will become more common. It is vital to capture important data about the development of these students early, particularly in the light of public debate about the quality of nurse education.

Research Aims.

1. Describe pre-reg MSc student nurses’ understanding of the concept of caring as it develops across the curriculum.

2. Explore the extent to which UH educational activity and clinical practice settings help graduate student nurses develop holistic caring competence.

3. Describe the employment plans of these students.

Methods.

Practice assessment documentation (PAD) will be analysed at the end of year 1 and year 2, using framework analysis\* (this includes written material for each of the essential skills clusters for a sample of students, their interview reports and their compulsory practice statements).

Pre-registration MSc Nursing students will also be invited to a focus group in each of the 2 academic years. Using critical incident technique, these interviews will chart the development of student understanding of caring. This technique overcomes reporting sensitivities (Redfern and Norman, 1999) and is used by many different nursing studies (Schluter, Seaton and Chaboyer, 2007). Our first cohort will be also be invited to take part in a focus group prior to leaving to review their experience & employment plans prior to qualifying. All groups will be encouraged to share incidents from university and practice which exemplify their developing understanding of caring activity.

Sessions will be recorded using a digital voice recorder with field notes. Framework analysis\* for both PAD and focus groups will be performed using the Caring Behaviours Inventory (Wolf et al, 1994). Career progression and aspirations will be measured using a survey approach, such as Roxburgh et al (2010) every 6 months for at least a year. This will be used to assess career aspirations, preferred clinical areas, intention to remain within London, perceptions of job demand, job control and job support, as well as CPD needs.

Dissemination.

This project will strengthen future tendering for these programmes, as well as inform future research. Knowledge will be derived which may inform an understanding of the development of holistic caring competencies in these students compared with more traditional nurse education programmes (work at UH examining BSc students is already in progress). With the support of departmental management, academic nurse educators will be able to consider their practices in the light of findings of the proposed study and adapt accordingly. Similarly, local practice settings will be able to review placement learning, strengthen commissioning patterns and improve workforce planning.

**Costings: TOTAL- £24,691 see attached sheet**

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**Chapter 2: Phase One. Practice Assessment Documentation.**

**Pre-Registration MSc Practice Assessment Documentation (PAD) Report.**

**Background:**

The assessment of student nurses in practice has been based on the Essential Skills Cluster as directed by the NMC (2010). This requires educational establishments to provide a method of demonstrating that competence in nursing practice has been demonstrated by each student nurse and this is commonly achieved by requiring each student and their mentor to complete a standardised record of achievement, completed in each clinical area, which taken together over the course of a programme forms a portfolio of practice. Prior to Sept 2014, all pre-registration students at the University of Hertfordshire were required to complete Practice Assessment Documentation (known as PADs) and these contained elements of care, which were required to be signed off in a “tick box” fashion, once a student was deemed competent in an area, together with written “free text”, which was designed to provide an audit trail of the learning that had taken place in that setting, completed by both student and their mentors.

Much has been written about the assessment of student nurses by their mentors in practice areas, and evidence has accumulated that indicates that this does not always occur in reliable and valid ways. Similarly, much has been written about nurses’ ability to care in practice in a way that patients find meaningful. This has sometimes been linked with the moving of nurse education to higher education institutions in the UK, although there is little evidence to support this view. This research sought to discover whether evidence of caring behaviours existed within the PADs for pre-registration nursing students who study on this master’s programme in England.

**Method:**

17 Practice Assessment Documents (PADs) were randomly chosen so that each year group within the MSc was represented. The Caring Behaviours Inventory (CBI, Wolf et al, 1994) was used to perform a framework analysis of the textual data from students and their mentors which gave evidence to the items from each essential skills cluster, as well as the written records of the initial, mid-point and final interviews, the compulsory practice statement, designed to show that the student behaves in professional manner at all times (Appendix D).

The written text in each PAD was coded manually using the item clusters within the CBI (see appendix one). This coded data was then transcribed under each CBI code and subjected to thematic analysis. Each section of coded data, was examined to ascertain what students and their mentors believed constituted important elements of caring that they had demonstrated or observed within their practice learning environment.

Three post-doctoral researchers coded and extracted data from a range of PAD documents within each cohort. They individually transcribed it, analysed for themes arising within CBI codes, and then subsequent to allocation of themes across the whole data set, produced reports pertaining to allocated themes.

Methodological rigor was achieved by each researcher piloting the initial CBI framework with 2 PAD documents, followed by a team review of the codings. This aided conceptual clarity, in turn enhancing transparency, reflexivity, dependability and consistency within the team. It also enabled the team to add a “learning foundations of care” category, which appeared to be important from the pilot. There were clear examples that students gave of their learning which were primarily about how they learned caring activities, but were not necessarily easily coded within the CBI, since this had been designed to capture caring behaviours in qualified nurses.

After the pilot, the team had achieved a good level of agreement about the use of the framework, with each researcher progressing to code and extract data from a selection of the remaining PAD documents for the MSc students in each year. To ensure that there was no “methodological drift” and to increase rigour, regular team meetings were held, during which data sets were reviewed and shared within the team.

Analysis of the codes was similarly reviewed within the team to promote rigor and dependability. During these discussions, the team became aware that there were a number of pieces of extracted data which could be considered strong examples of “caring behaviours”, but which were characterised by “woven” accounts of care. By this, we mean that individual exemplars of care, were relevant to several coding categories of the CBI, and often expressed as such within the same sentence. Where this occurred, we have noted it in the text. Once preliminary analysis had taken place, it was clear that the data set seemed to contain strong overarching themes, which better described what students and their mentors wrote about caring behaviours. For these reasons, the findings of this report will be presented in the overarching themes that are drawn from our second, deeper analysis. The highlights to our text indicate which Caring Behaviour it originated from, as shown in Appendix D.

**Results:**

The PAD documents contained an abundance of good examples in which MSc students described caring behaviours. Mentors also gave much evidence about this aspect of their progression in learning in practice about nursing. A parallel project, looking at BSc students within another Trust offering placements to students, found broadly similar elements in the written accounts of care, although MSc students tended to be more detailed in their writing, and were more often characterised by their mentors as “hard working”. A typical example of this would be:

“Has worked hard with all her interest, involved in all activities with patients, patient’s families and all team members” KRY1, p73

**Management of Learning.**

This category arose naturally through many written accounts designed to demonstrate the students’ ability to fulfil the essential skills clusters (NMC, 2010). MSc students write often about sharing the responsibility for learning with their mentors and other multi-disciplinary members of the team:

“I sought to understand and extend my knowledge and skills by reading in depth, asking questions, asking to be shown how to do tasks, going on doctors rounds and working closely with other staff members” RG12, student p1

“Shares her research and discusses about better ways of providing care for better patients experience”PW2, mentor p92

Mentors closely related shared learning responsibility to the students’ attitude to learning:

“She is a dedicated learner and I am happy with her progress” PW5, p37

“[name] has been a very pleasant student, who takes great emphasis on all requirements eg NMC conduct. She is a keen student asking appropriate questions with good basic knowledge. She will make a very good nurse once qualified” PW2, MSc year 1, p 70

“[name] reflects well on situations by asking questions and researching in her own time” KRY2 , year 1, mentor p80,

Students saw one of the benefits of doing extra work as related to achieving a level of confidence in practice:

“I seek to extend my knowledge by research areas I feel I am lacking in and taking additional learning opportunities such as spending days with a practice nurse at the leg ulcer clinic” PW3, p31

This confidence in skills acquired was also important to mentors and patients:

‘[Name] always show a confident approach when dealing with patients needs and they in return show confidence in her care…..

She is able to undergo tasks given to her confidently *(sic).*’ KRY3MSc yr 1 mentor

But there is an element of self monitoring and mentors’ monitoring the student, to ensure safe practice:

‘\_\_\_ has gained confidence and has worked within her capabilities and clinical governance frameworks under supervision at all times’ KRY1MSc yr1

Students saw shared responsibility for learning as a method for managing their own stress:

“I am able to manage my own stress by talking to my mentor or other nurses if I feel that I need to talk about a situation or a patient. Where a situation or a patient has been challenging or upsetting, I find that talking to the nurse helps me to de-stress and understand why something has happened” KRY2 , p99

“I felt a little out of my depth (ECG on a distressed patient). Another member of staff acknowledged my concern and reassured me…We agreed that I could demonstrate what I did know at a later date” PW2, p90

Like the BSc students, the MSc students were able to discuss how their learning impacted patient care, but importantly (as discussed previously), their narratives of learning (and that of their mentors) include more links to patients:

“I actively try to seek knowledge and extend my skills by using various sources of information, ward intranet site, policies and procedures of ward and hospital. This helped me to improve my care, for example, while working on a C Diff unit, I needed resources within a ward. This helped me to provide good quality care to the patients I cared for who suffered from C Diff” PW, MSc yr 1, p69

“I use reflection and self-awareness including feedback from mentor, patients, families to improve the level of care I give” RG13, p22

Both students and mentors identify a level at which the student is performing in relation to a specific skill or competence. This gradation and acknowledgement of development in skills acquisition appears to be unique within the caring behaviours, or much more overt than any others (i.e. students either do or do not respect patient’s dignity, they are not starting to, or developing respecting patient’s dignity). This may be as a result of prompting of ESC or greater awareness of multiple skill levels before reaching competence as opposed to something like respecting patients / informed consent. Both students and mentors occasionally suggest ways of remedying low skill level or enhancing practice.

‘I have become much more competent in preparing IV medication’ MSc year 2, PW 5

‘Needs to continue to developing practical skills in wound care/ aseptic technique has improved in patient medication administration and patient admission and care planning’ KRY3MSc yr1 mentor,

‘I know that I will become more competent at doing clinical tasks the more I undertake them. For example, I have given injections,insulin, enemas and catheterised 2 female patients, but try and practice these skills where I get the opportunity’. KRY2 MSc yr1

**Application of Theoretical Knowledge and enhanced understanding through seeing and doing in practice.**

Students talked about applying existing knowledge to practice, but also about getting a better understanding of their theoretical knowledge through seeing it in practice.

‘In the DSU patients were not isolated if they had an infection, however, often their treatment or procedure was administered at the end of the list to reduce the risk of infection spreading’. MSc PW 4

‘I have greater knowledge now of the diabetic patient and the care they require’ MSc PW 5

‘Throughout this placement I have developed knowledge about how illness and disability can effect individuals and their families at different stages. An example of this was an elderly lady admitted with a UTI and confusion, her family were distraught with this and therefore a sensitive approach was needed when approached and dealing with this family, taking respect for personal preference food choices, as she was Jewish she required kosher meals’. RG PAD 11 MSc.

Equally, skills, knowledge and competence acquired from on the job learning was clear in MSc Student PADs (as opposed to learning something in the classroom and taking it into practice):

‘She has really worked hard, even going out of her way in helping in this department. I am very impressed withal the skills she has acquired so far’ MSc PW 5

‘\_\_\_\_\_ was involved with medication rounds and preparing injections under supervision and she is capable to manage the workloads. Also attended IV infusion pump training and gained more knowledge of using pump.’ KRY1MSc yr1, mentor

It was common throughout the PAD s for both the students and the mentors to make lists of the skills they were developing, had accomplished and honed. Writing in the PAD was an opportunity for some students and mentors to recognise and showcase their competence and knowledge.

‘I know that the basic principles of wound care management are regular inspection, cleansing, removal of surface debris and protection of regenerating tissue from the environment. In the community, the frequency of assessing a wound and subsequent cleaning and dressing varies between patients and will change depending on the progress of wound healing… I have cleaned and redressed wounds and leg ulcer in patient’s own homes and on a general medical ward in hospital, using the aseptic technique and sterile dressing packs and gloves. Clearing of wounds is done using gauze and saline or prontosan…. Different dressings are used for specific wounds and the Trust has a wound management product formulary which guides the nurse in their choice of dressing so that optimum wound healing can be achieved.’ KRY2 pre-reg Msc yr 1

‘Involved in admitting patients, transferring patients to other hospitals, with preparing a transfer letter, arranging patients take home medications from pharmacy, involved in preparing fast track paper works, escalating patient to MRI department, involved with patients personal care and managing patients with mobility using aids and safety’ KRY1MSc yr1

Evidence based practice is a very small theme within the PADs, and is perhaps notable for this reason amongst MSc students, since we would have expected evidence based practice to feature far more highly. This may be because they see it as so essential to their practice that they do not see reason to mention it, or because they do not articulate their learning to care in practice in this way.

‘Throughout my placement I have used evidence based sources including the BNF and NICE guidelines’ RG PAD 11 MSc

Students identify a variety of methods to accomplish learning and these were more commonly related clearly to patient care amongst MSc students than their BSc counterparts:

“I have learnt more about the different drugs, what is involved in a surgical ward and the different procedures…by allowing me to have my own specific patients to look after which has made me understand how it feels to be a nurse….(p45)….I have been able to follow a patient’s journey and make an holistic assessment of their needs. This has given me more confidence and learnt a lot more about caring for a patient. I have learnt to prioritise and assess the patient’s needs and what they may need doing first” KRY3,student, p94

This student has identified 4 types of learning in practice: learning about an issue, learning about a placement’s procedures / activities, learning about the experience of being a nurse and learning about patients unique profile of needs. All of these types of learning are described as being embedded in learning through patient care delivery.

It is important to note that when mentors write about the students’ learning in practice they identify that they clearly enjoyed working alongside them. A typical example of this would include:

“[name] is an asset to the university. I have thoroughly enjoyed working and teaching her. She is always willing to learn and listen. [name] is hardworking and diligent. She is ready to take challenges, approachable and works well within the team” KRY2 , mentor, p85

**Being Watchful.**

This theme arose in our PAD data in a number of different ways, with links to observation, monitoring and checking the patient and watching them carry out self-care.

‘many of the patients that I have been caring for are prescribed furosemide at high doses and therefore their urine output needs monitoring and their blood pressure.’ KRY3, p107-8

And a mentor summarises the work of a student, saying:

’ she is very brilliant and she is able to communicate at all levels and *makes sure* that the patients feel very relaxed and calm during procedures. An example of this was shown when she kindly spoke with a client who was having ear syringing done and *made sure* he understood the procedure that was to be carried out’PW5, mentor, p.86,( italics added)

A student expresses that:

“Where possible I try to encourage patients to take an active role in their care. I try to encourage patients to participate in self care *(if able)”* (italics added) KRY1

This type of watchfulness was discussed in detail on many occasions in relation to dignity and respect, which seemed to indicate that students feel a responsibility in maintaining levels of vigilance about how this is addressed within their placement areas:

“Recently I had to constantly remind another staff member to cover the patient whilst we washed him. I asked the staff member to put himself in the patient’s ‘shoes’. By acting in this way I am able to maintain the patient’s dignity” PW2 p79

But there was a sense of continuously monitoring their own practice in this regard, too:

**“I try my hardest to maintain the patients dignity even when it is difficult. For example, patients with confusion undressing on the ward. I ensure that there are no gaps in the curtains and that when I want to enter a closed curtain, I am ok to do so and the patients remain dignified” MSc KRY1**

**‘I always ensure that I obtain consent from the patient or their relative / carer (where required) before undertaking a procedure or giving treatment. I always explain what I am going to do before doing something to the patient eg informing he that I am going to give the insulin or that I am going to insert the suppository, so that they are aware of what is going to happen and so they have the opportunity to refuse if they wish’ MScKRY2**

Mentors also reflected this need for vigilance in supervising students in placements:

‘[NAME] respects patients privacy and dignity at all times, always gaining consent ....’. MScPW4

And it seems to be linked to a recognition of the details of care, when a mentor notes the student:

‘will be a fantastic nurse. She pays attention to detail’. (PW5, p.86)

**Avoidance of Harm.**

Harm avoidance is often stated in a very straightforward way:

“She …. was able to care for the patient safely” KRY3,MSc yr 1, , mentor

However, it appears to be related to the watchfulness required in a caring nurse, previously described:

KRY3 states; ‘When I felt a patient may be vulnerable, I have reported this to a member of staff for safeguarding purposes’

This watchfulness for the vulnerable person and consideration of both primary and associated needs is evident throughout these PAD documents, as indicated in the following example:

‘Furthermore, leg ulcers can be very painful and restrict mobility which can further isolate these clients (KRY1).

Watchfulness is closely linked to planning ahead to avoid potential harm:

‘I have been involved in discussions with clients in relation to keeping the dressing dry so not to shower or bath but to have a sponge wash. I have explained that excessive moisture on a wound increases the risk of infection and inhibits the healing process…explaining that excessive moisture can slow the healing process…..’ MScKRY1

‘I help de-clutter the ward corridors and bed spaces to help promote health and safety’ KRY10.

“I have supported / safeguarded patient from vulnerable situations and protected them from harm eg using communication skills/ care/ compassion to reassure patients with dementia and stop them pulling out catheters/ cannulas vital to their well being. I have used the same skills to ensure the similar patients took their medication, took on adequate fluids etc RG13, MSc, p11

One mentor relates caring for the vulnerable patient to compassion, when she states:

‘is very caring and as we have mostly elderly patients, is very compassionate with them’ (KRY1, KRY).

Partnership and advocacy appears to be a theme within the data about harm avoidance, contained in the PADs:

‘I have engaged in person-centred care, empowering service users of all ages and backgrounds to make choices about how their needs are met when they are less able to meet them for themselves. I have achieved this by communicating with service users, families or carers and explaining the care planning process and asking questions about how they normally meet their needs given patients the upper hand in their care and involved them in the assessment and care planning process.’MScPAD12RG

‘I always explain to a patient what I am about to do as they can give consent, I also empower the patient as much as possible so they can make decisions about their treatment as much as possible’ MScKRY3KRY

‘I can appreciate the benefits of educating individuals and the wider public to promote and maintain the health and population. An example of this is hand washing initiatives from the department of health can we as nurses lead by positive example to actively encourage patients and relative to partake in their own care with regards to this.’ MSc PAD11 RG

They also make the link between harm avoidance, understanding and flexibility*:*

*“*The disposal of clinical waste in the community is sometimes difficult due to clients not having clinical waste bins. Where possible clinical waste is disposed of in a clinical waste bin in places such as residential and nursing home however in clients own home waste is double bagged and given to the clients/ carer to dispose of into outside wheelie bins. All clients requiring sharps at home are supplied with a sharps disposal box which I will always use. I have adhered to health and safety at work act as well as the infection control policy. I make an effort to protect myself and the clients with the appropriate use of gloves and aprons as well as regularly washing my hands, where hand washing facilities are not accessible I have used alcohol hand rub” KRY1, mSc yr 1,p105

“ I am aware that patients who become actively unwell within their home setting should be sent to A & E by calling emergency services to ensure safety is maintained” PW 2 MSC yr 1

**Flexible, Adaptive Care.**

Throughoutthe PAD documents there has been an emphasis on students making an assessment of patients and taking appropriate action, or seeking advice from the appropriate people on what action to take. One student states this succinctly:

‘I am able to adjust my nursing to fit the needs of the patient as every patient is different’ MScKRY3

This is often represented as a learning moment or opportunity.

‘I have increased my skills set, particularly related to assessment and RACE. I have a greater understanding of a normal ECG trace’ MSc PW 4

‘I am able to identify the cardinal signs of acute deterioration, for example, patient at risk score, early warning signs’ KRY10.

‘As part of the admission process I ask the patient or their relative questions about their needs to determine their level of independence, their psychological state, any social needs at home and any cultural or religious requirements…[these] are documented…so that these can be handed over.’ MScKRY2

‘I am able to recognise the main sign of a wound infection are inflammation, redness, pain, warmth, swelling, malodour and offensive / excessive exudate. I know that if an infection is suspected I should report it to a senior member of staff’ KRY1MSc yr1

‘\_\_\_ has observed different types of wounds whilst in the community such as fungating, post-op, lacerations, skin tears and leg ulcer. She knows what signs to look out for and what action needs to be taken if infection is suspected.’ KRY1MSc yr1

This ability to assess patient situations, contextual and organisational factors is key to the provision of flexible and adaptive care, which forms a major theme in the PAD data. This can apply equally to relatively simple nursing tasks, which might be considered the foundations of care:

“I have been feeding many patients. When I do I ensure that they are in a good position and are fed straight on. I always ensure that patients can reach their drink and that it is in the appropriate container for the patient’s needs” KRY1, MSc yr 1, p108

Or with added complexity, allowing for patient choice:

“I have worked with patients and ensured their rights in decision making and consent are respected and upheld, for example, allowing patients to decide whether they would like to be turned on to their sides every two hourly, seeking consent before administration of injections” PW MSC yr 1 3 p89

Or for adaptations to care according to emotions:

‘So not just fixing the problem but also looking at the psychological and social issues and family members. The approach must be holistic and look at every aspect’ Student PW5;

This flexibility includes addressing the needs of families, also reflected in many other comments:

‘I have also cared for patients with fractures/broken ones who had advanced dementia and had to be aware of how disorientating /frightening hospitalisation can be for them and used care/compassion in caring for them and given assurances to their families’ (PAD RG 13)

‘I take pride in my caring and compassionate nature. An example of this was when caring for a palliative patient. A family member started asking me some sensitive questions about death and dying. I used my **communication skills** to actively listen to the concerns and respond as best as I could. Shortly after the family member thanked me and told me they had praised me to the ward manager regarding the sensitivity and care I had shown in what was quite a challenging conversation’. KRY1

And one student was particularly concerned for those who cannot express themselves fully:

‘In some patients it is not always obvious when they are in pain and they are unable to communicate their level of pain verbally. On my surgical ward placement we have a patient with dementia that cannot communicate his pain, but signs of agitation and restlessness have indicated that he is likely to be in pain’ KRY2

‘For example one Italian patient does not speak any English so I used my mobile phone to try to find key phrases to try and communicate with him and keep him entertained’ KRY2

‘Another patient kept forgetting where he was so I wrote this down for him so he could read it when he needed to’KRY2

Adapting care according to cultural and personal norms was another way in which MSc student nurses sought to provide high quality care:

‘Muslim and Hindu women may be reluctant to sign consent forms for their care as in their culture it is traditional for their husband or father to carry out this task, Legally and ethically in the UK the patient(any female patient specifically) signs their own consent to care form. However out of respect for the woman’s beliefs this may be done in the presence of her family.’ MScPW2

“When caring for an elderly gentleman, who needed help with self care, I asked him would he like me to help him wash. He noted that he preferred the male health care assistant to assist him and his wishes were respected.” MSc PAD11 RG

There is also recognition by mentors that adapting care is closely linked with issues of consent:

Consent was continuously upheld and no decision was made without the patients input, providing a person centred approach to care. MSc PAD11 RG

This link with patient choice was evident in abundance, and could apply in the widest sense:

‘Spending time with the GP practice nurse has allowed me to gain a greater understanding of how lifestyle factors and choices impact on a person’s well-being’. MScyr1PW2

There is also a sense of the need to adapt a plan of care according to changing need, when it becomes appropriate:

‘I have been involved in care planning, ensuring the required nursing interventions are explained carefully to the patient and by actively involving them in the assessment process, listening to their responses and responding to their expressed wishes/needs…. I also appreciate the need to sometimes adapt care when needs change and the importance of always keeping the patient involved in this’ MScyr1PW2

**Compassion, Empathy, Attitude and Communication.**

The evidence from the MSc PAD documents is focussed on **communication** with *vulnerable patients* and *in times of distress*. There are several examples of the students going ‘out of their way’ and making an extra effort with patients. One student writes about a man with learning disabilities who was worried about his admission and asked many questions.

‘[I] made an extra effort to listen to this patient, laugh at his jokes and at the same time tried to reassure him ‘(PW2).

The mentors also commented that this student spends time listening and talking to patients. There are several examples of the nurses **reassuring** patients by explaining and answering questions. Student notes:

‘I have reassured a patient during a procedure and explained what is happening, answering any questions they might have’. (PW4)

The mentor confirms this by saying:

‘The patients felt reassured by her presence’. PW4

Another states her student has:

‘used enhanced communication strategies and can engage therapeutically with patients, actively listening to expressed need’ e.g. when there were concerns of pain or discomfort’ (PW8).

One student writes extensively about different communication strategies e.g. explaining, listening, distraction, using her phone to find key phrases to communicate with a non-English speaking person, non-verbal skills, and observation that she uses with patients. She demonstrates a particular perceptiveness and to patient’s needs. Some examples of this are:

‘Whilst undertaking procedures such as injections or removal of dressings, I will talk to the patient and try and take their mind off of what I am doing if I feel that they are anxious or in pain. In hospital when patients seem bored or depressed, I will spend some time talking to them or fetch them magazines or leaflets to read. One patient with learning disabilities expressed that she was fed up so I went and got her some colouring books and spent some time helping her complete her jigsaw puzzle’. (KRY2 ,)

Another student writes about the need to include families in the care:

‘I have also cared for patients with fractures/broken ones who had advanced dementia and had to be aware of how disorientating /frightening hospitalisation can be for them and used care/compassion in caring for them and given assurances to their families’ (RG 13).

Compassion is worn by students as a badge of pride:

‘I take pride in my caring and compassionate nature. An example of this was when caring for a palliative patient. A family member started asking me some sensitive questions about death and dying. I used my **communication skills** to actively listen to the concerns and respond as best as I could.’ KRY1,

‘I try to apply the 6 C’s to all aspects of patient care, particularly compassion. This also applies to my involvement with relatives and carers’. (PW2, p.42).

This is linked to specific non-verbal **communication skills**:

‘While working in the leg ulcer clinic a few clients commented on my soft touch, saying that I am a natural’(KRY1,).

‘When people are upset I try to comfort them by talking to them in a kind and calm way and use touch where I feel it is appropriate. i.e. touching their hand or putting my arm around them. For example one patient was upset about not seeing her baby son and felt that no-one was telling her what was going on. By listening to her and giving her time, she felt better, and her mother said they appreciated me taking the time to talk to them as they felt no-one else had’ (KRY2).

This theme was also evidenced by comments from the mentors about the empathetic nature of students:

‘[Name of Student] has demonstrated a high level of compassionate care. Has excelled on what can be a challenging ward. She has worked with many patients with dementia and displayed empathy and compassion’ (RG, p.2/2).

‘She is very caring and compassionate with patients as well as their families’ (KRY2).

‘the patients have felt reassured by her presence and she has shown care and compassion’. (PW4)

The themes of **comfort**, **support and reassurance** are not often explicitly related to the concept of compassion in the MSc PADs (which occurs more often in the BSc students), although one student states:

“The role of the nurse is particularly important at this time and is a source of comfort to both the patient and family members at such a difficult time. This offers compassionate care for individuals at a time when they need it most and compassion is at the heart of nursing care” RG11, MSc p14

Whereas the mentor in the same portfolio writes in response about how the development of a therapeutic relationship reflects holism and dignity:

“(student) has worked well with patients and their families at what can be a traumatic time. She does not shy away from difficult situations such as patients with an end of life care plan, Instead she seeks ways in which the result is the patient and families being cared for holistically and with dignity” RG11, MSc p14, mentor, p15

There is a concern that compassion, reassurance and comfort become devalued if they are purely viewed as instrumental; as means to a particular end (e.g.to quieten a patient, to make caring for them easier). We found only one piece of writing which might reflect this:

“I have ensured patients are ready to be discharged by ensuring they are dressed, TTAs are ready and that their personal items are packed. Some patients have been anxious prior to discharge regarding how they are going to cope at home or what will happen when they arrived at the new hospital etc. It is important to explain things to these patients and try to reassure them, explaining that the hospital is for people who are unwell, the risks of being in hospital (acquired infections) and that they are now medically fit to return home” KRY2 , p97

However, this writing was atypical for the student, whose mentor’s comments stated:

“\_ works well under supervision... She is a careful and keen student nurse who is always practising safely” KRY2,p113

Taken within the context of the remainder of the PAD, the student demonstrates numerous examples of compassionate behaviour, and this exemplar is thought to represent the difficulty of the discharge she was attempting and the level of skill at the halfway stage of her learning.

There are several examples of students who demonstrate a good in depth understanding of interpersonal needs, leading to a demand for highly adaptive care. These examples rely extensively on subtle, advanced communication choices and ability to manage the emotional burdens of themselves and of others. There is evidence to believe that mentorship is key to learning these skills in practice:

“I have cared for patients whose families have not been ready for their relative to pass away and have insisted treatment to continue though it was distressing to the patient. This was a particularly difficult situation and when the patient passed away the family were ever so distraught. I was involved in the care of this patient at the end of life and found this quite an upsetting experience….I feel good communication has made passing of a loved one easier to accept and makes a “good death”. I am happy to communicate with other health care professionals to support me in the care I have given” KRY1, MSc yr 1, p96

Compassion for the patient population as a whole was loosely linked to being non-judgemental (italics added):

‘She respects and cares for all her patients equally *without discrimination’* MScKRY2

‘(I) realise the importance of remaining non-judgemental at all times *to ensure patients are being treated with equality and dignity*.’ MScyr1PW2

‘I have handled patients under police custody *with the same respect* as other patients with their condition’. MScPW1

Compassion is linked by one student to harm avoidance:

“I have supported / safeguarded patient from vulnerable situations and protected them from harm eg using communication skills/ care/ compassion to reassure patients” RG13, p11

**Therapeutic relationships**

There is evidence of the development of therapeutic relationships in the PAD’s, but this is a small category:

‘I am kind and friendly, sensitive and compassionate towards all my patients and this has been commented on positively by both patients and fellow nurses (PW5, p84).

‘I saw that she acts in a warm and sensitive way towards her patients. She is kind and caring and she keeps focussed on what she is doing. I also found that she has dealt with patients concerns in an understanding way’ (PW2, mentor p.92).

‘The student ‘assists patients in a warm and compassionate way at all times’ RG13, mentor.

The student 'was very supportive to patients, staff and relatives’ (PW7,mentor, p.92),

**Summary**

The themes from our data describe not only how students learn to care, but also how their mentors assess their ability to exhibit caring behaviours in practice. The analysis of PAD documents shows:

* Pre-Registration nursing students pursue a shared management of their learning in practice. By this we mean that they actively seek and are able to access feedback from qualified staff and their patients which is enthusiastically assimilated into their everyday practice. They appear to pursue a more collective style of learning than their BSc counterparts in a parallel project, which may reflect their graduate skills in teamworking.
* Caring behaviours demonstrated in practice are often the result of different emphases and prioritising of patient or situational needs. This is not easily reduced to a measurable, objective account of care.
* We found good quality evidence of high quality caring behaviours and excellent levels of commitment from MSc students and their mentors.
* All of our themes contain “feedback cycles” which demand perceptual acuity in the learner. Evidence suggests that graduates entering nursing are able to observe and analyse the practice setting in detail, and that this produces students who work extremely hard to process what they see and to achieve high quality learning within the given time frame.

The themes derived from our analysis can be summarised as shown in Figure 1.

**Discussion.**

The process of reading, coding and analysing the Practice Assessment Documents for the MSc students has produced much data which demonstrates caring behaviours. The use of the caring behaviours inventory as a starting place to analyse their writing has proved useful to produce academic rigor across a team. However, there are some interesting observations which can be made about this which include the following:

* Written accounts of care are necessarily limited and may not reflect the actual care given by students and those working in their practice areas. They depend on vocabulary, nuanced understandings of theory and practice, and on levels of analytic skill and synthesis. It is

**“Flexibility” Adaptive Care**

* Individualised
* Contextual
* Not strict interpretation of nursing
* Holism

Culture and Religion

Patient as an Individual

Makes an assessment and take appropriate action

**Holistic Care**

Respecting patient choices

Involving patient and families in care planning

Consent

Shared Assessment

Confidence

**Management of learning**

Self BSc

Shared MSc

**Application of theoretical knowledge and enhanced understanding through seeing and doing in practice**

**Being watchful**

(Observation, monitoring, assessment)

Assisting/helping/ contributing with practical action

Understanding

* How to deliver care
* About patient and their context

Achieving Understanding

Acquisition of skills/practical learning

Evidence based practice

Gaining confidence

I did/she did/he did/they did…

Uses established patient management tools/guidelines

Increasing confidence

Development – insight into own skill level/ competence

Attitude to

Learning

Enjoyment

Maintaining dignity through nursing actions

Teaching of practice learning

* Practising skills
* Information gathering from patient involvement

Care Enhancement

**Relationships**

Therapeutic Relationships

Trust

Rapport

**Communication**

Communication

Manner

Non-Judgemental

**Compassion, Empathy and Attitude**

Empathy

Support, Reassurance and Comfort

**Avoidance of Harm**

* Pointed to knowledge of patients, condition and context
* Risk management

Safety and Safeguarding

Advocacy

Being a patient advocate

Empowering patients to make decisions/choices

* possible that where we have noted differences between MSc student writing and those of their BSc counterparts, it is the MSc students ability to express their learning in practice in written form which is different. This needs further investigation, but is not able to account for the findings where it is mirrored by the writing of mentors.
* Some of our best examples of caring behaviours included threads of writing which, even within the same sentences, often addressed several different codes within the CBI. Whilst we could use the CBI to identify caring behaviours in our MSc students, we could not justify a continued use of the codes to remain true to the narratives of students and their mentors.
* Whilst we have produced themes from the qualitative narratives of students and their mentors about caring behaviours, we acknowledge that there is nuanced judgement required of researchers who attempt to show linkages across these themes. It is possible that other researchers would not have organised their findings in the same way, although the involvement of 3 experienced researchers / nurse educators is likely to have increased dependability, transparency and credibility of the findings.

**Conclusions.**

Caring behaviours have been well distributed across all the PADs that were examined. There are some students who particularly excel in producing detailed text about their caring behaviours in practice, written in a detailed, insightful way. Evidence suggests that pre-registration MSc students are not just “an asset” to practice areas, but that mentors enjoy their contribution to team who offer nursing care for patients.

Further work is in progress which will examine what students say about their learning in focus groups and a career’s follow up questionnaire should further illuminate future planning, both for commissioners and for programme management.

**References.**

NMC (2010) “Standards for pre-registration nursing Education. Essential Skills Cluster: Annexe 3” Nursing and Midwifery Council, 16th September, 2010

Wolf, ZR., Giardino, ER, Osborne, PA, Ambrose, MS (1994) “Dimensions of Nurse Caring” Jo of Nursing Scholarship, 26 (2) 107-110

**Chapter 3: Phase 2. Student Focus Groups.**

**Method.**

We conducted student focus groups across the MSc which extended across 3 different cohorts and were collected from August 2014 to February 2015. Thirteen volunteers were interviewed in four groups, one of which was conducted before their programme practice experience had begun. Four students from the newest cohort chose to be interviewed both before and after practice.

Each focus group was facilitated by one of the research team. This researcher had no teaching, assessment or pastoral responsibilities for the students being interviewed to enhance the trustworthiness of our work. This approach also enhanced the ethical underpinnings of our study, particularly with respect to safeguarding autonomy, freedom from coercion and the right to withdraw informed consent at any point.

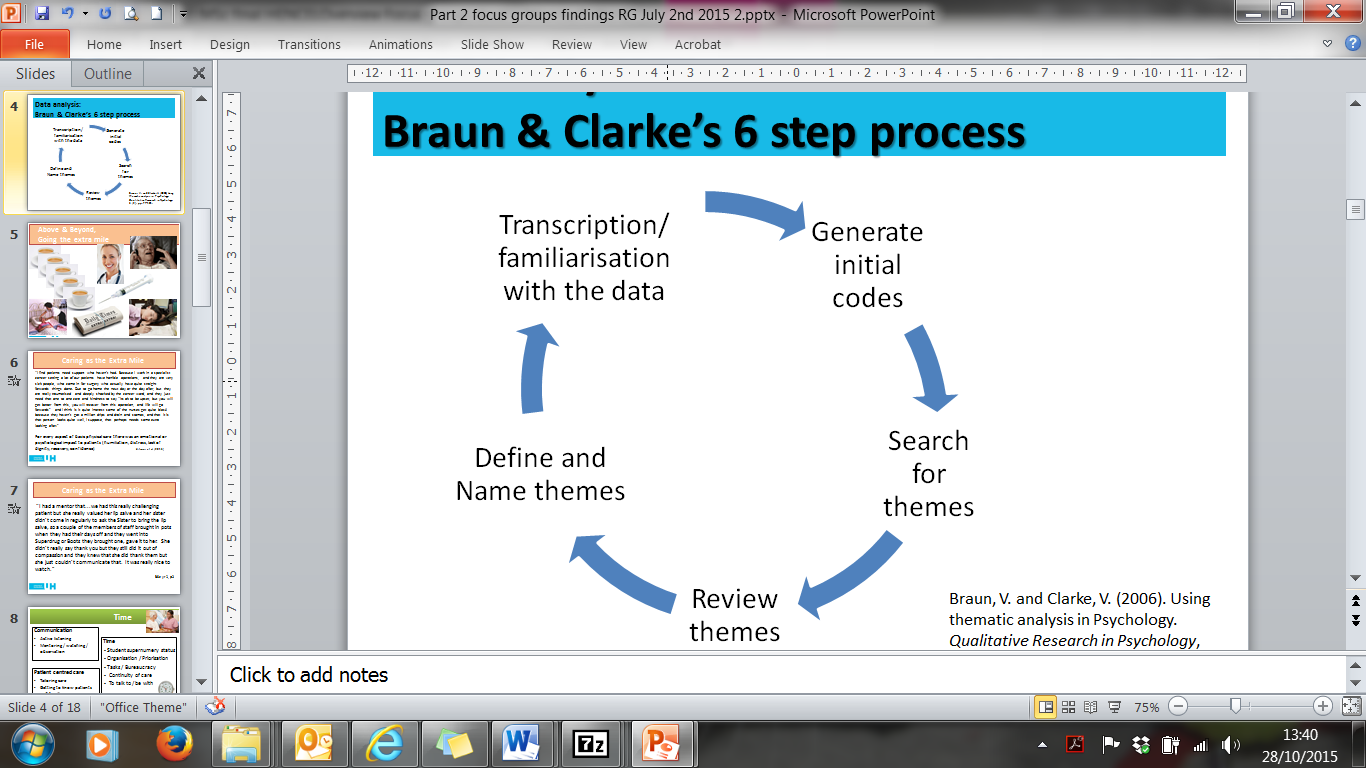
Students were asked to discuss the following questions:

* What recent experiences have you had in clinical practice that demonstrates caring?
* How can staff be enabled to demonstrate care to patients they are looking after?
* What strategies are / should be adopted in clinical practice to ensure caring is routinely embedded in nursing care?

The purpose of the interviews was to understand they thought were “good examples of caring behaviour” in nursing, bringing examples from their personal and professional experiences. The philosophical stance taken by the researchers was appreciative inquiry, although students were able to discuss any situations they chose.

The analysis of this phase of our study followed Braun and Clarke (2006) process as described below:

***Figure 2: Analysis of Focus Group Data***



One researcher for each focus group used coding to develop initial themes for that focus group. Dependability and confirmability was then explored across the team of three researchers for each focus group and then across focus groups. Reflexive discussion enhanced transparency throughout. Final themes were refined and named through a process of co-operative inquiry (Reason, 1998). Findings were presented in two settings, a workshop for practice staff, lecturers and students to check that they reflected participants original meaning and were credible, further enhancing trustworthiness.

**Findings.**

The themes were as follows, shown in Figure 3.

**Above and Beyond:**

Students often talked about good examples of care by contrasting with poor examples of care to illustrate a point:

“It’s very, um, very, very rushed, it’s very, there is no involvement with the patient. For example if you are washing a patient. There’s been occasions where I have helped an HCA out and it’s, there’s no interaction and there’s no explanation to the patient, we are doing this now, we are going to take your gown off, we are going to wash your back, it’s shoving the patient around, doing the task and then. I’ve seen that quite a lot. Not bad examples, but I’ve seen very good examples where it’s all about the patient, about talking to the patient. As I said earlier it’s using that time that you are washing the patient to interact with them and to talk with them, not just about what you are doing, but just generally how they are and ...”

Pre-reg pre qualifying MSc yr 2

In common with our BSc students, they spoke about good caring behaviours being demonstrated when nurses acted outside strict interpretations of her role in order to ensure patients needs were met:

“I remember once she’s[Tissue Viability Nurse] like saying to me ‘I can’t wash this patient’s head because I can’t take them out now[stitches], it’s too late’ but she got a bowl full of water and said to me ‘Come and hold it for me’ so that she could just wash this patient’s head because it was so filthy.

Interviewer: How lovely.

She proper gave it a scrub and washed it and then dried. So she proper did her job with a lot of passion.”

Pre-reg MSc yr 1 after practice

This comment also demonstrates another important finding, which was that this “above and beyond” caring was often seen in the nurse’s own time at lunchtime, breaks or in unpaid overtime.

Students discussed where the professional boundaries should be drawn in caring about their patients when they spoke of caring ‘above and beyond’:

“And I do believe that it has to go beyond a professional line. I don’t believe you have to get your own opinions involved but you have to **go slightly definitely on the side of a friend otherwise**, **to get a really positive change in someone. To get them to engage in their own healing process you need to go to that kind of extra level,** otherwise they’re like a number and that’s, not really engaged in that healing process as well.”. MSc yr1 pre-practice

**Time**

Time was frequently mentioned as a modifier to the ability to care:

‘I’m going to add **time** into this. You, if there was a way to put into the structure, the nursing structure, the routine, the daily routine of a half an hour period where they go and sit purely with one of those patients, *just half an hour, and just talk to that person, or do other things, just, but just be there. That would make a massive improvement because that single half an hour alone would absolutely boost that person because it’s more about… care is really human interaction’.*

Yr 1 MSc Pre-Practice

“I know they didn’t have time but, so if somebody was to do that I would have thought ‘Oh, they’re really sort of pushing the boat out a bit’ because they’re, you know, they’re putting themselves behind just trying to make the patient feel a bit better. “

Interviewer: Putting themselves behind, can you explain a bit more what you mean by that?

Student: Yeah, because on their bits of paper they’ve got everything they need to do, big lists of things, and I know if they spent an extra ten minutes with, you know, a patient, they just sort of miss their lunch or finish later, so, you know, if they were to make the extra time it would be… good.

Yr1,MSc post practice

These findings have been discussed in our lecturer focus group (conducted on our workshop day, funded by BSc and MSc projects) with a focus on the need to enable a more explicit learning within the university teaching about time management, professionalism, and the setting of personal and professional boundaries that are congruent with good health and high standards of care. This is currently being taken forward in curriculum development of BSc and MSc pre-registration nursing programmes at UH.

**Relationships**

The notion of nurse’s who were committed to spending time in ways which demonstrated the “personal investment of self” as an expression of caring appeared often in varied ways (buying newpapers or toiletries, making cups of tea, playing a particular type /genre music from their mobile phone to cheer a patient who wanted to hear it).These caring behaviours with patients often happened despite the bureaucracy surrounding nursing care:

‘I thought it was really nice, my mentor was, she was sitting with me doing my PAD document and then over the other side of the bay there was this little old lady and she was going “I’m frightened, I’m frightened” and my mentor was like “Oh, she looks so sad”. She left the paperwork she was doing with me and went over to the patient and sat with her and was really, really nice and she said “What are you worried about? Why are you scared?” Like, “You’re in the best place, you’re safe” and everything and it was really, really sweet.’

‘And it was good that she, like, prioritised making sure the patient was okay over doing paperwork which I thought was nice. And it wasn’t to, **it was just to have a chat with her and reassure her rather than doing a task that she had to**…’

Pre-Reg MSc Yr2

The purpose of the time spent was often about getting to know patients, putting them in the centre of their care and providing reassurance and safety.

“Whereas some um, other nurses, because of the way they organise themselves, because of their priorities, they will spend the time to talk to them and it makes a massive difference to how the patient feels and to how the patient, and also that, how the end result of their stay in hospital. It normally is shorter and more positive.” 2nd yr MSc pre-qualifying, p1

Another learner discusses the relationship with her mentor and how this has had an impact on her. This demonstrates several things: the use of touch, the calming voice, developing a culture as well as the importance of behaving in a certain way when things are particularly busy.

“I remember one, like one of the mentors I had when I was on placement, when we came in in the morning and then everything is looking chaotic and you think ‘Oh my God, what is going to happen?’ **she looked at me because I was doing the drug round with her and she held my hand** and she went **“It’s going to be all right**” she went “I want you to learn something, in nursing you will come on a shift when it’s like this but everything will happen so you just need to calm down and make sure the patients… because it’s no good you coming in and people standing and moaning that they’re short-staffed or this or that is not happening and time is going, go to the patient and get on with it and we will get there”. That is a caring person because if you don’t care all you want to do is moan because things are not right instead of trying to sort things out and **going to the patients because that’s the time they need you the most because there’s not enough people to look after them*.”***

MSc yr 1 pre-practice with HCA experience

The ability to demonstrate care was very commonly centred on relationship.

“If I’ve had the opportunity to maybe to, look after them on several consecutive days, then it helps than, but yeah, I think, yeah, I think one of my strengths is that I can establish relationships with patients quite easily and quite quickly. So there have been occasions when I’ve become quite attached to patients, to the patients and when they’ve left they presented me with presents, chocolates and that, so that establishing that relationship is, is important, and that as a result the care that I have given them is much more patient-centred sound too..., but much more tailored to their needs. MSc yr 2 pre-qualifying

“some nurses will take the **time out to talk** to patients and realise that there’s the **emotional and social aspect** as well where some patients maybe don’t get that many visitors and stuff, so they actually take the time out just to find out how they are, how they’re feeling.

Because I feel that sometimes we skip those things because we just think it’s not that important but some people do see that as an important role in nursing’. MSc yr 2

Sometimes relationship was discussed as personal reassurance, or in a functionally productive way.

‘I think that really works because when we take our clients in as much as the nurse is going to do everything but I’m still there*, I’m still reassuring the patient that I’m here, “*The nurse is going to help you with that” and then she will let them do it, like “You need to take your tablets”, because they are not family they think ‘Who is this person and where am I and why am I being given these tablets?’ but because you are there you then help out, communicate, even if it’s like a child, their mum is there *so build the relationship with that parent as well as the patient* which would make your lives easier, both your patient and yourself because there’s somebody out there who is coming to advocate for them.’

MSc yr 1 pre-practice:

Students sometimes talked about caring behaviours through the medium of a negative example. This commonly occurred by contrasting good and poor nursing and Health Care Assistant (HCA) behaviour:

“I suppose the nurses seemed to, the ones that I saw, were more wrapped up in the functional duties of a nurse like drug administration and writing up notes and stuff like that. I don’t know if they were deliberately avoiding it, I think it had just become part of, you know…” MSc, yr 1 post practice

“I really liked the attitude of a lot of the HCAs and the other student nurses that I was with. They’d really make an effort to talk to the patient, we even had like some really old patients who, you know, the nurses probably didn’t chat to, we had some in-jokes with them that we, you know, had little jokes every day and it was, you know, it was fun.” MSc, yr 1 post practice

“And like I think, if you get a good HCA who can like bring some humour or something positive into the situation of the washing, the dressing then it really makes a difference for the patients.”

MSc, yr 1 post practice

Skilful communication was also something demonstrated by nurses, which demonstrated caring:

“My mentor.. actually, she would tailor how she spoke to different patients, so she knew that she could be, you know, have a laugh with, you know, Mr So-and-so and that she could call him by his first name and he wouldn’t be offended whereas other patients she would, you know, she had to be quite formal because that’s how they were.

So she was quite good at, you know, getting to know how she could talk to somebody or how far she could push joking around and things.” 1st yr MSc post practice

The students also learned how to adopt communication strategies which helped relationships by becoming self aware:

“With me I found that you have to be aware of yourself because how you are affects the patients. Because it was my first day and going into people’s houses and I was really nervous and there was a man had dementia, and he said I seemed suspicious, and I didn’t mean to come across that way, I didn’t mean to come across that way but because I was so nervous kind of thing and not knowing how to present myself and I realised that I had to be aware of how I was being because it impacted on their like, the care they were receiving.” 1st yr MSc post practice

Several students explicitly link a growth in professional knowledge and competence with developing appropriate levels of confidence:

“Yes, definitely if you have knowledge the more confident you are because if you’re asked to do something and you’re not competent then you don’t look so confident because you just don’t know how to handle it. I think the more experience you get, the more confidence you gain.”

1st year MSc, post practice

Mechanisms for achieving good relationships included touch, patient centred care, talking, spending time, reassuring and comforting patients and being human, and this was recognised by our pre-practice group of students:

“And also when I come in the morning they might...oh they are really pleased to see me rather than oh it’s that, really pleased to see me, rather than oh it’s just another nurse it’s actually just that a relationship has been them and the nurse that is taking the time to get to know them. I also think that if you, I also think that if you give a little bit to them...information about yourself, , not the whole details, but they might ask you if you have children or , that sort of thing breaks the ice and they start talking about their, their family and their background.” MSc yr 2 pre-qualification

Figure 3: Learning about Caring

Role modelling = Culture

Leadership=teamwork=MDT

**“Above and beyond” / “Going the extra mile” / “Back to basics” / Going “out of the way for patients”**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Cups of Tea | Investing own time & money | Needle Phobia | Music | Advocacy for patients |
| Humanity  “smiling faces” | Doing meticulously | Bringing  Newspaper | Hair  washing | Consideration of important needs amidst pressure |

**Time**

Organisation of time in the day

Continuity of care across a week

To talk/to be with/to get to know

Tasks

Organised structure

Bureaucracy

Supernumerary

Professional knowledge/experience

Reflection

Skills/learning

Applied learning(PADs)

CPD

Lose caring

Virtue

Desired place to be

Professional

Personal

P9 pre-practice 1st year MSc

Aristotle all virtues avoid extremes

**Nature/Nurture**

Can I learn to care or is it in me?

Objectification of self - persona - authenticity

Caring Conscience

Personal knowledge/experience

Recruitment

Self-awareness, being shy, confidence, reflection

**Compassion and Dignity**

Passion

Humour

**Communication**

Can learn active listening

Mentoring/watching/observing

**Patient centred care**

RG building relationships

Getting to know patients and families

PW for supporting, enabling, comfort, support, protection

Empowerment –PW

Advocate

Tailoring care

**Culture**

Students discuss the culture of a place of work as being very important in enabling this type of working:

**‘**Well I think if you’re on a nursing team that actually cares about the patients themselves it makes a difference’ ... So, like, I think *it’s the attitude of the whole team and everybody has to genuinely care* rather than have this attitude against people because you’re there to help them.’

MSc, yr 1 pre practice

Role Modelling in relation to culture was also something that was spoken about as a facilitator to nurses being able to demonstrate caring behaviours towards their patients

‘My last placement, the sister actually came out and spent most of her time on the ward going and talking to patients, doing drug rounds, doing washes and mucked in with everybody whereas on all my other placements the sister has just sat in her office pretty much the whole day.

And you do hear nurses make comments that, “Oh, she’s in the office” you know, that kind of thing, and I just think that whole caring culture needs to come from… the sister downwards, yeah’

Pre-Reg MSc yr 2

Role modelling for our students was vital:

“there are people to look out for and try to emulate as well” 1st yr post practice, p33

Negative examples of role modelling and ward culture did exist:

“I had a lot of nurses who would like, would say ignore a patient or, you know, an Alzheimer’s patient crying out in the night, near to death’s door, this was one who was going to die a few days later, and I said to the family, because I was on the night shift, I said ‘Look, I’ll keep an eye on her and if she calls out I’ll go and have a little chat with her because I have time on the night shift, I always do’.

MSc yr 1 post practice

“And I went in just to check on her because she was crying in the night and the nurse said ‘Just ignore her, just leave her alone’.

… I, to some extent I did ignore what the nurse told me what to do**, I did,** and I just, I still went and checked on the lady. So just spoke to her, held her hand.” Pre-Reg MSc yr 2

There was a strong sense that, in these situations, caring could involve the need to behave in a counter-cultural way. This appears to involve courage, perseverance in retaining a caring attitude and a determination to behave in a caring manner :

“Yeah. Sort of ends up being do you care about the patient or do you care most about your colleagues and what they’re going to think?” 1st yr,MSc post practice, p29

This might be coupled with a need to act as patient advocate:

“And I don’t know, you’ve got to, when it comes to your handover you’ve got to speak up, speak loud and make sure everybody else hears you and let them know that there is, you know, if something doesn’t happen about this you will be going somewhere else with it.” 1st yr,MSc post practice

The need to learn despite some of our students being placed in an unsupportive organisational culture of learning in a ward environment occasionally appeared:

“I’ve had some terrible mentors, what is the point? You know, I’ve had people disappear for hours. I think my first week I was on a ward for two hours alone, you know, where was she? She’s gone for a little tea break, you know, and another sister that she’s got away with that for years …..

If you had decent mentors you would get shot of the people that don’t really want to do nursing. Because we’ve heard a few stories of people getting to the end of their pad and not passing, how does that happen? That happens because you get mentors who are lazy, hardly see you at all, like my last one, two days out of my whole placement and ticks me off, how does she know? She hasn’t got a clue what I’ve done, but she’s ticked it off and because she’s had me for that period of time it’s not the last placement, it’s not going to be on her head, far better to say I’ve passed everything rather than fail me on things which means she’d have to pass some sort of input and if she failed me on things then she’d be, then there’d be questions ‘Why has she failed, what are you not doing with this student?’.

So they pass these people all the way along and then they’re failing them at the end and it’s not possibly even the people who are failing, it’s not their fault they’re failing. You’ve got to be taught things, you can’t pick them up via osmosis” MSc, 2nd yr

Ward culture was highly influenced by the leadership of an environment.

“The ward manager on the ward I was on, it was a community hospital, she was, she was lovely but because she had a lot of paperwork to do she never really, you know, she did handover and everything but she never actually, I never saw her deal with any patients in the whole seven weeks.

But, and so amongst the ward, amongst the nurses and the HCAs there was a lot of ‘Oh, it would be good if we could do this’ like just general things like, you know, they’d leave trollies out all day and you’d sort of nearly run into it, and just little bits like that. And all the nurses would suggest different things but nothing ever happened because there wasn’t the manager to take control.

But halfway through the placement they had a new matron and she started and she was in every single day, you know, eight ‘til five and she brought in, ‘So yeah, once you’re done with the trollies put them away’ and she started bringing in all these new, just tiny things like that, you know, she would go round and speak to the patients.

So I think her, I don’t know if it’s because she had a new perspective or that’s just how she is as a matron, but her leadership made such a difference to the ward I feel, just improving it really. “

1st yr Msc post practice

This can also be created by excellence in key team members :

“Back to my, what I said, I remember there was like, near the end there was a new nurse that started and she’d been a nurse for quite a long time but she was kind of old school like everyone would say that she’d done everything properly, she’d make sure at the people’s houses they had their prescription charts, like their drug charts, and all the folders were in order and she done everything to the book type thing.

And everybody was, the nurses that were already there were kind of a bit like ‘Oh, she’s really good’ type thing ‘We’re glad to have you on their team’. So I haven’t been able to see if she’s had an impact on how they work, hopefully she’s kind of benefited the team there because she does things to the T and they’re kind of a bit like… a bit slap dash.” 1st yr post practice

**Nature/ Nurture**

Our first years mentioned empathy and compassion a great deal, whereas our second years were more focused on other demonstrations of care. Both the attitude and the behaviours associated with caring are often spoken of in relation to culture:

“You can learn to care, you know, I think you can learn to care better and more effectively I think. You’ve got to have that willingness to actually want to in the first place though I think, it needs to be nurtured; it’s like a small flame that needs to be fanned a bit with some people.

I mean I think it comes down, you know, to how you perceive right and wrong; is it right to leave that person suffering like that, or how can you actually in conscience leave him with having that, you know, somebody calling out and nobody going to them. You have to have that twinge of conscience before you can actually, you know, if you don’t have it or you get blunted to it from hearing it so often which I think is, you know, people talk about compassion fatigue, I think that’s what happens to a lot of nurses. They suddenly become less focused on the person there because they’ve heard it so many times before.

And the whole thing is, you know, you need some positive people there to actually stop that little spark getting extinguished.”

1st yr MSc post practice

The intensity of learning (which came up in the PAD documents from students and mentors), the shared group culture of being on a pre-registration master’s course and developing a professional demeanour which was consistent with the “personal self” also appeared in the narratives about learning to care:

“You know, the Masters group, we’ve got this idealistic view of what nursing is. …you’re really driven …you know, people have been earning decent money, have given it up, are struggling and really made sacrifices to be on this course. So I think for us, on my first placement I think about three times I was almost in tears because of the disappointment. And we’ve had discussions where I said, you know, if this job, if, on this course people that aren’t going to be stressed and are going to be fine with it are going to be the ones that are lazy because they’re quite happy to turn up, be sent home early, fluff around, have a chat, do a few...but with us, we’re so desperate to learn …..

… because we are idealistic and we want to learn and we are, have been, you know what I mean, it’s a vocation and we are driven and I think there are some people that have done it in the past maybe just because it is a job and I don’t want to say that because there are brilliant, really brilliant nurses out there who really, really are…

But I think … we’re stressing because we’ve had a placement and in six weeks we haven’t learnt anything, whereas if we were just laid back and didn’t care we’d think ‘That’s quite a nice placement, there’s really nice people, we had a laugh’ you know, we’re all going home in tears thinking ‘Oh, all I’ve done is change beds, I don’t know how to do this’ and, you know, that’s how we are because we want to be really, really good nurses and we are, you know…”

MSc student, beginning 2nd yr

The lecturer focus group and practice facilitator group on the workshop day have, as a result of our findings, further recognised the importance of frequently articulating and reinforcing the availability of learning when they are conducting routine tasks to this group of students. Renewed emphasis on communication and patient monitoring during these times is believed by all to be vital. We aim to cultivate clearer understandings of the roles of the nurse and of the HCA as a person who works with delegated responsibility for the nursing care of patients. Equally, commitment to the quality of learning experience in our placements is ongoing and was evidenced by a link lecturer focus group in our parallel project.

The following quote demonstrates another findings which is that students may try to apply theory in relation to their practice, but are not always successful in negotiating barriers to care:

“Another thing I’ve learnt as well is like, you know, when we were taught that pain is what the patient says it is, because if you go in there and listen to what everybody else says, like people will tell you ‘Oh leave them alone, that’s what they do, they scream all day all the time’ and you think ‘This person probably is in pain’.

Because I remember one client who always used to sit by, if you went to sit next to her to talk she used to say ‘I’m in pain, can you take me to the hospital please?’ and I went ‘What’s the problem?’ and I went ‘Where is the pain?’ so I used to go like that, I remember once I went like that and she went ‘Ow’ and I went ‘Is that where the pain is?’ and she went ‘Yes’.

And I kept asking people ‘She keeps saying she’s in pain’ and people went ‘Oh, well she always moans. She sits there and moans all the time’ and in the end she actually had like a big problem and she died.

Interviewer: From that problem?

“Whether it came from that or not, but I remember her sitting there complaining all the time ‘I’m in pain’ and because you’re sitting in a care home like if you’re a student your hands are tied and you think ‘There’s nothing I can…’ all you can do is report it to either the nurse or whoever is in charge and they’ll tell you ‘Oh, don’t worry about it, she always moans, she sits there moaning all the time.”

MSc 1st Year, post practice

In common with other students who are in difficult situations, this student is clearly very concerned about the situation. Although the student clearly does not understand what the actual cause of death was in the situation described, it seems to represent a learning opportunity taken by the student, even from such a negative situation. This can be viewed as a failure in knowledge transmission / mentorship on many levels. The need for this balance between emotional detachment and professionally appropriate caring is discussed in our focus groups and in the literature and appears connected to the development of knowledge and relationship with a patient.

‘I was just thinking about things that sort of bring out the sort of caring and compassion it’s quite often listening to patients and patients’ stories, like in the IPE module, you know, listening to the patients and carers or reading something that just makes you connect a little bit more with somebody that might not be like you or is going through something that’s completely different, just to be able to see, have that insight.’

MSc 2nd year

Several reasons were given for this. Our focus group interviewees discussed the notion of compassion fatigue:

‘they’re [nurse are] tired and they’re stressed but I’m sure they do actually care. But sometimes you just don’t have the time to sit with a patient and just have a chat with them unfortunately’ MSc Yr 2

“Not everybody who’s been in the NHS for 40 years is completely jaded, that is a total misnomer, a misconception. You do talk about compassion fatigue but there was one lady that used to come in who’s actually retired, used to come in a couple of times a month who was absolutely full of energy, who used to inject a whole load of enthusiasm in people when they come into the unit.” MSc yr 2

“sometimes people might not always, inside they could feel like caring about someone but they might not always show it. Because some people are more like introverted and some people are really caring and they will go and like stroke someone’s hand and stuff like that, but other people just because they don’t like outwardly demonstrate it doesn’t mean that they don’t care.’ MSc yr 2

Participants identified being caring as an integral part of personhood as being important, but different from learning how to care. The following example demonstrates this by discussing recruitment practices:

‘Yeah, so you could get some like quick like suggestions whether they’re like a nice person or not. But then maybe if you did recruit them to it, maybe there could be something **where you’re looking at their like profession or like their attitude and stuff, so like if it was over a period of like six months and have they always shown like a caring attitude, have they always demonstrated compassion and empathy and stuff.** And if their attitude was really, really like rubbish which like I’ve seen so many nurses I’m just like ‘Oh my God, like I would hate to leave my mum in your care overnight’. But over time that shows so maybe there needs to be like a follow up.’

1st yr MSc post practice

“Then they qualify and then some of them, some of them carry on being passionate, I’ve worked with a nurse who, just a couple of days with one nurse, who qualified from here a couple of years ago and she was fantastic, she was lovely and really nice with the patients and then you see some people who’ve been qualified maybe five or ten years and there’s this drop in the attitude in, you know, being smiley and wanting to chat to the patients and being so nice.

And it just seemed that like the longer people have been doing it the more negative their attitude tended to be towards just stopping and having a chat. Like it kind of, they were just sort of bled dry of their drive to see these people as people.”

1st yr MSc post practice

**Discussion.**

The findings from our focus groups clearly demonstrate that students on the pre-registration MSc are able to identify and learn from good examples of caring, refining their nursing skills to reflect what they see that they admire. They are clearly motivated to care properly for their patients and can identify areas in which caring behaviours can be modified and improved in the settings in which they work. They are prepared to advocate for their patients where things are less than ideal, and think creatively about achieving what their patient needs despite resource constraints.

A very small number of students expressed disappointment about their learning experience in some of their nursing placements and in the quality of the mentorship that they had. The problems that they described centred around resource constraints, and the impact of this on learning.

“Reality shock” after first placements was palpable in our MSc students. Although this is well documented, when we compared our MSc students with their BSc counterparts in a parallel study, MSc students have greater perceptual acuity and describe difficult practice situations in detail, in analytically advanced ways. This simultaneously helps and hinders their learning – many of our students become highly stressed and require more intensive support from practice staff and lecturers to ensure that this acts as a facilitator, rather than a barrier, to their learning.

The barriers to caring behaviours in practice are cited as time available, culture of placement area, paperwork, disrupted ability to make connections (patient turnover, staff continuity), education, attitudes of staff and staff recruitment.

Facilitators to caring behaviours were in the main the reverse of the barriers, but also included “thinking outside the box”, flexibility in care practices, team building, reflection and leadership.

Focus group material supports the assertion that students maintain their ability to care across their learning trajectory through a programme. They speak passionately about their patients and the care they receive, and expend time and energy thinking about how it can be improved. By the time they leave the programme, they appear to have developed resilience and are able to carry the “emotional burdens” associated with provision of nursing care.

Focus groups show that the mechanisms for learning to care in nursing are complex, multifactorial, and contingent on a multitude of interdependent feedback loops. This might be best described as learning to nurse within a rapidly changing, complex web of evidence, which includes synthesising information from research, patients, local environment, colleagues as well as personal and professional experience (Rycroft-Malone et al, 2004).

These findings, taken with Phase One of our study which focused on practice assessment documentation), show how navigation across this web of evidence in nursing practice is assimilated. Students can learn active listening and how to monitor patient concerns/ needs. They can learn how to communicate any concern to their mentor in a way that facilitates information exchange. Understanding how to address need is, in turn, dependent on an ability to know the extent to which adaptations may be made to standards of care to incorporate the patient’s perspective. Necessarily, both mentor and student require judgement about when to speak, when to listen and when to take action in unpredictable work situations. The work environment itself will need monitoring as it may vary considerably in intensity of workload/ time pressure during any day. Students and/ or their mentors frequently have to decide what methods of communication work best with which MDT members in rapidly changing circumstances and what constitutes an appropriate engagement of senior members within the MDT. Knowledge of the associated time and resource constraints of the different services might in turn require flexibility in problem solving and adaptation to demonstrate caring behaviours suitable for an individual patient. Focus group findings articulate good and poor examples of caring behaviours with various facilitators and barriers as nurses go about their daily work.

Many students who took part in the focus group expressed their enjoyment in the process of discussion and involvement in the study. In doing this, they made it clear that they believed that they had personally benefited from the opportunity to share their reflections and those of others about the care they gave. Many of the anonymised examples of nursing care shared were centred around inherently sensitive issues in practice, and it is possible that providing this opportunity for discussion helps students. This relates well to the ongoing work with qualified staff by the Schwartz Round Initiative, the “Point of Care” studies, and also to the principles of clinical supervision. This is an important finding which needs further research.

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**Chapter 4. Phase 3. Career’s Follow Up.**

**Introduction**

Students were admitted to the MSc programme with characteristics displayed in Table 1. These demonstrate good widening participation activities and the success of our recruitment for this programme locally when compared with national trends for taught post- graduates (Equality Challenge Unit, 2014 *figures shown in italics*).

**Table 1: Characteristics according to Widening Participation Agenda1,2**

|  |  |  |
| --- | --- | --- |
| **Characteristic** | **Students** | |
| Gender | Male 13%  *(42.2%)*  **(10%)** | Female 87%  *(57.8%)*  **(90%)** |
| Age (Average 31 yrs) | Aged 21-25yrs 25%  *(36.3%)* | Aged more than 25 yrs 75%  *(63.7%)* |
| Students declaring a disability | 19%  *(6%)* | |
| Residential Status | Students from the EU 3%  *(15.4%)* | Students from UK 97% |
| Ethnicity | White 53%  *(80.6%)3* | Black or Black British 34%  *(6.2%)3* |
| Asian or Asian British 6%  *(8.1%)3* | Other Ethnic background 3%  (5.1%)*3* |
| Information Refused 3%  *Not given3* |  |

1Equality Challenge Unit, 2014 *figures shown in italics*

2RCN (2014) RCN Labour Market Review **figures shown for all nurses in bold where available.**

3 Percentages based on total number of students minus those whose ethnic group is unknown.

*Method*

MSc graduates were surveyed by telephone at six months by one researcher. One student chose to complete by email. The person conducting the survey was known to students as a lecturer on the first year of the programme. Students were often difficult to access due to shift work; although all said that they were happy to be contacted, the logistics of completing the process meant that data was obtained between 6 and 8 months following the end of their programme in April –May 2015 and again at 12-13 months. Two students were not available during the first survey, and this was taken as a wish not to participate in the study. The students who completed the surveys appeared to be representative of those who qualified according to the above characteristics, although numbers are small.

The career’s follow up questionnaire was designed specifically for the purposes of this research study, primarily because of these logistical reasons. The most commonly used validated questionnaire for use with newly qualified graduate nurses was the CWEQ-II by Laschinger et al (2001). However, this was on a request only basis and was not delivered within the required timeframe, and our exploration of Roxburgh et al (2010) showed that it was not suitable as items with this tool were not sufficiently allied to the research aims. In research terms, the use of an unvalidated questionnaire is not ideal, but the questions were designed by three experienced researchers with a view to obtaining data to inform HENCEL within the specification of the project. It does mean that there is less ability to compare findings with other studies in a precise way; this is a limitation.

*Findings.*

**Table 2: Detailed Age Breakdown Cohort 1** **- Graduating Students from HENCEL Careers Follow Up**

|  |  |  |
| --- | --- | --- |
| **Age in years** | **Students at survey point 1 (n=)** | **Students at survey point 2 (n=)** |
| 21-30 | 3 | 2 |
| 31-40 | 1 | 0 |
| 41-50 | 3 | 3 |
| 51-60 | 1 | 1 |

*Response Rate = 8 out of 10 graduating students in the 6 month survey,*

*5 out of 10 in 12 month survey.*

*One student who not complete the survey at 6 and 12 months had given birth to a child.*

At 6 months of those surveyed, 100% are working as a nurse since qualification at Band 5 (see table 2). 75% worked in full time posts. 63% students qualified on time with no delay. 37% students experienced some delay (of between 3 and 5 months) in qualifying due to academic referral or practice time requirements for reasons of sickness or pregnancy. Students experiencing delayed qualification all worked as health care assistants in their place of employment which was secured prior to graduation. 63% students were working in London in a range of clinical specialities, all were in hospital settings except one working in a community hospital. The reasons given for their choices are varied (see Table 3). One student was waiting from qualification for funding for a unique post to be created which combined her previous degree with the nursing role, choosing to do part time work in the setting and bank work on a ward where she had previously worked in our first survey. At this time, all other students were working full time, with one doing extra shifts as overtime.

62% respondents were working in London immediately post-qualification for reasons of speciality, previous placement experience or location (the remainder chose elsewhere for reasons of speciality or access to continuing professional development). In our second survey, all participants except one were in full time employment, three out of five had changed jobs or moved clinical areas, only one was employed on a rotational post, one had recently embarked on a full time health visiting programme, another had moved to a community nursing post within a district nursing team. Another participant was waiting to begin health visitor training in February. Only two of those interviewed still remained in London. All are now working full time.

Only 2 graduating students were working 12.5 shifts, the remainder (75%) were all working 8 hours shifts in our first survey. Only one person was not rostered for night shifts as this was not part of the regular work pattern in her clinical area. One respondent was working extra shifts at 6 months in her clinical area for NHS professionals, with a further graduate doing this at the time of our second survey. 50% graduates at 6 months worked for employers who offered flexible working patterns for staff, but stated this was not a factor in taking up employment. This is unsurprising since they have just exited a programme which required them to be available for the full range of working shifts, although two further graduates had stopped working nights at 12 months.

Continuing professional development (CPD) courses accessed by recently qualified master’s nurses were varied at 6 months as shown in Table 3. It is significant that 25% of our participants had not

**Table 3. Clinical Setting of first place of work as nurse.**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Placement Area:** | Elderly ward | Assessment and emergency dept unit rotation | | | Stroke Unit | Orthopaedics pain nurse | | ENT Surgical ward | ITU | Community Staff Nurse in District Nursing Team | Acute Respiratory medical ward |
| **Reason for Choice of First Place of Work:** | Speciality  63% | | Location  50% | | | Previous Placement Experience 38% | | | | Good environment for Continuous Learning 50% | |
| **Continuing Professional Development Undertaken\*** | None  *(25% students)* | Venepuncture | | Male catheterisation | | Female Genital Mutilation | Attendance at Stroke Conference | | Preceptorshhip  (75% students) | Ward management | In house critical care course |
| **Continuing Professional Development Planned\*** | Catheter care | Pain management | | |  |  |  | |  |  |  |

*N.B. figures may not add up to 100% due to provision of more than one answer and rounding*

*\*unless indicated, these were given as answers by one participant in each category*

accessed any preceptorship, and only 38% partipants had obtained a place on a formal preceptorship training scheme.

Table 4 and 5 shows transition stress experiences of newly qualified MSc nurse graduates with the reasons for their answers shown in italics.

**Table 4. Stress Encountered in Transition to Qualified Nurse**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1  (Least Stress) | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10  (Most Stress) |
| 0 | 1 | 1 | 0 | 0 | 2 | 2 | 2 | 0 | 0 |

**Table 5. Transition Stress Compared with Other Newly Qualified Nurses from Traditional Programmes**

|  |  |  |  |
| --- | --- | --- | --- |
| **Less Stress** | **The Same Stress** | **More Stress** | **Don’t Know** |
| 3 | 3 | 1 | 1 |
| **Reasons given:** | | | |
| *Previous work within NHS;*  *Variety of experience within programme* | *Intensive programme with same practice hours;*  *Person dependent rather than course dependent;*  *Intensive course support;*  *It is always stressful for everyone whichever course taken, especially in the first few months* | *Within a 3 year course there is time to consolidate your knowledge* | - |

Stress was variable in our small sample, and, as one person identified, appeared to be person and job specific. One stated:

“it depends on the person rather than the course”

By the second survey, all participants believed that they had the same stress as those trained on a traditional BSc course, except one, who described herself as “less stressed”. One wrote:

“I personally feel that the MSc programme and in particular the transitions to profession practice module greatly helped the transition from student to staff nurse, as it helped to highlight the common problems and challenges we were likely to face and therefore I wasn't as shocked or upset when I experienced similar problems. The transition is always going to be difficult but by starting work and having to deal with problems by yourself, the transition period becomes easier through experience and your confidence grows as your ability to deal with daily problems improves.”

In our first survey, 88% UH pre-registration MSc graduates said that they liked (n=4) or very much liked (n=3) their jobs, with only one feeling neutral about their enjoyment of the job. At the time of our second survey, this student had changed jobs and now very much liked her job, whilst another was very frustrated because of organisational delays to a promised promotion. All graduates except one stated that the primary reason for their work enjoyment was an ability to be with patients and this had not changed at 12 months. A selection of these comments included:

“I enjoy the patient interaction and find it rewarding caring for patients who need help. I also take satisfaction from seeing patients recover and improve during their rehabilitation journey.”

“I am passionate about caring for older people when I see them going from hospital to discharge …, seeing the improvement”

I particularly enjoy being able to have time to talk with patients”

“I like not knowing what to expect…which patient you have for the day. I’m expected to do things every single shift to learn something new”

This continuing study until September 2016 will be able to explore this further.

The things graduates least liked were related to continuous burden of shift work and resourcing issues at both interviews. Resourcing issues were not liked because of their relationship to patient experience of care:

“being in the mandatory assessment unit feels a little like being in a ward, we will keep people a lot longer than we should, and it is not equipped to do this, this is difficult to deal with, not ideal, have to make the patient aware that it is not where you would like them to be.”

“I find time constraints the most difficult barrier to nursing. I’m lucky to have supportive colleagues however … I sometimes struggle with the high work load, maintaining a high level of care and meeting the needs of highly dependent patients, especially if we are short staffed.”

“too many things to do and not enough time to do them. Couple of shifts where patient is still on recovery bed, with no beds or nurses to help get the profiling bed.”

**All those that responded to the first survey stated that they wanted to remain in the nursing profession for the rest of their working life, demonstrating commitment even though the working environment could be challenging.** Future career plans were commonly cited as staying patient focused with only one person wanting to go into management in 3-5 years. Many wanted clinical nurse specialist posts, most wanted to remain within the hospital setting (2 graduates had plans to work in the community). Facilitating factors for their career plans included supportive management and opportunity for CPD, whilst barriers to career plans tended to be related to the widening participation agenda: being health related, caring responsibilities, pregnancy and lack of management support related to this.

“Having a family … a career break. Would love it if it wasn't, but it will be quite difficult to get enough experience under my belt before taking a career break, but would like the opportunity to come back at the same level. Not having support from whoever you work with.”

At the time of our 12 month survey, the student who was least satisfied said in response to a question asking whether she wanted to remain in the nursing profession:

“I don't know now to be honest, maybe not for the rest of my working life, but for the forseeable future. I get a little bit discouraged because a lot of nurses coming to the end of their nursing life they say that they wouldn't want to be me and they have spent all their working life as nurses, whereas I am just starting out, and that can be...[discouraging]”

However it was more common to find graduates more positive, with one graduate at 12 months saying:

“Nursing was the best thing I have done in my life for a very long time”

When asked what attracted them to the MSc Nursing, graduates commonly cited the 2 year rather than the 3 year programme length and the higher level of study:

“I liked that it was a masters, getting a better qualification in a shorter amount of time. When I applied, I applied for the BSc because I didn't know the Masters was there, and when it was offered at the time, It was ideal and I was academically at that level anyway. Saved me from doing a masters in the future to move up the career path”

**This is a selection of representative comments about what they liked best about the programme**:

“I feel the experience of the lecturers helped prepare us well for qualification. I liked the idea it was 2 years as opposed to the usual 3 years and I feel that although the course was challenging the necessary area were covered within our academic training to enhance our practical skills and development”

“I liked the small class sizes majority of the time, it was a better with a more tailored learning experience. I also liked that we kept quite a lot of the same lecturers and they were very consistent throughout … this helped you to function better and it made it more personable.”

“We got to know each other and support each other. This peer support was vital, apart from lecturers, which was also vital …having their help on email immediately. All lecturers were very supportive.”

“2 years!, challenging, placement varieties, really good lecturers, interesting modules, and simulation”

**All graduates said that the programme had prepared them very well or well for their future roles** with an even split between the two categories. Summarising this, one said:

“The MSc programme was extremely helpful and successful in preparing students for transition to a staff nurse. When I finished university, I felt as if I had enough knowledge and practical experience to make the transition. The barriers and challenges you face on qualification are inevitable, however, you just have to experience them and deal with them in your own way. I don't believe that anymore academic training in a classroom would have been of any benefit. There is no better way of learning than whilst out on the wards and having to handle the problem yourself - that is when the real learning starts.”

“I would recommend the course, especially for mature students. Life experience helps you through. Previous contact with people really helps. Previous NHS experience really helps.”

“I love all my teachers, … the teaching is very good”

Graduates in both career follow up points raised some issues for improvement to the programme. Several stated that they would like to have learned more practical communication skills, which was particularly mentioned in relation to talking with relatives and breaking bad news. Others would like some logistical and organisational issues to be smoothed out, one suggesting:

“staggering the assignments towards the end of course. The first year was ok, but the 2nd year, you felt that you were ‘drowning’”

There were also comments that related to the small size of the cohort in comparison with being taught as part of big groups with BSc Nursing Students:

“sometimes was bit disorganised and feel like we were forgotten about!”

Discussion.

The delay in completion of studies (37%) compares similarly with 31% students who experience delay for these reasons recently cited on an Australian undergraduate nursing course (Pitt et al, 2014). Mulholland et al (2008) present evidence that suggests that people who enter nursing with an honours degree have lower completion rates than their peers, although the pre-registration programmes studied included a large cohort of diplomate pre-registration nurses. It is possible that studying on master’s programmes changes the progression and completion rates, although direct comparison is not possible. What can be surmised is that the first cohort compares favourably with known rates, since delays in completion have been estimated to be as much as 50% (Mulholland et al, 2008). A systematic review by Andrew et al (2015) has confirmed that intimate partnerships are likely to have a mediating effect on completion and progression on nursing programmes, and our study suggests that MSc students also progress through their careers with this as an influential factor.

Deasey et al (2011) chart undergraduate nursing students transition from final year student status to qualification at 6 months, finding that stress levels decrease significantly during this time. The master’s students in our study may follow a similar trajectory. Hoffart et al (2011) believe that transition to nursing competence and confidence post-qualification continues for 2 years, and emphasise the importance of transition preparation within programmes and in organisational support following employment as a qualified nurse. This continuing study of graduates from the 2 year MSc programme, running until September 2016, will continue to explore these issues. MSc graduates from UH have shown varied stress levels coupled with a pragmatism about the source of this, many stating that they believed it was person specific response to the working environment, rather than directly influenced by the programme or route studied. Casey et al (2011) found that accelerated students with degrees studying undergraduate nursing were similar to their peers in their ability to use evidence and confident in problem solving in the clinical arena. Conversely, Park et al (2011) demonstrated that MSc graduates were thought by their mentors to be less clinically competent at qualification and more able to discuss patient care with the multi-disciplinary team. We found evidence in our focus groups with mentors that clinical competence was directly comparable and Practice Assessment Documentation demonstrated that mentors often gave glowing comments in detailed form about the students. This may have been caused by a heightened vigilance for the students as their learning was accelerated.

Deasey et al (2011) also discovered that only 57% of undergraduate students believed that the course content was relevant to their role as a nurse. In our survey, the MSc students appear to be more positive about the preparation in their programme.

In response to the comments indicating programme improvements could be made, the programme / management team decided to remove most shared sessions with BSc students from the timetable (except interprofessional education modules), so that more tailored teaching could occur that reflected the different academic levels and gave students more opportunity for discussion, expertise from academic staff and cross fertilisation of knowledge within the classroom from prior academic learning. Discussions with the first 2 cohorts of students during the period of this research have helped us to refine this aspect of programme delivery.

In common with our MSc graduates, Casey et al (2004) also found that being patient focussed was commonly cited as a reason for job satisfaction by nurses who had graduated from bachelor’s programmes. This persists in our sample until 12 months and was cited as the reason for 2 out of 3 job moves.

Casey et al (2004) found that the burden of shift work and resource issues were also a large issue for nurses who qualified with a first degree in the USA. These qualified nurses sometimes related this to their work environment and sometimes believed that they were still learning to prioritise and organise their nursing within the given time. Saber et al (2015) found that managing workload and prioritising was something that newly qualified nurses commonly cite as a stressor whether they were on accelerated courses or on normal length nursing programmes. Students in our study also stated that these were areas which contributed to their stress.

*Limitations*

This study has been completed with a small first cohort which has permitted us to study their views in depth, exploring reasons for the experiences that graduates have post-qualification. However, it was conducted by a researcher who had contributed to the teaching on the programme, and this may have influenced the responses obtained.

Conclusions.

Pre-registration MSc Nursing has been shown to be viable across 3 cohorts, the second of which is to be included on future career’s follow up surveys still to be completed. Broadly speaking, the graduates are demonstrably satisfied with the programme after qualification, and have similar stressors and factors which mitigate stress as do nurses on traditional programmes. The opportunities and work choices following graduation seem to indicate positive career trajectories, and may indicate greater opportunity, although it is still too early to predict this with any certainty. MSc graduates speak enthusiastically about their career plans and broadly speaking, their commitment to the profession of nursing seems secure.

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**Chapter 5: Conclusions.**

Initial work within the research team focused on understanding the national picture of pre-registration masters in nursing, prior to the commissioning of this project by HENCEL (abbreviated findings are shown in Appendix A). This showed that the pre-registration MSc Nursing at the University of Hertfordshire is one of the shortest routes to qualification as an adult nurse for those who already have a first degree.

The project team have completed a full analysis of the Practice Assessment Documentation as shown in Chapter 2 and this clearly demonstrates that students on the programme are developing excellent caring skills and competencies, which are valued by their mentors. The writing in these documents was more extensive and analytical than that seem in the BSC PADs, despite them being similarly presented. There was more evidence of being able to engage others in a “shared learning” approach to the practice setting than with their BSc counterparts.

The Focus Groups for phase 2 of the study was presented in Chapter 3 and shows good evidence that those arriving on the programme are motivated to recognise and learn from excellent examples of caring from fellow nurses working with them in their practice settings. The findings from this part of our study have also indicated that future exploratory work is desirable focused on developing facilitated debriefing strategies for students who witness difficult situations in practice in order to further enhance their learning and decrease stress. MSc students in the focus groups recognised that opportunities for this already exist, and that many of these afford good ability to deliver teaching and pastoral care with smaller numbers of students in a more personal way. Our findings from the career’s follow up phase of the study (chapter 4) clearly show that the benefit of teaching within a smaller cohort is valued highly by our students and is an important part of the success of the programme.

**Dissemination and Future Work.**

We are currently writing to disseminate our findings, and intend to publish this work in high impact factor, peer reviewed, journals. These will be forwarded to HENCEL for future planning. We ran a workshop day in July 2015 for nurse mentors, practice educators and University of Hertfordshire (UH) Nurse lecturers to disseminate these findings and plan future action (See Appendix B, part of a service improvement project), which is being assimilated into future curriculum development as we approach revalidation. To ensure that the findings have a wide audience, we also presented PAD findings at the Nurse Education Today Conference in September 2015, collated together with a parallel funded sister project for UH BSc nursing students (see Appendix C). Our work on the careers follow up has recently been used as evidence to support a HENCEL quality award nomination in the “**Excellence in widening participation and wider workforce development**” and the results of this phase of our study will include 2 cohorts, and will be completed by Sept 2016.