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The influence of assistant grade nurses on the clinical development of student mental health nurses: A phenomenological study.

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“This thesis is the result of the author’s original research. It has been composed by the author and has not been previously submitted for examination which has led to the award of a degree.”

Signed: Mark Gillespie

Date: 13/9/17

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List of abbreviations used

Abbreviation	Phrase
BBC	British Broadcasting Corporation
CINAHL	Cumulative Index of Nursing and Allied Healthcare Literature
CoP/CoPs	Community/ Communities of Practice
DH	Department of Health
ETHoS	E Thesis Online
EU	European Union
MHN	Mental health nurse
NA	Nursing assistant
NES	NHS Education for Scotland
NHS	National Health Service
NMC	Nursing and Midwifery Council
RCN	Royal College of Nursing
RNs	Registered nurses
SIGN	Scottish Intercollegiate Guidelines Network
SMHN	Student mental health nurse
TA	Teaching assistant
UK	United Kingdom
UoS	University of Strathclyde
UWS	University of The West of Scotland
WHO	World Health Organization

Abstract

There has been increased professional, public and press focus in recent years over what are perceived to be deficiencies within healthcare delivery in the UK. Government commissioned reports have highlighted suggested limitations within the attributes and preparation of nursing staff as contributing to this and have recommended integration between nurse education and the role of the nursing assistant as a remedy. This has been done without any significant investigation of the existing interrelationship between these staff groups, a relationship that is presently considered under-researched, and which has been largely excluded from any significant investigation or recognition. As the small number of related studies available have largely focused on students training for the adult and older adult fields of nursing, so there is even less known about the contact nursing assistants have with student mental health nurses and the impact of this relationship on the students' clinical development.

To explore this phenomenon, a study was undertaken to investigate how individuals from each of the groups most closely involved with student mental health nurse clinical development; mentors, nursing assistants and the students themselves, understand how nursing assistants contribute to student nurse training within the clinical setting. This study involved an initial review of the literature relevant to this subject, a review that shaped a subsequent mixed methods study underpinned by a phenomenological ontology. Data was collected via the use of diaries and individual interviews and analysed using Interpretative Phenomenological Analysis.

Analysis of completed diaries and transcribed interviews from the nine participants identified three superordinate themes that provided recognition of key involvement of nursing assistants in the clinical development of student mental health nurses during practice placements. The nursing assistants were seen to provide guidance around complex and significant skills and interventions, and often provided this at crucial times within the students training.

Chapter 1-Study overview

1.1 Background and Rationale

The quality of healthcare delivery in the UK has been strongly challenged through the publication of several high-profile reports (Healthcare Commission, 2009; Mencap, 2012; Mental Welfare Commission for Scotland, 2011). While each was critical of a variety of aspects of care, all commented negatively on the standard of nursing provided, a factor that has been highlighted by both the media (Triggle, 2013) and the UK government. A focus on nursing, nurse education and the role of nursing assistants (NAs) intensified with the publication of the largest of these inquiries. The Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis, 2013) reviewed the circumstances surrounding over 400 deaths more than would be expected at one NHS trust (British Broadcasting Corporation (BBC), 2010), and culminated in the rapid development of no fewer than three governmental publications (Department of Health, (DH) 2013a; 2013b; 2014). These documents drew subsequent responses from both the Nursing and Midwifery Council (NMC), the organisation that regulates the nursing profession within the UK (NMC, 2013), and the Royal College of Nursing (RCN), the professional body that represents nurses and nursing assistants (RCN, 2013). The term Nursing Assistant (NA) is one of many job titles employed across Britain to describe this role and is used here as it is the one advocated by the Cavendish report (2013), a government sponsored inquiry subsequently commissioned to review this staff group.

Emerging as a response to concerns arising within these inquiries, the conjoining of both practical and educational experience between NAs and student nurses is considered an approach through which improvements can be made for both groups in areas such as recruitment, in selection of suitable applicants, and in assisting in the provision of compassionate care, while also offering NAs the opportunity for occupational advancement (DH, 2014).

This drive to link these two groups was pursued even though the regulator for nursing had previously included no recognition of NAs as an influence in student nurse training (NMC,

2010), few research studies have been published examining the relationship of these groups (Hasson, McKenna & Keeney, 2012) and one recent study even suggested no benefits arose in terms of the development of compassion (Snowden, Stenhouse, Young, Carver & Brown, 2015). Compassion being considered a key attribute in the delivery of high-quality nursing care (Davison & Williams, 2009).

A comprehensive literature review confirmed that the lack of evidence identified in relation to the role of the NA in the clinical development of student nurses is even more apparent when the focus is narrowed to investigate those training for the mental health field. As anecdotal evidence from students, mentors and nursing assistants working in this field suggest a widely recognised link between these groups, a phenomenologically influenced mixed methods study was utilised to explore how those closest to this phenomenon actually understand and experience it.

With such uncertainty in the current understanding of significant influences on clinical practice and on the educational preparation of nurses in training for the mental health field, there is a consequential need to investigate such key and current issues. Undertaking the EdD has allowed time, space and support for the author to complete such a study. In addition to developing personal capabilities it is also hoped that this endeavour will generate information that will influence practice improvement.

1.2 Introducing the Thesis

This thesis details and explains the strategies employed to investigate how the group of care staff falling within the overarching title of nursing assistants influence the clinical development of student mental health nurses from the perspectives of those most closely involved. This phenomenon is investigated through review of existing literature and via subsequent exploration of the experiences and views of student mental health nurses, mentors and nursing assistants. These results are subjected to descriptive and interpretative analysis, with the findings leading to the presentation of recommendations for the future of nurse education.

The thesis is presented under the following headings:

Chapter 1 Introduction:

This chapter is brief, providing the outline context and justification for the research undertaken, as well as mapping the content of the chapters to follow.

Chapter 2 Contextualising the role of nursing assistants in the clinical development of student mental health nurses:

This chapter reviews the symbiotic relationship between nursing assistants and student nurses taking place over the past thirty years, and uses that as a background to explain the current context of clinical education for student mental health nurses (SMHNs), defining the expectations for each group involved. Explanatory epistemological theories are introduced here to make clear the routes through which nursing assistants can be involved in knowledge transfer and in the wider development of student mental health nurses within the practice setting. The research aims that frame the study are set out here, evidenced as emerging from the current context of student mental health nurse clinical development.

Chapter 3 Literature Review:

The literature review identifies a dearth of research available on the influence nursing assistants have on the clinical development of student nurses, while recognising the increased interest emerging around this phenomenon since 2013. The existing research findings are considered in relation to published policy requirements and epistemological theory, in order to determine a working understanding of the existing consensus, and of the gaps this research aims to fill. This review shapes the research questions that the study seeks to answer.

Chapter 4 Methodology:

This chapter identifies the ontological underpinnings of the study, explaining the relevance of the guiding methodology; Interpretative Phenomenological Analysis (IPA), and details the methods through which this research was completed and analysed. Originating with Smith (1996) and refined by Smith, Flowers and Larkin (2009), IPA has now become a well-respected and firmly established research methodology and its relevance to the

investigation of this topic is explained. This chapter also details the ethical considerations underpinning the research strategy and outlines how these guiding principles were applied within the process of the study. The inclusion of relevant data, emerging from the completed work diaries from the NAs, student nurses and mentors involved helps illuminate the context through which the participants understand this phenomenon.

Chapter 5 Findings:

The purpose of this chapter is to identify the key perceptions arising from the participants' accounts. From those narratives the chapter identifies the three superordinate themes that emerged from the study, explaining how they relate to the defined research questions and detailing the relationship between the participant's perceptions around the role of nursing assistants in the clinical development of student mental health nurses at the level of the individual, the staff group and overall. The qualitative data produced is augmented by the inclusion of the diary findings detailing a snapshot of work practices and the result provides evidence supporting the understanding that while nursing assistants contribute significantly to student nurse learning during practice placements, this learning is most frequently informal and largely unsupported.

Chapter 6 Discussion and conclusions:

This chapter sets out to provide an explanation for the themes emerging from the study, considering established and developing theoretical frameworks in seeking explanation for the creation of the perspectives arising from the individual participants, and from each of the groups involved. Participant's perspectives were shaped by the occupational group they belonged to and the relationship this group had with the others, and there was evidence of assumed understandings of this subject which altered after participants focused their attention on it. Explanatory frameworks were drawn from a variety of fields and included consideration of both learning theory and sociological considerations concerning societal change, group processes and occupational development. The social constructivist theory of socially influenced occupational learning termed Communities of Practice (CoPs), devised by Lave and Wenger (1991), is utilised throughout this study in explaining how learning occurs within clinical teams. It is therefore revisited here in relation to the participants' experiences.

This chapter also provides a brief summation of the thesis, incorporating analysis of the strengths, weaknesses and findings of the study, then considering the emergent themes in shaping recommendations for improvement in the fields of clinical practice and research.

Chapter 2- Contextualising the role of nursing assistants in the clinical development of student mental health nurses

2.1 Chapter Overview

This chapter provides the context for the research project, explaining the shape and function of pre-registration nurse training and more specifically providing illumination of the programme preparing student mental health nurses. The complex interaction between student nurses and assistant grade nursing staff is presented and includes an explanation of the historical symbiosis between the groups. The possibility that recent enhancements to the NA role may be detrimental to student development is considered and social constructivist learning theory is offered in order to explain how the interaction between these groups shapes knowledge transfer within the clinical setting.

2.2 Nurse Education

2.2.1 Background

The function of student nurse education is to produce a capable practitioner at the point of registration (NHS Education for Scotland (NES) 2012). In the UK the educational preparation of student nurses is delivered by regulator approved higher educational establishments, with the Nursing and Midwifery Council (NMC) fulfilling the regulatory role of quality assuring these programmes, as well as determining standards of outcome and process that these education providers must meet (NMC, 2015). The standards defined by the NMC are regularly updated to maintain the currency of content and structure, and while the most recent review was published in 2010, an update is imminent. These standards reflect current expert opinion and must adhere to wider European Union (EU) directives designed to unify educational qualifications across member countries (Collins & Hewer, 2014). Standardising the duration of the clinical component of the course is one such dictate, and such practice based learning must constitute at least half of the overall 4,600 hour programme (Jokelainen, Turunen, Tossavainen, Jamookeeah & Coco, 2011).

Clinical placements have been described as providing the most substantial impact on the student's development (Clarke, Gibb & Ramprogus, 2003), and the quality of placement support provided is crucial in this process (Finlay, James & Irwin, 2006). The NMC (2010) determine therefore that students must be supported by a named mentor during each practice experience. To qualify to undertake such a role requires a registered nurse to complete post-registration academic and clinical preparation.

The preparation required for undertaking the role of supporting, assessing and supervising students in the practice setting involves completion of mandatory training, recognition of such on a register of mentors, triennial review of performance and attendance at an annual update, with a further level of scrutiny attached to those mentors capable of confirming the student as capable and fit to practice at the very end of their training (NMC 2008). With the NMC (2010) detailing that student nurses on placement must be able to spend at least 40% of their time alongside such a defined mentor, the undefined 60% indicates that there is recognition of the contribution of other clinicians in supporting both the student and their mentor in this process. In practice, this often takes the form of a team approach to mentoring with other registered nurses frequently contributing to and taking short-term responsibility for, the students learning (The National Nursing Research Unit, 2012). This means that mentors and registered nurses who are not mentors frequently work together in shaping the student's clinical development. The NMC (2010) also recognise the role of other professions, clients and carers in contributing to the students' clinical development, though strangely, NAs are the only prominent staff group not specifically identified within those NMC standards as required to contribute towards the student's clinical progression.

2.2.2 The uniqueness of Mental Health Nursing

Human beings are intricate creatures comprised of a delicate balance of behavioural, cognitive, emotional and physical systems, and damage to one of these systems, through illness or trauma will have a resulting impact on the others (Wills & Sanders, 2013). This means that people who require nursing support for physical illnesses are likely to need some degree of care for their cognitive or emotional needs, and those with mental health concerns may well have physical sequelae or precursors requiring attention. This is borne

out in the literature highlighting the specific physical health needs associated with conditions such as schizophrenia (Padmavati, McCready & Tirupati, 2010), and acknowledgement of the emotional needs of people experiencing progressive and enduring physical disorders (Patten, 2001).

Despite some writers arguing that mental health nursing is focused sufficiently on the psychological aspects of care to justify removing the word nurse from their designation (Collins, 2006), there is wider acceptance of the crossover of skills required between the various fields of nursing in order for the provision of comprehensive holistic care (NMC, 2010). There is also a requirement for focused skills relevant to the practice area and client group catered for, and within mental health nursing, this manifests in a particular emphasis on the use of the therapeutic relationship as a medium for change (Barker & Buchanan-Barker, 2011; Scottish Executive Health Department, 2006). This rapport is developed via the application of interpersonal skills, a skill set far less definable or easily measured than the practical skills associated with the acute physical care setting (Gillespie, 2013). The NMC recognise this underpinning set of shared clinical competencies across each of the four fields of nursing they distinguish, while also confirming the unique skills sets that define each (NMC, 2010).

2.3 The synthesis between NAs and student nurses

2.3.1 Enmeshed roles

The roles of the student nurse and NA do not exist in a parallel manner as many student nurses were NAs prior to commencing their nursing programme (Gillespie, 2013), and a considerable number of student nurses supplement their income through part- time work as NAs (Hasson, McKenna & Keeney, 2013a). This is unsurprising as previous experience of care delivery is likely to be considered an advantage for those applying for nursing, and there seems to be obvious value for employers in attracting student nurses to fill part time NA vacancies.

The combination of the two roles concurrently can, however, be detrimental as it is associated with lower attendance, poorer academic performance, and increased experience of stress and the development of negative perceptions around some client groups (Hasson, et al., 2013a). There is also conflicting evidence supporting prior care experience as being useful for those undertaking student nurse education. Such prior experience is said to resolve any misconceptions students may have prior to commencing their training. Preconceptions about the perceived role of nursing has significant impact on the expectations of the student (Gillespie, 2013), contributing to their choice to commence the programme, effecting how they engage with, and react to, the clinical and academic demands placed upon them, and even influencing whether they persevere on the course in periods of difficulty (Spouse, 2000).

2.3.2 Development of the roles

Since Florence Nightingale championed the development of nurse training in the 19th Century (Watkins, 2000) there has been a synthesis between student nurse preparation and the advancement of the role of NAs within health delivery in the UK. Evolving in tandem from what was originally a single group providing care largely as untaught subordinates for medical staff in asylums and hospitals across Britain (Brimblecombe, 2005). The gradual introduction of formalised training and education formed initial steps in the professionalisation of nursing and in its separation into two distinct groups (Chatterton, 2004); those who had no regulation or standardised educational preparation, the NAs, and those achieving the educational requirements to qualify for registration, or Registered Nurses (RNs).

Nurse education moved wholly into the province of higher education in the 1980's, having previously been delivered mainly through colleges of nursing allied to local health boards, with student nurses salaried employees of the NHS, and as such encompassed within that organisation's workforce planning (Allan, Smith & O'Driscoll, 2011). At that time student nurses were considered to be delivering in excess of 70% of hands on care in the NHS (Fitzpatrick, While & Roberts, 1996). The move to full student status that involved their removal from scheduled duty rotas, therefore, generated a substantial gap in the NHS

workforce. This gap was filled through employing nursing assistants, a body seen by the government of the time, and those in power since, as a cost effective alternative (McGowan, 2006).

The Cavendish Report (2013) identified heterogeneity around the levels of qualification required for the role of NA and in the standard of training required for them by health authorities, with this often fashioned by the extensive range of roles now undertaken by this group. With over 150,313 NAs now working in the NHS in England alone (Health and Social Care Information Centre (HSCIC), 2015a), the ratio of registered nurses has declined (Hancock & Campbell, 2006) to a position where they comprise only between 52 (HSCIC, 2015b) and 73 (ISD and National Services Scotland, 2015) percent of the UK NHS nursing workforce.

NAs in some areas are now offered the opportunity to undertake tasks such as the monitoring of pulse, respirations, temperature and blood pressure (Bach, Kessler & Heron, 2005) as well as carry out neurological observations and the removal of cannulas and catheters (Hancock & Campbell, 2006). This means they are now taking the lead role in completing some of the tasks previously associated with registered nurses, tasks that student nurses are still expected to master during their clinical experience (NMC, 2010). These tasks are often those criticised in reviews of care standards and include essential care needs such as providing sufficient food and fluid for clients (Francis, 2013). It has been suggested that this has also been accompanied by registered nurses taking a less hands on and more managerial role in coordinating care that is provided, in the main, by NAs (Griggs, 2011).

This shift appears to have fostered some merging of roles between both groups as well as creating overlaps in responsibilities that do not seem to be recognised within current standards set by the NMC around nurse education. NAs are now able to access related education up to what is termed associate degree level (Griggs, 2011), and their experience in delivering care within specialist settings and in delivering specific tasks is suggested to situate them in an ideal position to support student nurses placed alongside them (Callister, 2011). These attributes support the opportunity for a recognised role for NAs in the clinical development of student nurses; however, this is not formally acknowledged at present.

Officially then NAs are not acknowledged as contributing to student nurse education within clinical placements, yet in reality, they spend significant periods of time working alongside students while delivering essential and often highly complex care. The skills utilised by NAs and the tasks they are using them for are often those that students are required to acquire whilst on placement (Hasson et al., 2012), making it highly improbable that there is no cross development between these groups. Hasson et al also highlight that there is inadequate understanding of this subject, and few research studies published around it. They consequently call for further exploration, especially in as yet unexplored specialisms such as mental health. If NAs then do have an active role in the clinical development of student nurses, this lack of recognition appears detrimental as in comparison with the support and preparation available to mentors, NAs may be under-prepared and under-supported for this undertaking.

2.3.3 The NA role in socialisation of the student

Anecdotal evidence and personal experience suggest that the influence of the NA is most often recognised within the healthcare setting in relation to the unofficial culture of the clinical environment. In explaining how this relates to student nurse education, Cope Cuthbertson and Stoddart (2000) identified the significance that students attribute towards fitting into the social milieu of the clinical placement, with acceptance into the working culture of the setting ascribed the same standing as the opportunity to apply and hone their clinical nursing skills. Lack of acceptance during clinical placements is felt to engender considerable risk to the students learning, in that it lessens their learning opportunities and diminishes their learning experience (Jackson et al., 2011). As NAs have been shown to engage in significant face to face contact time with student nurses (Hasson et al., 2012), there is support provided for the claim by Fitzpatrick et al. (1996) that NAs are often role models whose behaviour is strongly influential on the socialisation of student nurses. Such an influence is not necessarily desirable for student nurses, however, with a study by Gillespie (2013) identifying that they are likely to have a strong reticence to engage in what they see as the non-nursing tasks that they associate with NAs. It seems realistic therefore to consider NAs as contributing significantly to the students' socialisation, even if such

contribution is rarely recognised by the student, or within related studies of student experience (e.g. Felstead, 2013).

While research on the role of NAs in the development of student mental health nurses is sparse, it is undeniable that NAs constitute a significant proportion of the UK nursing workforce, and that within that they provide the bulk of essential care delivered to patients. Student nurses spend considerable time working alongside these NAs, learning those essential skills, and in mental health, this includes a more discreet relationship development skill set, in addition to the core physical care skills needed across the profession. With no current formal recognition of the contribution of NAs to student nurse clinical development, it is essential to identify a theory, or theories, of knowledge transfer, that would help explain, and guide the investigation of, any such crossover of knowledge among these groups. Such epistemological theory is explained below.

2.4 Social Constructivist Epistemology

2.4.1 Social constructivism

Exploration of influences on student nurse learning would be incomplete without identification of the epistemological theories that shape the author's understanding of how learning occurs. Such theories are significant as in addition to framing the perspective through which this study takes place, they also shape how formal teaching programmes are organised, and as a result are likely to lead to different outcomes for the learner (Bates, Waynor & Dolce, 2012). The theories relevant to this study are considered here in relation to nursing education.

Following what is described as traditional pedagogy (Peters, 2000), formal nurse education was initially shaped through what could be described as a deficit model of learning (Dickson, 2005). Within such a model students are considered blank slates who are passive recipients of knowledge, chosen and delivered (often didactically) by expert teachers (Hayes, 2014). Success within this approach is measured on what the student is able to recall or complete, and not necessarily by what they comprehend (Hase & Kenyon, 2001). The increasing

complexity and changeability of modern healthcare is suggested however to rely on the preparation of professionals who are sufficiently insightful, adaptable and resourceful to be self- sufficient in determining and meeting their own learning needs (Bates et al., 2012). Traditional approaches to pedagogy are therefore unlikely to achieve the NMC (2010) requirements for nurse education to produce such academically autonomous graduates, or to use the NMC description of such individuals, lifelong learners.

Cruess and Cruess (2006) argue that the most effective method for developing the values and skills required by graduating professionals is an approach termed situated learning. This concept considers that learning occurs as a result of human interaction happening within a series of shared situations (Perry & Paterson, 2005) and falls under the wider theory of how learning and development occur, termed social constructivism (Hayes, 2014).

Social constructivism facilitates a shift from the pedagogy described above to an andragogical understanding of learning wherein there is recognition of the opportunities offered through the interaction between the individuals' socio-cultural environment, their prior learning and their intrinsic motivation (Knowles, 1984). This allows the learner to shape their own learning to the stage where they develop comprehension of complex concepts in a manner that allows transferability across a range of situations (Peters, 2000). The concept of legitimate peripheral participation (Lave & Wenger, 1991) explains how this occurs within situations such as clinical placements.

2.4.2 Communities of Practice

Lave and Wenger (1991) consider that legitimate peripheral participation is the process through which individuals are incorporated into what they term communities of practice (CoPs), in turn contributing to the maintenance and development of that community. CoP's are heterogeneous groupings with each defined through participants who have shared interest in the development of a subject and who interact regularly with the purpose of advancing their expertise (Hoffman, Desha & Verrall, 2011). In relation to nurse education, this could take the form of nursing in general via online forums, student nurses

collaborating within a pre-registration programme or even the nursing team working within the one clinical area.

Entry into each CoP takes place through a recognised and accepted process described by Lave and Wenger (1991) as legitimate peripheral participation. This title recognises the graded familiarisation of the newcomer, into the skills, knowledge, language and practices of the community (Risling & Ferguson, 2013), and this progress is aided by the social nurturing of the wider community members (Seibert, 2015). This process is formalised within some pre-registration nursing programme through the inclusion of structures such as the Bondy Taxonomy (Bondy, 1983). This framework identifies a staged process of development, with the learner moving gradually from being fully dependent on more expert colleagues, through to them finally attaining recognition as independent practitioners. Education providers such as the University of the West of Scotland (UWS) utilise such frameworks to guide recognition of expected student performance (UWS, n.d.).

These social constructivist learning theories have previously been applied to the investigation of clinical nursing (Ranse & Grealish, 2007: Grealish, Bail & Ranse, 2010), supporting the appropriateness of their use within this study. Lave and Wenger's original work explored the theories outlined above in relation to groups entering a single trade or profession (1991). It is doubtful, however, that nurse education takes place in isolation from other influential groups and Li et al. (2009) suggest that apprenticeship type CoP's (like nursing students) differ from those whose purpose is knowledge generation and sharing. There is a need therefore to consider the interface between the two that occurs within clinical placements.

The Scottish government have a clear desire to progress what they term integration within health and social care (Scottish Government, 2014). The results of this are that care is increasingly delivered through multi-disciplinary teams, which include a variety of health professions and support staff, integrated with social care teams. This means that clinical nurse education takes place within increasingly complex clinical environments, and requires significant collaboration (Perry & Paterson, 2005).

Student nurses will frequently find themselves joining a clinical area as a requirement of their programme. They will, therefore, retain links to their programme provider while trying

to integrate within a clinical nursing team comprised of RNs and NAs, working as part of a wider multi-agency team that includes medical staff, occupational therapists, psychologists, dieticians, social workers and many others.

Each of these groupings is likely to meet the criterion described by Risling and Ferguson (2013) as defining a CoP and many appear to overlap in areas such as purpose, language, culture and shared physical space. An example of this would be a student mental health nurse who is part of the CoP of student mental health nurses (and indeed mental health nurses), but also part of the CoP of a specific clinical environment whilst on placement. The placement CoP also includes colleagues who are from different health and social care disciplines, each with their own professional or occupational CoP. Lave and Wenger (1991) accommodate this through emphasising the primacy of the role of the social environment in driving learning. This would provide strong support to the notion that NAs, who comprise around half of the workforce within clinical nursing teams (RCN, 2006), constitute a significant component of the clinical CoP, and as such influence the clinical development of student mental health nurses.

The requirement for pre-registration nurse education to deliver practitioners capable of engaging quickly and effectively within clinical teams (NMC, 2010) signifies a considerable emphasis on developing the student's capability for social integration. Portoghese et al. (2014) identify the CoP as crucial in understanding the interface between nurse education and the social environment that is clinical practice. The CoP concept provides an ideal structure through which this professional development can be understood, framing the student's journey within a process in which community members each contribute in their own way to the learner's development (Goodwin, Pope, Mort & Smith, 2005). The consideration that NAs form a key part of this community supports the use of the CoP concept to guide this investigation. This concept is not, however, entirely free from criticism.

2.4.3 Criticisms of The Community of Practice concept

The CoP concept is considered under-explored within healthcare organisations (Li et al., 2009) and with Chua (2006) identifying that negative experiences of it are less frequently reported it is important to explore any criticisms and potential limitations already identified. While authors such as Bates et al. (2012) highlight factors related to individual's attributes generating concern, for example, identifying the need for learners in such settings to be actively motivated and engaged in the process, a significant focus of published criticism relates to the organisational relevance of the concept.

It is evident that the bulk of the use of the CoP concept in healthcare research has been applied within a uni-professional perspective (Cornes et al., 2014), meaning that limited consideration has been given to its relevance within the multi-professional approach to care now prevalent. Li et al. (2009) indicate that insufficient relevance has been given to the power dynamics within an organisation influencing the development of the CoP, a stance supported by the lack of preparation student nurses are given for negotiating such an integrative process within their programmes of study (Cope et al., 2000). This is concerning as potential CoP members need to understand and accept a benefit in joining, though Hoffman, Deesha and Verrall (2011) suggest such a community may in fact be seen by some as perpetuating outdated practice traditions and delaying progress.

Successful CoP's require nurturing in order to develop, and key constituents need to be in place to allow this to happen. Chua (2006) suggests that this includes supportive leadership, shared values, cohesion and a community that is naturally occurring. Cope and colleagues (2000) and others, however, identify components of nurse education that conflict with these ideals. Short placements and supernumerary status are identified as significant barriers preventing full acceptance of the student within the clinical team during internship experiences (Cope et al., 2000). While Gillespie (2017) recognises reluctance from students to engage in tasks associated with the NA component of the placement CoP. The concept of the CoP as a collective of likeminded individuals collaborating to enhance practice may then provide an oversimplified and overly positive image of the practice team.

2.5 Study aims

In view of the factors outlined above the aims of the study are:

1. To determine whether NAs provide training, instruction and/ or support to student mental health nurses during the student's clinical placements, identifying the form of any such interaction, including the tasks and skills involved.
2. To determine the perceptions of nurse mentors on the involvement of NAs in the education, training, instruction or support of student mental health nurses during practice placements, including the mentor's role in this.
3. To identify how NAs perceive their role in the development of student mental health nurses placed within their clinical area.
4. To determine the students understanding of any influence that NAs may have on their development during practice placements.
5. To consider whether the role of the NA is appropriately recognised and supported around any influence they have on the clinical development of student mental health nurses.

While the aims of this study arose as a result of concerns raised by personal experience in dealing with nursing students undertaking clinical placements, and which involved them working extensively with NAs, subsequent consideration of current literature, as detailed within the literature review chapter, has developed the initial aims into the research questions defined in the next chapter.

In accepting that there should be a close fit between the ontology and epistemology guiding a research project, it is apparent that there is cohesion between them within this study. Both recognise the individually constructed nature of knowledge, as well as the importance of social interaction in shaping this. The use of IPA, which in turn investigates how individuals experience the reality of their world while remaining cognisant of the role of

social and psychological influences on this, therefore facilitates a fidelity within the core components of the study.

Chapter 3- A review of the literature

3.1 Chapter Overview

The planning of any research study requires consideration of the context within which the phenomena under investigation exist. Crucial in shaping that understanding is the identification and appraisal of existing knowledge on the subject, and a review of available information enable this scrutiny. This chapter details the process used to gather and analyse relevant information and explains the findings in relation to changing work practices and occupational structures. These changes are examined in relation to social constructivist learning theories, most notably those of Lave and Wenger (1991), and considered at national and international levels, as is their impact on individual students, mentors and NAs. The strengths and limitations are identified for the research available and through this emerges identification of opportunities for further study.

3.2 Still Too Posh to Wash?

3.2.1 Background

It is now over a decade since headlines declaring that nurses were "Too posh to wash" were conveyed via national news media (BBC, 2004). This headline, rather overdramatically, recounted a motion proposed, and expectedly defeated at that year's annual Royal College of Nursing (RCN) conference (Scott, 2004). The sensationalist reporting underlining the level of concern then prevalent, that the hands-on aspect of nursing was being increasingly undertaken by the then unregulated NAs, thereby enabling RNs to focus on the more technical and managerial aspects of their role. These apprehensions seemed to reflect longstanding unease around a drive to increase the proportion of unregulated staff within the nursing labour force (McKenna, 1995) and the shift of student nurse training into the domain of higher education (Spence, Vallant, Roud & Aspinall, 2012), with each of these developments engendering fears over possibly consequential falling care standards.

There are continuing concerns about the appropriateness of NAs for completing complex tasks they are being asked to undertake (BBC, 2015). This has considerable relevance to the clinical development of SMHNs, as student nurses must spend at least half of their programme in clinical placements (NMC, 2010) where NAs are felt to provide more client and carer contact than any other group (Stonehouse, 2013). While the opportunity for a crossover of learning is obvious, such co-development may not always be advantageous around the honing of interpersonal skills for those undertaking nurse training (Snowden et al., 2015). With a recent study identifying an existing, if largely unrecognised role for NAs in the clinical preparation of student nurses in the adult field, and calling for further investigation into their influence on students within other fields (Hasson et al., 2012), there is a need to identify if and how NAs influence the clinical development of student nurses, and in particular their impact on those students training for the previously unexplored mental health field. Such an exploration was initiated through a systematic appraisal of the available literature.

3.3 The Literature review

3.3.1 The literature review process

The literature review is suggested to be crucial to research in that it determines the need and purpose for a study within the context of what is already known about the subject (Swetnam, 2004). To include a comprehensive range of sources of information within this review, the recommendations of Edwards and Talbot (1994) were followed in examining materials available from three main sources. This included a University library, a review of local, national (Scotland and UK) and International information, which mainly comprised governmental and cross governmental reports and policy documents, and finally relevant research data, which was searched through the process detailed below.

3.3.2 The literature search

The literature search followed guidance suggested by the University of the West of Scotland (UWS) (2015a), accessing MEDLINE, Proquest, and what UWS describe as the most comprehensive database of nursing journals, CINAHL plus (UWS, 2015b), as well as ETHoS, the British Library repository housing the thesis collection from UK universities. These databases were chosen as they provide access to the largest pool of profession related journals and studies available via the university website. The university in question is one of the relative few chosen by the Scottish Government to provide specialist nurse education in Scotland and therefore has a significant focus on this area. While the limitations inherent within only accessing data constrained in this way are accepted, the use of these subject specialist databases is suggested to provide a rigour, relevance, breadth and thoroughness to the search (Aveyard, Sharp & Wooliams, 2011). As the investigation was undertaken as part of an academic programme that spanned over five years, so the literature was reviewed initially in 2012, and the process repeated in 2017, with intermittent scrutiny between these dates triggered through an alert facility set up online. The process and search results are detailed within the appendices (Appendix 1).

3.3.3 Search terms

Keywords used in the search included "student nurse, assistant, auxiliary, support worker placement and clinical", and both Boolean terms and truncation were used to enhance the search. Cavendish (2013) identifies that a multitude of terms have been used to describe the NA role, therefore the keywords used were selected as they were identified as being the most relevant and most frequently occurring within an initial review of the subject. Glasper and Rees (2013) advocate that this is the most effective method through which to identify effective search terms.

Search filters included accessing only peer-reviewed English language papers published between 1980 and 2017, these dates encompassing the relevant changes in nurse education discussed previously. Using these limiters identified 145,213 possible papers in CINAHL alone, therefore, the subject heading filter "nursing role" was used to reach a workable and

relevant scope of resources. Recurring themes within these searches led to a more specific review of the Wiley Online Library, the Journal of Clinical Nursing, Nurse Education Today and the annals of the British Journal of Healthcare Assistants, all of which contained a slightly higher concentration of relevant articles. Where articles included reference to other relevant studies not identified within the search results, these "hidden" papers were procured and included, a process termed Snowballing (Moule& Hek 2011) or the network approach (Epp, 2008).

This scope of searches produced more than 1,300 potential papers including unpublished theses and these were filtered through examining their titles and, where indicated, abstracts for relevance. This process is advocated by Cook, Beckman and Bordage (2007). Studies examining any aspect of influence on student learning within the practice setting were subjected to more rigorous scrutiny. It is recommended that the CASP appraisal frameworks (CASP, 2017) be used to guide the close review of health-related research (The College of Occupational Therapists, 2017), and these guides were applied to analyse the studies identified as relevant to this project.

As a reviewer for both Nurse Education Today and The Journal of Clinical Nursing, identification to both journals of my interest in placement based student learning meant I was also approached by these journals to review relevant pre-publication papers submitted to them. This meant that I was also able to access unpublished papers and keep in touch with new materials emerging from these sources.

3.3.4 Wider dissemination

The peer review process is well established as a method through which to ensure the veracity, relevance, and accuracy of research (Solomon, 2007) and presentation of research at subject related conferences add to this an opportunity to generate further information pertaining to the topic. This project was disseminated through both posters and conference presentations in each of the years of its duration (Appendix 2), allowing for the collation of audience feedback at university, subject-specific journal and professional organisation organised events.

3.4 Workforce and educational change

3.4.1 Literature review findings

The literature review identified that during the 1980's opposition was mounting in the UK towards the traditional apprenticeship style of nurse training, originally championed by Florence Nightingale a century before (Watkins, 2000). By the 1980's student nurses were salaried employees of the NHS, and as such considered an integral part of the nursing workforce and therefore rostered during their clinical experiences (Allan et al., 2011), and included within NHS workforce planning. While there were some exceptions (Ousey, 2011), nurse training was generally funded through the NHS and provided by colleges of nursing attached to local healthcare services, with training most often provided to certificate level. This, however, did not fit with a drive for professional identity strongly prevalent at the time, a drive that saw the publication of "Project 2000: a New Preparation for Practice" (United Kingdom Central Council for Nurses Midwives and Health Visitors (UKCC), 1986). This document triggered nurse training moving into the higher education setting, where those undertaking the programmes achieved full student status, trained to diploma or degree level and became supernumerary whilst on clinical placement (Bach et al., 2005).

3.4.2 Replacing the students?

Removing students from NHS staffing numbers created an obvious gap, as they were suggested to be providing over 70% of bedside nursing care only a decade before (Fitzpatrick et al., 1996). While Initial plans had been to meet this shortfall through the provision of a nursing workforce rich in qualified staff, fiscal concerns led politicians to reconsider (Bach et al., 2005), and health care assistants or auxiliary nurses were seen as a viable, and cost effective alternative (McGowan 2006). The role of the auxiliary or assistant nurse had been formally recognised since the 1950's (Keeney, Hasson & Mckenna, 2005), having attracted titles such as healthcare support worker, healthcare assistant, nursing auxiliary, ward orderly, pauper nurse and nursing assistant (Waldie, 2010).

In the mental health setting, staff fulfilling the role later to be undertaken by registered nurses did so originally to provide support to the physicians who ran what were at the time called asylums (Barker & Buchanan-Barker, 2011). These individuals largely carried this out without training and were described as attendants (Brimblecombe, 2005). Despite later reluctance to allow staff working within such roles to engage in state registration for nursing, this was the first branch of the nursing profession to go on and encompass a uniformity of training and qualification and to develop a registration process (Chatterton, 2004).

By 1992 the number of qualified nursing staff employed by the NHS had fallen by between 17 and 33% depending on the clinical speciality, the number of untrained nurses had risen by 21% (McKenna, 1995), and by 2002 the number of assistant grade staff working in this organisation had risen to an estimated 120,000 (Keeney et al., 2005). It was also apparent that these NAs were being asked to undertake tasks that they were not recognised or rewarded for, fulfilling roles that were obviously out-with their job description (Thornley, 1998). The reduction in the availability of registered nursing staff to provide basic patient care was compounded by the publication of European guidelines on permitted working time (European Directive, 1993; 2003), which curtailed the number of hours' junior doctors could work. This created opportunity for nurses to undertake more specialist roles (Hancock and Campbell, 2006), including tasks traditionally associated with trainee doctors (Santry, 2010). Griggs (2011) even postulates that registered nurses have since distanced themselves from direct patient contact, and are instead now assuming an overseer role, in managing, coordinating and evaluating care delivered by others. This shift in role definition is suggested to be part of a modernisation process for healthcare delivery within the UK; in which workload has increased while the ratio of registered nurses employed has declined (Hancock & Campbell, 2006). These developments could not fail to have had an influence on the clinical environment in respect to care delivery and to nurse education as experienced within that setting, and were prophesied as far back as 1986, when initial concerns were voiced about nurses losing their clinical role (Keeney et al., 2005) for the very same reasons as those outlined above.

3.5 Mental Health Nursing

3.5.1 Mental Health Nurse education

Mental health nursing has incorporated a mandatory training regime, distinct from Adult or General Nursing, since the late 1800's (Leishman, 2005). In 1885, the organisation representing asylum doctors, The Medio-Psychological Association, met in Glasgow and agreed to develop a manual, thereafter known as the red handbook (Leishman, 2005), standardising the duties of the Asylum Attendants who assisted in the running of such institutions. Within four years the certificate awarded for meeting these defined competencies incorporated the word nursing in describing the care offered to a group referred to at the time as the insane (Nolan, 1993). While titles for this group have subsequently evolved from attendants, through psychiatric nurses, mental nurses and then mental health nurses (MHNs), the existence of MHNs as a separate branch of nursing has rarely been as precarious as over recent years. The NMC consultation shaping the development of the currently live 2010 Standards for Pre-Registration Nurse Education, had originally dropped the mental health branch from the qualifying options offered, suggesting instead that it should exist as an optional add-on specialism, available for those already qualified nurses interested in working in the field. Pressure from lobby groups such as The Mental Health Nurse Academics UK (2008) saw the NMC drop that proposal, and Mental Health Nursing remained one of four recognised fields of nursing attracting registration with the NMC. The unique skill set required by MHNs being clearly defined as a consequence.

3.5.2 Core and shared competencies

Recognising the skills shared across all fields of nursing, the current NMC competence standards additionally identify what they see as the core requirements for qualification as a mental health nurse (NMC, 2010). With an added focus on understanding mental health legislation and risk management, the NMC echo the Scottish Government (Scottish Executive Health Department, 2006) in seeing the core of the craft set within relationship

building skills. NHS Education Scotland (NES) (2012) determine that achieving such therapeutic focus within relationships as requiring the application of advanced communication, relationship and therapeutic intervention skills. There is, therefore, a widely-shared recognition of both the fundamental responsibilities of the role associated with the rest of the nursing profession and of the unique nature of the skill set required to work within the mental health field.

For SMHNs qualification requires successful completion of a programme that is partially shared with students from the other fields, and partially focused on the subject specialism. For the whole of the UK the students completing the mental health programme must meet the demands outlined by the NMC (2010), and in Scotland, they must also achieve the additional requirements determined by NHS Scotland (NES, 2012). Meeting these competencies is facilitated via a mix of academic study and a series of placements within, in the main, specialist mental health settings. Student mental health nurses are therefore recognised as requiring developing core nursing skills and specialised mental health skills, through working with a unique client group within dedicated settings. Their learning experience is consequently markedly different from those undertaking the other fields of nursing, and their interactions with groups such as NAs likely to differ as well as a consequence of these unique learning environments. If a conjoining of the roles of these groups is to be developed, then it is important to understand the current interaction between them.

3.6 The nursing assistant role

3.6.1 Role diversity and title

Internationally agreed job definitions are detailed within the International Standard Classification of Occupations (International Labor Organization, 2010). The European Commission, the World Health Organization (WHO) and the Organisation for Economic Cooperation and Development have all agreed to the categorising of three groups identified

there as providing nursing care (European Commission, 2017). The groups; Registered nurses, Nursing Associates, and Healthcare Assistants are separated in the main by the level of expertise and responsibility attributed to them, as well as by their level of regulation. There are three distinct groups recognised then as delivering nursing care, however, data released by the European Commission in 2017 identifies variation in the makeup of the nursing workforce across member EU states, including that of the UK. Their statistics suggesting that the UK employs more Healthcare Assistants than any other EU Country, has one of the lowest numbers of Nursing Associates and along with Ireland is one of only two countries that saw a drop in registered nurse numbers between 2009 and 2014.

The shape of the nursing workforce in the UK is, therefore, different from many of its European contemporaries and it is important to understand how this is framed for both The UK and wider International care delivery structures, to understand the context within which clinical nurse education takes place.

In the UK heterogeneity is the word that most accurately reflects the preparation of, and roles undertaken by, NAs. Described variously as support workers (SWs) (Griffin, 2013), Assistant Practitioners (APs) (Hand, Evans, Grainger, Lloyd Jones & Peate, 2013), Care workers (CW) (Annear, Lea & Robinson, 2014), Healthcare Assistants (HCA) (Hyatt & Firth, 2014) and Healthcare Support Workers (HCSW) (Matthews & Bedson, 2014). Calls to standardise the title to Nursing Assistants in the UK (Cavendish, 2013) have subsequently been ignored, with the NHS in Scotland settling on HCSW, senior HCSW and AP, Northern Ireland using CW, Wales HCSW and SW and NHS England adopting a two-tier HCA/ AP approach (RCN, 2015). With the wide array of terms currently being used it is more convenient for the purposes of this paper to employ a simplified description for this group, hence continuation with the term nursing assistant. While recognising that this title does not fully encompass all of the roles undertaken by this workforce, it does clearly relate to the group relevant to this study; those working in this support role as part of clinical nursing teams, the NA abbreviation also tying in with the emerging Nursing Associate role currently under development in England (Health Education England, 2016).

3.6.2 Opportunities for assistant grades

The complexity of titles used for this group reflects a marked diversity around their level of training, experience, and education (Keeney et al., 2005). While still strongly associated with the delivery of essential care skills such as personal hygiene and the nutrition and hydration of clients (Glasper, 2013), NAs have been subject to the generalised up-skilling, seen across the healthcare workforce (Matthews & Bedson, 2014). It has been recognised that the continuing development of the NA role is an important factor in supporting healthcare modernisation (Waldie 2010). In addition to the availability of degree level qualification, in some NHS areas NAs are now able to carry out skilled tasks such as the monitoring of blood pressure, temperature, pulse and respirations (Bach et al., 2005), catheter and cannulae removal, and neurological observations (Hancock and Campbell, 2006), even undertaking phlebotomy and carrying out ECG's (Glasper, 2013). These skills were all at one time firmly within the remit of registered nurses, or even medical staff, and their widening application show the flexibility with which healthcare employers are able to shape NA roles to fit local need. That these skills are not uniformly recognised as being within the domain of one staff group or another suggests a growing sense of role blurring within health delivery services, and in particular between nurses and NAs.

3.6.3 Assistant grades in context

The NHS is the largest healthcare employer in the UK and that organisation utilises a banding process for pay and conditions that were implemented in 2004 under the title Agenda for Change (Mullen, 2013). The bands range from 1-9 and include an incrementally increasing level of remuneration in return for an increasing level of competency determined through an agreement titled the Knowledge and Skills Framework (KSF) (NHS Employers, 2015). NAs are currently banded at levels 1-4 (Bradley, 2013) and registered nurses at 5-9, suggesting a continuing understanding of a less complex role for NAs. The diversity of role, therefore, increases the attractiveness of the role to employers and politicians. Employers can focus training on a specific clinical need while remunerating assistants at a lower pay banding than nurses (Thurgate, MacGregor & O'Keefe, 2010), keeping healthcare costs at a

minimum, thereby meeting the cost-effectiveness prioritisation of current political policy makers.

3.6.4 Assistant grades and regulation

The frequent and longstanding calls to regulate NAs (Hasson & McKenna, 2011) were finally answered as a consequence of the Cavendish and Francis reports when Cavendish's recommendations for a minimum standard for training or Care Certificate were enshrined within The Care Act (UK Government, 2014). The Scottish Government had pre-empted this, having considering regulation as early as 2001 (Scottish Executive, 2004) and formalising this in the setting of standards for NAs across the health and social care spectrum. NAs in social care settings in Scotland have been required to join a central register since 2009, requiring the attainment of relevant care qualifications and a commitment to ongoing development (Scottish Social Services Council, n.d.). In the Scottish NHS, a clear progression of qualifications has been detailed for each of the defined NA roles since 2010 (NES, 2010). As this research project was undertaken within Scotland so the Scottish regulations frame the context for the clinicians involved, though the relevance of findings will be considered within a national and International perspective.

3.6.5 Assistant grades and education

The availability of staff with specific skills strongly relevant to a particular area of practice makes employing trained NAs attractive to clinical managers (Keeney et al., 2005), and ironically these skills are often developed within an apprenticeship style of training and under the supervision of registered nurses (Griggs, 2011). The support of a clinical mentor is acknowledged as key to the development of such clinical practice for NAs (Matthews & Bedson, 2014), and while some mental health settings currently mandate that such mentors must be a registered nurse (Knight, Parker, Carmichael, Esser& Aspden, 2015), there is recognition of the opportunity for NAs to take on this role (Norman & Roche, 2015). This cross-group educational responsibility is at present not reciprocated, as under current guidance NAs are not allowed to assume a mentorship role for student nurses, no matter

their experience, qualifications or skills. This means that any such support for students is recognised generally only as an aside to the NAs allocated duties and therefore there is no mandated preparation or support available to them for this role.

Expansions in the NA role have been identified as problematic in relation to the relationship this group has with student nurses. Difficulties have been identified around the impact of educational advancement of NAs on student nurse development within some adult care specialisms. In the surgical environment, the increased capability brought by the attainment of occupational qualifications by NAs has led to a re-establishing of organisational hierarchies and some students subsequently identifying a sense of being disadvantaged as a result (Wakefield, 2000). These changes in occupational influence are also seen beyond the confines of the clinical area.

3.6.6 Assistant grades and political power

In addition to financial savings, politicians are likely to appreciate that the lack of role uniformity and professional recognition diminishes the likelihood of this group lobbying with the influence of established professional groups. This is important as Davies, Nutley and Mannion (2000) suggest that healthcare is strongly associated with competing professional bodies, powerful enough to impede governmental influence over the organisation and delivery of clinical care. The rise of the NA may therefore reduce the power of professional nursing groups such as the NMC, though the main professional organisation representing nurses in the UK, the RCN, has responded to this by actively engaging with this staff group by including NAs as full members since 2011 and including their representatives onto the organisations management group (RCN, 2011).

3.6.7 Assistant grades and change

The recent introduction of the Nursing Associate role within the English healthcare system has created an intermediary staff group with more education, responsibility and regulation than NAs but less than RNs (Health Education England, 2016). This initiative brings English

nursing more in line with other European Union member states where the Nursing Associate role is commonly adopted (European Commission, 2017). The use of this tiered approach, incorporating varied levels of defined nursing roles is also seen elsewhere including America (American Nurses Association, 2017) and Australia (Jacob, Sellick & McKenna, 2012). Nursing in the UK is, therefore, opening an opportunity for individuals to provide skilled nursing care without having qualified through the traditional registration route.

These are critical times in the development of the NA role. Related legislation and policy guidance have rapidly evolved in recent years and the impacts of these changes are yet to be fully seen. Opportunities are opening up for NAs to obtain occupation related qualifications up to degree level (Griggs, 2011), and for them to emerge from a role of supporting a variety of healthcare professions, into developing as autonomous practitioners who as a group may be better placed to meet evolving healthcare need than the established professions. Their attributes are yet to be fully recognised, especially in the clinical development of student mental health nurses, a group training to undertake a specialised form of nursing. The development of this role has been mirrored in professional organisations outwith the healthcare environment.

3.7 Similarities in other professions

3.7.1 Similar occupational work groups

To ascertain the context within which the identified changes in healthcare delivery are taking place requires consideration of the experiences of other professions situated within the public sector in this country. Within the UK, the growing use of unregulated staff in supporting registered professionals in not unique to the healthcare environment, with similar initiatives occurring in both social care (Manthorpe, Martineau, Moriarty, Hussein & Stevens, 2010) and Education. (Rubie-Davies, Blatchford, Webster, Koutsoubou & Bassett, 2010). Within the social care arena both social work assistants and support workers fulfil this role, however, it is in the education setting where the involvement of an equivalent

staff group, often termed classroom or teaching assistants (TAs), has been most widely studied.

The proliferation in the number of professional support posts such as NAs and TAs has been supported within each of the workforce domains identified above through the publication of governmental employment recommendations. These documents often conveying an argument that providing varied levels of skill within the workforce, facilitates matching the appropriate worker to the specific level of need in any given situation, and therefore provides better management of resources (e.g. The Department of Health (DH), 2000). Within healthcare "A Health Service of all the Talents" (DH, 2000) sets out this agenda, while within education "Raising Standards and Tackling Workload" (Department for Education and Skills, 2003) and "A teaching profession for the 21st Century" (Scottish Executive, 2001) carries the same message regarding the use of support staff within the classroom setting for England and Scotland respectively.

While still considered an under-researched group (Edmond & Hayler, 2013) there is recognition of a significant increase in the ratio of TAs to registered teachers within UK education over the past fifteen years (Blatchford, Basset, Brown & Webster, 2009), to the extent that TAs now comprise around a quarter of the staff compliment in schools (Rubie-Davies et al., 2010). While requiring no formal qualifications (Butt & Lowe, 2012), TAs are now described as “key pedagogic partners” (Cajkler & Hall, 2012 p 225), and considered to currently spend more face to face time with vulnerable groups than teachers do (Butt & Lowe, 2012), with their presence directly influencing a reduction in the contact time teachers have with the most vulnerable pupils (Blatchford et al., 2009).

3.7.2 Teaching assistants and vulnerability

While concerns have been raised about the ability of TAs to undertake the teaching element that many are now seen to assume (Butt & Lowe, 2012), it seems that their interactions with pupils have largely been shaped by the tasks defined for them, in that supporting more vulnerable pupils has led to them having more individual exchanges with such pupils than teachers do, and these interactions are more focused and active than those these pupils

have with their teachers (Blatchford et al., 2009). This has led to some authors postulating that having been incorporated into educational settings in order to provide an addition to the educational support such pupils receive, TAs now, in fact, offer an alternative (Rubie-Davies et al., 2010). This is significant because of the parallels in the evolution of these posts in both settings, as both NAs and TAs were initially envisaged as supports for registered professionals, however, their presence has since coincided with a distancing of registered staff from what could be argued as the people who need their attention most. It is also important to note that the role of TAs in the development of teachers in training is largely ignored. Despite this staff group providing such a high percentage of the school workforce, and a likelihood that they will frequently be providing input to the more vulnerable pupils within the classroom setting, their influence on the development of student teachers during their programme placements seems to be generally unrecognised. A recent report on the role of TAs by the Education Endowment Foundation (2015) makes no mention of the existence of any such role.

3.8 The International perspective

3.8.1 Standardising education

The formalising of the Bolognia process in 2010 signified a move to standardise nurse education across the 48 European member states signed up to that agreement (Collins & Hewer, 2014) and is representative of a drive to create International standards of nurse education as seen within the World Health Organisation (WHO)'s directives on task shifting (WHO, 2007). To fully understand then the relationship NAs have with the clinical development of student mental health nurses requires consideration of the global context within which this relationship sits.

The rapid expansion of the support role in the delivery of healthcare is a phenomenon seen globally and is part of a process of rationalisation of the health delivery workforce known as task shifting. This process involves developing skills for the completion of key healthcare tasks in groups previously seen as underqualified for undertaking them and has obvious

benefits where resources are limited (WHO, 2007). The most striking use of task shifting is likely associated with under-developed health systems, particularly those in parts of Africa, where the approach has been used to target epidemics of AIDS/ HIV (WHO, 2007), in midwifery (Colvin et al., 2013) and mental health care (Kakuma et al., 2011). The phenomenon is also prevalent across what are considered as developed health systems.

The benefits of expanding nursing capability through creation of a less academically prepared but frequently more accessible workforce has obvious benefits and has seen the NA role expand across the globe. Pearcey (2007) identifies expansion in the NA workforce and scope of responsibility across several European and North American countries and this is also apparent in an even wider range of settings. In the USA, there are a variety of titles used for what is predicted to be the largest emerging job role of this decade (PHI Policyworks, 2013) and NA grade staff there are considered to provide 90% of care delivered in some care settings (Lerner, Resnick, Galik & Gunther Russ, (2010). In Canada, what are termed unregulated care providers are recognised as increasingly undertaking tasks and roles previously associated with regulated healthcare professionals, and the limitations of the role are defined in law (College of Nurses of Ontario, 2013). These limitations are most clearly identified through delineation in terms of responsibility, with unregulated staff unable to practice without supervision from a healthcare professional. This is mirrored in Ireland where the standardisation of the qualifications and competencies required by this group have been in place since 2003 (Kyle, McLoughlin, Browne & Greene, 2015). In Australia, the NA workforce is growing rapidly within some clinical specialisms and over the last decade, the numbers undertaking this role within aged care is considered to have risen by ten percent, with this group now providing over two-thirds of the workforce within this setting (Annear et al., 2014). As NA numbers rise there, so RN numbers are seen to have reduced, though an intermediate Enrolled Nurse grade also contribute to their overall nursing numbers (Carrigan, 2009). In addition to the growth of NAs as a percentage of the healthcare workforce, their interface with student nurse education is also evolving.

3.8.2 Forms of nurse education and their impact

The UK is the largest Western healthcare provider to offer nurse qualification across a range of specialist branches, with Australia, Canada, the USA and most European countries utilising a single, generic qualification approach, with specialism an optional add-on. Specialist areas include mental health, the care of children and aged care. A by-product of this has been a subsequent reluctance from qualified nurses to work in areas such as older adult care, rural environments or mental health settings in these countries (Happell, Robins & Gough, 2008). This reluctance has contributed to shortages of qualified staff within such locations and to the growth of the use of NAs to fill the void (Annear et al., 2014). These shortages have been amplified through changes in population characteristics and treatment need.

Demographic shifts are influencing healthcare provision, particularly in regards the ageing profile of the population of Western countries (WHO, 2009), with increasing life expectancy associated with higher levels of disability (Henderson, Xiao, Siegloff, Kelton, & Paterson, 2008), and increasing numbers of people requiring long-term care (WHO, 2009), delivered outwith traditional hospital settings (DH, 2005). Increasingly then care is required for client groups associated with levels of disinterest from qualified nurses (Gillespie, 2013), and this care is delivered in environments where similar disinterest has influenced a reliance on NAs to deliver care (Annear et al., 2014).

These developments have resulted in a change in the profile of placement environments available to organisations delivering pre-registration nurse training and in the qualifications of staff able to support students within these settings. Efforts have therefore been made to incorporate these developing areas more successfully within nurse education and to encourage NAs to take on a formal support role to students within these teams. In Switzerland training for the NA role is seen as an integral component of their nurse recruitment strategy, and they expect that around half of those who undertake such vocational training will continue on to nurse education programmes (Trede & Schweri, 2014). In the USA, there has been a drive to use care homes for student nurse placements (Chen, Brown, Groves & Spezia, 2007). In Australia, this has been taken a step further and considerable support needs were identified to assist NAs to successfully undertake a

mentoring role with student nurses (Robinson, Venter, Andrews-Hall, Cubit, Jongeling, Menzies, & Fassett, 2005). In the last two of these studies, placement providers faced considerable reticence from nursing students around the value of the learning these areas offered and of the appropriateness of NA grade mentors. This is significant as student perceptions around the worth of a placement have a significant impact on the learning arising from it (Hamshire, Willgoss & Wibberley, 2012).

3.9 Existing research on the influence of assistant grade staff

3.9.1 Active research groups

Direct investigation of the relationship between NAs and student nurses has been evident, if sporadic and sparse, even prior to the shift of nurse education into the higher education setting. Melia (1981) for example identified student recognition of the power of the staff group then known as auxiliaries, finding that this unregulated staff group held significant sway over the acceptance of the students within the ward team and at times both contributed to student learning and competed with the students for completion of key clinical tasks. The use of the term auxiliaries highlights the dated nature of that study, however, aspects of the power relationships within the nursing team, recognition of the NA role in student learning and student perceptions of the NA role highlighted by Melia are evident in more recent research.

There is a concern, however, as the infrequent application of related research and the pattern of one-off stand-alone studies as demonstrated in the papers by Wakefied (2000), Wright (2006) and Melia (1981) are reflective of a snapshot approach to healthcare research. Sandelowski, Docherty and Emden, (1997) suggest this approach results in a lack of accumulation of knowledge as each project is almost like starting afresh. It is important therefore to recognise the added value of evidence emerging from groups involved in the sustained investigation of related topics.

Over the past two decades, three research groups have been significantly active in directly investigating the role of NAs in the clinical development of student nurses, and have

reported related research over an extended timeframe. Each of these groups has incorporated a combination of methods in their approach to data collection, and as their initial studies were carried out almost a decade apart and emerged from two countries with markedly different formats for nurse training, so they allow comparison over time and across culturally diverse health systems. The studies by the University of Tasmania (Robinson et al., 2005) and the University of Canberra (Grealish et al., 2010) meeting Australian government intentions to identify how best to support student nurses within older adult residential care settings, and the study by Hasson et al. (2012) reporting the NA perspective on the topic within a Northern Irish, adult care setting.

3.9.2 Tasmanian studies

The Tasmanian researchers published a paper in 2005 detailing what they identified as the final report in a series of documents emerging from the one research project. Utilising a mixed methods approach to data collection, that study sought to identify placement experience factors, including interactions with NAs, contributing to student nurse decision making around plans to pursue a career working within aged care settings. Australia is one of many countries experiencing shortages of qualified nurses willing to work within such a specialism (Lovell, 2006) hence the importance of investigating this particular setting. Subsequent publications from this group have explored the efficacy of interventions they implemented to overcome deficiencies in student support within such environments, including one specifically relating to the role of NAs as student mentors (Annear et al., 2014).

Their 2005 study identified that continuity for the student was a significant factor in shaping their satisfaction around a placement experience. Continuity was important for familiarisation with the placement area and in developing interpersonal relationships between the students and the ward teams, and in addition to their mentors, NAs were identified as significant influences here, providing up to 60% of the students' supervision (Annear et al., 2014). Time spent with NAs strongly shaped the tasks students were involved in, with higher levels of time supervised by NAs correlated with engagement in what the study termed "basic care". This involved carrying out personal hygiene and

attending to dietary needs of patients. More time with registered nurse mentors equated to more involvement with clinical tasks such as medication administration. As other research has shown a frequent reticence from student nurses around the worth of their involvement in the delivery of such “basic care” tasks (Gillespie, 2013; 2017; Abbey, Abbey, Bridges, Elder, Lemcke, Liddle & Thornton, 2006), so additional support is likely required to achieve successful placement experiences for students within similar settings. These authors subsequently trialled such additional input. This 2005 study also recognised that research was lacking around the role of the mentor in coordinating other clinical team members supporting students during clinical placements.

Subsequent research by this group has investigated the effects of NAs undertaking a mentorship role with student nurses placed within aged care settings in Australia. Findings reflected initial similarities with other studies, identifying student nurse concerns around the worth of “basic care” tasks and the value of NA grade staff in contributing to their learning (Bowers, Esmond & Jacobson, 2003). Within this project, the learning opportunities arising from the placement and from the experience of NAs were clearly signposted to students during a series of group meetings over the duration of the placement. This additional support was associated with increased satisfaction from mentors and NAs in both their role in student education and around team-working in general. For students, this fore-fronting enhanced recognition of the relationship of "basic care" (such as hygiene) to the more complex skills, they had originally valued (such as the assessment of pressure areas). The authors again called for further research on the subject.

3.9.3 Research in Canberra

The work of Grealish and associates in Canberra reflects several studies spanning a term of over a decade, building a picture of student nurse development within Australian aged care settings. The earlier papers are of interest to this study mainly because of their use of a social constructivist lens through which to investigate the phenomenon (for example Ranse & Grealish, 2007: Grealish et al., 2010). Their focus has however included consideration of the social environment of the workplace on the development of student nurses on placement (Grealish, Lucas, Neill, McQuellan, Bacon & Trede, 2013: Grealish, Henderson,

Quero, Philips & Surawski, 2014). More recently recognising that student awareness of the value of learning from NA contact needs to be aligned to a more positive and realistic perspective to maximise the effectiveness of the relationship (Grealish & Henderson, 2016).

This group has also recognised similar themes to those emerging for the other Australian researchers. The reticence for students to engage in what they see as NA work is common and therefore, clinical areas associated with this are unpopular placement areas for students (Ranse & Grealish, 2007). This, however, appears amenable to improvement if additional support and preparation are provided to NAs, mentors and students prior to and during the placement (Grealish & Henderson, 2016; Annear et al., 2014; Annear, Lea, Lo, Tierney & Robinson, 2016). The presence of students was also seen by care staff and informal carers as enhancing the standards of care provided and facilitating staff recruitment (Grealish et al., 2010), however students advocated that the quality of the relationship they had with mentors and NAs was the most significant influence on this (Grealish et al., 2014). These findings would suggest a deficiency in the routine preparation of students undertaking clinical placements and in the training provided to NAs who support this.

3.9.4 The UK experience

The major recent, UK focused, research on this subject reported on a large scale mixed methods study (Hasson, 2012; Hasson et al., 2012), completed as part of a doctoral qualification programme by an individual associated with a group of researchers with a longstanding interest in this topic. This study canvassed almost sixty NAs and around 400 nursing students on the educational relationship between the groups. Findings were similar to the Australian studies in that NAs were identified as providing significant input to student nurses on placement within their clinical areas. NAs saw themselves as teaching student nurses an extensive number of skilled clinical tasks including venepuncture, the delivery of patient education and the use of a variety of clinical assessment formats. This role, however, seemed to be completed on an ad- hoc basis. The students generally allocated to work with NAs either because mentor support was unavailable, or because the assistant was seen as having a particular skill, useful to the students' development.

Student responses indicated a complex interaction between the groups that modified as the student progressed on their programme, and often felt they were being used as surrogate NAs, seeing limited relevance in learning from the tasks allocated to them. This study did incorporate student mental health nurses as participants, however, did not separate their views from the far larger contribution of students on the adult field programme. The emphasis of the questionnaire used in this study also seems to have generated a considerable focus on the delivery of skills more relevant to the adult field of nursing.

This study used Thematic Analysis as a medium through which to synthesise the participants' responses and some author's voice concern over the appropriateness of such qualitative approaches to investigate information emerging from participant populations as large as the one in this study (Crowe, Inder & Porter, 2015). Despite these methodological concerns, the evidence emerging is reflective of that arising from the Australian experience, further confirming an important, if unstructured and generally unsupported role for NAs in the clinical development of student nurses. The authors of this study call for similar investigations within other clinical specialisms, including mental health.

These studies identify reliance upon NAs to contribute towards the development of a wide range of clinical skills in student nurses placed within their clinical teams. These skills range from those labelled as basic, though essential may be a more accurate description, through to highly complex therapeutic interventions. This role is informal and therefore NAs are not involved in the coordination or documentation related to the student's programme and learning needs. Each of the studies identified that further research was required and as the studies took place in several clinical teams in different continents a decade apart, it is obvious that the phenomenon is not isolated to one care environment and that, in context, surprisingly little research focus has been directed to investigate what seems to be a major influence within student nurse education. As no previous investigations of this relationship have taken place within mental health settings or since the UK commenced NA regulation, there is a need to investigate whether students recently placed in those environments have similar experiences to those already studied.

3.10 Perceptions of the NA and student relationship.

3.10.1 Student perceptions of the NA relationship

As can be seen in the research examined above, important work has already been done in exploring the perceptions mentors, NAs and student nurses hold of the role that NAs have in the clinical development of students on placement. The study by Wakefield (2000) illuminated this relationship relatively soon after NAs replaced students as the main care providers within the NHS and consequently identified a competition between the groups as the new occupational structure bedded in. This is important as it signifies that the relationship between these groups is dynamic and subject to change in response to external forces, with likely consequential transformation in how individual nurses, NAs and students perceive it. The current reconfiguration of the NA role then seems likely to generate such a conceptual shift.

The studies identified that were completed within the last 15 years suggest that the occupational hierarchy within nursing teams had subsequently settled and that for many students, what NAs do came to be seen as irrelevant to their learning needs (Bowers et al., 2003; Gillespie, 2013). This occurs to the extent that clinical areas associated with NA related care are considered less attractive learning environments to students (Gillespie, 2017). This is also evident in studies taking place out-with the UK (Ranse & Grealish, 2007).

The format of pre-registration student programmes in the UK has largely remained consistent across the past forty years, generally comprising blocks of theory with practice placement experiences of varying duration. This transient linking of students with clinical practice meaning that they struggle to feel part of the healthcare organisation (Grealish & Henderson, 2016). Consequently, student nurses frequently see clinical teams as unwelcoming and unhelpful (Smith, Gillespie, Brown & Grubb, 2016), and consider NAs, as permanent team members, having significant influence over their acceptance during practice placements (Lea et al., 2015). Some even believing that NAs determined whether they would be accepted or not (Hasson, 2012). The early stage of placements was identified as the phase where NAs were most prominent in the student's progress (Melia, 1981) and

the extent of the NAs welcome generally considered influential in determining the success of a placement experience (Ranse & Grealish, 2007).

Melia (1984) reported that in the early 1980s students were identifying that NAs were involved in teaching them clinical skills, however, it was evident even then, that the complexity of fitting academic and clinical expectations was impeding the students' incorporation within clinical teams, and therefore their integration of theory and practice. These concerns continue to surface (Scully, 2011), though work by authors such as Annear et al. (2014) have been seen to support more positive student perceptions of learning from NAs, and through this more effective placement experiences for all involved.

Student nurses regularly identify the importance of a nurse mentor in creating a supportive learning environment, in teaching them clinical skills and crucially, in providing a professional role model that they can base their practice on (Dale, Leland & Dale, 2013). The prioritising of clinical time spent with mentors then provides an obvious draw for students working towards registration. There is evidence, however, of an acceptance of a need to traverse a period of closeness with NAs in the early stages of a student's programme, to emerge later into a student role more in tune with what RNs do (Murray, 1983; Hasson, 2012). This however can lead to uncertainty in more senior students, as their shift away from hands on care creates dissonance around what they, and their patients, expect of a nurse (Murray, 1983; Harmer, 2010). The progressive shift away from tasks seen as the domain of NAs was not met with universal agreement, as senior students seen as moving away from the "dirty work" that was routine care, were also seen as moving away from patient contact (Melia, 1981). Early stage students viewing this as unprofessional (Hasson, 2012).

Involvement in what was frequently described as routine care tasks was associated with NAs and as a result generated mixed emotions in students. Routine care was felt useful for early stage students to learn (Grealish & Henderson, 2016) and NAs were understood to commonly teach such skills (Melia, 1981). Fears were expressed though that the NAs lack of training meant they could be modelling flawed or outdated techniques (Lascelles, 2010) and this was identified by students as a reason for reluctance for NAs to mentor them (Annear, et al., 2014). Exposure to such routine care skills was seen to disadvantage students in that

they considered peers learning more technical skills would leave them behind (Grealish et al., 2013) and routine care tasks were difficult to see as learning (Ranse & Grealish, 2007). Students often felt involvement in such tasks equated with them being treated as NAs (McKenna, 1995) and in older adult care settings students saw little difference between their role and that of the NA (Melia, 1981).

Students saw significant advantages for the NA role in supporting their clinical development. This group offered on site, approachable direction on local expectations (Melia, 1981) and students would often approach them informally for assistance (Hasson, 2012). Positive feedback from ward staff, including NAs, was felt to bolster the student's confidence (Ranse & Grealish, 2007) and working within a clinical team enabled students to understand the professional and organisational context of their role (Grealish et al., 2013). Supportive involvement from NAs was seen to enhance student interest in essential care (Annear et al., 2014) and encourage an interest in working within the placement area (Lea et al., 2015). Despite these benefits arising from NA and SN interaction there appeared to be little done to support it. Students had little preparation for managing NAs and the requirement for this generated anxiety and fears of conflict (Hasson, McKenna & Keeney, 2013b). When preparation and ongoing support was provided, students reported an enhanced placement experience (Lea, et al., 2015).

3.10.2 Mentor perceptions

It has been suggested that registered nurses are showing a docile acceptance of NA encroachment into what had previously been their role (Pearcey, 2011), and this unthinking accommodation may also be representative of how this group consider the influence of NAs in the development of students on placement. There has been relatively little consideration of the RN perspective on this subject, which is concerning, as the attitude of those fulfilling the nurse mentor role, towards how NAs are included, is considered highly influential in determining the effectiveness of the support given (Grealish et al., 2014). RNs are however suggested to be accepting of the role of NAs in developing students essential care skills (Grealish et al., 2014) and open to the idea of more formal inclusion of NAs within student learning programmes. The closeness of the NA to patient care, their familiarity with the

routine of the clinical area and their approachability are identified as key reasons for this (Padfield & Knowles, 2014). There is evidence that mentors link students with NAs where the individual NAs have a specific skill, or when they are completing a task useful for the students learning (Hasson, 2012). The informal use of NAs in this educational role is concerning as some mentors are unwilling to take responsibility for the direction given by NAs (Keeney, Hasson, McKenna, & Gillen, 2005) and there is tacit acceptance by mentors that NAs are teaching beyond their qualifications (Hasson et al., 2012).

3.10.3 NA understanding of their role in student learning

The perceptions of NAs have only infrequently been reported in relation to student learning (Lea et al., 2015), however, evidence exists that, like their contribution to the delivery of healthcare in general, the extent of NA involvement is felt to be undervalued and largely unrecognised (Thornley, 1998). Hasson et al. (2012) identify a lack of conscious awareness of any such contribution in the NAs themselves, seeing this emerge only when the NAs are directed towards contemplating the relationship. This uncritical acceptance may be associated with a lack of confidence in teaching students recognised in NAs, a state considered to impede the relationship between the groups (Robinson et al., 2007, Grealish & Henderson, 2016). This uncertainty in NAs creating a reticence to fully engage with students, a situation that generates a tension between the groups considered to impact negatively on student learning (Grealish & Henderson, 2016). This lack of confidence suggested to heighten when NAs worked with more senior students (Grealish et al., 2013) where they recognise a change in the students learning needs in the form of a more managerial emphasis (Hasson, 2012) and consequently find more difficulty in identifying where they can meaningfully contribute (Grealish et al., 2013). Some NAs even believe that this shift in priority for students was associated with the development of an uncaring attitude, some of which was role modelled by their RN mentors (Hasson, 2012).

Some NAs have identified experiencing a sense of disrespect from students (Annear et al., 2014), despite considering that students enter the clinical team at the bottom of the occupational hierarchy, a notion based on their perceived limited usefulness to the team at

that stage (Hasson, 2012). With such concerns apparent, it is obvious that more positive factors must counterbalance such concerns as NAs routinely contribute to student learning.

Research suggests that NAs contribute to student learning for a variety of reasons, often associated with their unique role within the clinical team. They believe that their availability and closeness to students and patients situates them well as an accessible resource of salient information (Hasson et al., 2012). NAs identified that their work position allowed them to fill this role when the RNs were busy (Hasson, 2012), with such involvement seen as a way of contributing to the overall needs of the team (Elliot, Annear, Bell, Palmer & Robinson, 2014). In explaining why they contribute to student learning, NAs have identified a perception that they welcome the fresh insights students bring to the placement and see successful placement experience as a medium through which to support successful nurse recruitment for the area (Grealish et al., 2010). In addition, NAs identified that they provided student support largely because it was expected of them, and that, somewhat worryingly, because of being excluded from formal involvement in the student's learning process they often enforced their own emphasis on that learning experience (Hasson et al., 2012). This involvement frequently lacking any consideration of the implications or responsibility associated with teaching student's clinical skills (Hasson, 2012).

The involvement of NAs in student learning can be enhanced through the inclusion of preparation and support. A study by Wright (2006) found that a brief educational session for NAs, outlining the students' programme and detailing the NA role in supporting the student, enabled the NAs attending to situate themselves more clearly in relation to student learning, validating their involvement and consequentially positively changing their perceptions of their role in this process.

3.11 The Quality and relevance of the evidence available

3.11.1 Critique of the currency of available research

Sanders and Wilkins (2010) emphasise the need to critically appraise the worth and relevance of research while Fothergill and Lipp (2014) point out the importance of this process in the transition of theory into practice development within nursing. Several authors provide templates through which uniformity of consideration of research quality can be made and the templates presented by CASP (2017) are used here as they were designed to assist in the appraisal of journal papers relating to healthcare research. The templates in question incorporate a focus on the quality and timing of the study under review.

An obvious limitation of older studies is the likelihood that the context within which the research took place is no longer fully reflective of current practice conditions and therefore uncertainty arises around the relevance of their findings. Ingham- Broomfield (2014) additionally cautions that this can be exacerbated through the at times lengthy delay between study completion and the subsequent publication of related research papers. In relation to the influence of NAs on student development, the few studies directly investigating this has been spread across the past five decades, leaving them open to criticism around currency.

Several publications including Allan et al. (2011) and O'Driscoll, Allan and Smith (2010) contend that the shift of nurse education into the higher education sector and accompanying adoption of supernumerary status for student nurses on placement was fully realised in the 1990's. This suggests that findings emerging from research completed prior to this would not be fully transferable to the current healthcare setting. Papers such those detailing the study by Melia (Melia, 1981; Melia 1984) should thus be identified as determining how practice was, not necessarily how practice is. This caution should also include the study by Wakefield discussed above. While published in the year 2000, the paper reports on research completed at least 5 years before and hence now over twenty years old. That it included investigation of only one clinical area further limits the relevance of its findings to the current study. Such limitations mean careful consideration is required to ascertain which aspects of these studies have current relevance. The recent acceleration of development in the NA role and accompanying influence on the access routes to nursing

registration mean that even studies completed prior to the government driven change in 2013 may not fully capture the realities of the current situation.

3.11.2 Methodological critique

Methodological design is considered critical in ensuring that the methods of information collection and analysis used within a study fully meet the purpose of the research (Edwards & Talbot, 1994). Ingham-Broomfield (2014) identifies that authors of research reports should include an operational definition determining exactly how the methods used can explore the issue under investigation. While many of the studies reported here, that used qualitative approaches have justified their use, for example; Grealish et al. (2010), Annear et al. (2014), Wright (2006) and Annear et al. (2016), few have accounted for possible reactivity of involvement in participants through a process known widely as the Hawthorne effect (Rebar & Gerch, 2015). These authors describe this effect as being the over- inflation of positivity in participants, triggered through increased interest being shown in them. In the case of the studies mentioned, each incorporated introduction of a new process assisted via enhanced support either before or during clinical placement, yet none incorporated the impact of study involvement within their findings. The possibility of such reactivity over-inflating positive study findings should, therefore, temper acceptance of the conclusions. The authors of each of these studies do though recognise the unrepresentative nature of their clinical environment because of the high level of educational support provided.

In addition to the impact of the research on the participant, evidence of methodological rigour requires adherence to the stated methodology (Hays, Wood, Dahl & Kirk-Jenkins, 2016). The paper by Hasson (2012) identifies being guided via Symbolic Interactionism. This is a sociological theory that emphasises interpretation of human interaction in the development of a sense of self (Shattell, 2004) and to achieve this requires consideration of the environment within which these interpretations are made (Benzies & Allen, 2001). In omitting mentors, patients and carers from their study Hasson fails to encapsulate a comprehensive consideration of the clinical environment as related to nurse education. Through this, they provide only a partial appraisal of that setting, excluding key

perspectives, and consequently present a limited identification of the clinical experience and its influence on the development of meaning for study participants.

3.11.3 Methodological worth

The other major field of criticism in relation to the research available on this subject is generated via the worth attributed to research methodologies by organisations influential on policy development around clinical care. Smith et al. (2009) suggest that quantitative studies are more valued by such organisations and SIGN (2015) confirm their preference for large-scale quantitative research. The use of qualitative methodologies in studies such as Ranse and Grealish (2007), Grealish, et al. (2010), Hasson et al. (2012) and Annear et al. (2014) therefore rank low in relation to shaping policy guidance. The predominance of qualitative methodologies in investigating this topic consequently reduces the likelihood of subsequent impact.

While there are areas evident within which criticisms can be levelled at the literature available on this topic, the same factors also identify strengths within the evidence presented. The fact that similar issues arise around individual interpretation of organisational issues within both the Melia (1981) and Hasson (2012) studies suggest that there are trait factors constant through this process. The availability of historical data, therefore, provides illumination of the process of change while identifying features that are constant and current.

Similarly, the fact that analogous issues have arisen within studies using a varied use of qualitative and quantitative methodologies allows stronger claims to be made around their accuracy (Rebar & Gersch, 2015). Qualitative approaches used include Action Research (Annear et al., 2014), Grounded Theory (Elliot et al., 2014), and Thematic Analysis (Grealish et al., 2010). The quantitative studies available have in addition employed robust statistical analysis including the use of significance markers. Statistical significance identifies the level of confidence in the accuracy of test results (Sanders & Wilkins, 2010). Studies utilising this include Stratton, Lea, Bramble, Eccleston, McCall, Lucas & Robinson (2015) and Lea et al. (2014). The depth, duration and breadth of studies completed suggest confidence can be

placed in the evidence emerging from the research available detailing what is known about the NA role in the clinical development of student nurses. Such findings provide important information on the phenomena regularly recurring within related clinical research as well as identifying the gaps still to be explored. The influence of NAs has also emerged within studies not directly investigating this phenomenon.

3.12 The wider influence of nursing assistants

3.12.1 Other spheres of influence

In addition to the connections between student nurses and NAs identified within the focused studies reviewed above, and in the socialisation process during clinical placements discussed earlier, the interrelationship of the roles has often been illuminated as a consequence of research investigating peripheral, though related, topics. The delivery of nursing care has traditionally been provided by a team comprised of RNs, student nurses and NAs (Hand et al., 2013). The balance of responsibility for the completion of this skilled nursing care is increasingly shifting into the domain of NAs (Stokes & Warden, 2004) with little exploration of the impact this has on the success of the student's placement experience (Hasson et al., 2012). As actual accommodation of such changes are considered to lack uniformity because their interpretation is mediated by the cultural context of individual teams (Hancock, Campbell, Ramprogus & Kilgour, 2005), so the need to understand the interaction between NAs and student nurses across a range of settings becomes apparent. It is also clear that there is a need to accept some variation between clinical specialisms while recognising that there is available evidence relevant to most, if not all clinical settings.

The importance of successful placement experience for student nurses is well established (Dale et al., 2013), as is the significance of the on-site mentor role (O'Driscoll et al., 2010) and the value of a welcoming and supportive clinical team (Lea et al., 2015). The placement experience allows the student to develop competence in clinical and interpersonal skills, the theory for which they will have received via the Higher Education Institution responsible for

their programme. Their time within the clinical environment also facilitates the embedding of professional norms and values within a live workplace setting (Halse & Hage, 2006), and within this, the effect of workplace peers often attains prominence over theoretical influences in the development of their practice (Thomson, Schneider & Wright, 2013). It is even suggested that integration within the placement team is as significant to their development as achieving the theory-driven competencies set out within their educational programme (Goodare, 2015).

Within these practice placements students are strongly influenced by role models (Price & Price, 2009), often these are their mentors or other registered nurses, though other practitioners, including NAs, are considered to fulfil this role (Felstead & Springett, 2015). With nursing students frequently cited as being reluctant to take on what they have considered as a menial NA role during placements (Grealish & Henderson, 2016), it seems problematic to consider them accepting and valuing NAs either contributing to or taking responsibility for, their practice learning. The narrow definition of clinical competence as related solely to skills acquisition, associated with nursing students (Gidman, McIntosh, Melling & Smith, 2011) provides some context for this reluctance to accept the worth of NAs. Changing patterns of healthcare delivery are, however, challenging this, somewhat insular, perspective.

3.12.2 Nursing assistants in student education

There is support for NAs to become more formally involved in contributing to student nurse learning. It is recognised that NAs are likely to develop significant familiarity with, and competence in, the application of skills common to their clinical environment (Callister, 2011). Students also perceive NAs as more approachable for assistance in developing specific clinical skills (Hasson et al., 2012). These attributes place them well for contributing to the students' clinical development, and some authors even advocate that they should undertake mentor level responsibilities (Annear et al., 2014). There are calls for caution here, though, with concerns raised about NAs lack of qualifications and preparedness for this role (Kendall-Raynor & Duffin, 2008). In addition, it is recognised that mentors are required to promote higher thinking skills in their students, including problem-solving and

analysis (Kilcullen, 2007) however none of the Scottish Credit and Qualification Framework (SCQF) requirements for the educational levels of qualifications associated with the NA role (SCQF, 2012) reach such cognitive heights.

NAs are considered strongly influential in facilitating the acceptance of a student nurse within a clinical team (Christiansen & Bell, 2010). There is evidence that around a third of student nurses experience what they perceive as bullying from NAs, and that this most frequently takes the form of passive behaviours that prevent the inclusion of the student within the clinical team (Stevenson, Randle & Grayling, 2006). This is concerning, as, in addition to facilitating the development of nursing skills, the placement experience also provides an opportunity for the professional socialisation of students. Felstead and Springett (2015) suggest that this socialisation includes the development of the values and cultural expectations that frame practice, as well as the knowledge, skills and professional identity that defines nursing. Ousey (2009) emphasises the social process inherent within nurse training and the influence of groups such as NAs in shaping this, and with NAs also currently pursuing their own professional identity, distinct from that of nurses (Stonehouse, 2015), so the opportunity for role confusion is apparent. As failure to meet pre-course expectations is associated with increased anxiety (Brown & Edelman, 2000), and considered to contribute to the high attrition levels seen in the early stages of nurse training (Goodare, 2015), so the importance of clearly defined professional boundaries are evident.

3.13 The social constructivist lens

3.13.1 The applicability of Social Constructivist theory

Social constructivist learning theories have previously been employed in underpinning initiatives seeking to enhance the learning relationship that exists between student nurses and NAs. Grealish and Henderson (2016) advocate that the socio-cultural emphasis of such approaches offers an opportunity to overcome deficiencies in the infrastructure available to facilitate the number of placement environments required to support nurse education and do this through identification of the learning offered in less traditional placement settings. The same theories also facilitate the analysis of organisational culture (Grealish et al., 2014)

and provide a useful guide to appraise the understanding of the NA and student nurse relationship as described by the three groups detailed above as most invested in the process. The issues of concern identified in the experiences of these groups' warrants exploration, and prior successful engagement of social constructivist theories within similar studies support their use in the analysis here.

There is a need to create an alignment between the ontological and epistemological theories underpinning a study (Denscombe, 2010), and in this case that means identifying a connection between the social constructivist learning concept and IPA. The fit of social constructivist learning theory and IPA is most clearly evident within the double hermeneutic associated with the analysis process employed within this research methodology. Within this activity there is recognition of the social influences shaping how individual participants make sense of their world and importantly how they understand the specific phenomenon under investigation (Dempster, 2011: Dempster & Hanna, 2015). There is also acceptance of the need to account for the influence of social interactions on the interpretations of emerging narrative made by the researcher (Smith et al., 2009), and such recognition of socially constructed meaning is suggested to link IPA with constructivist learning theory (Dempster, 2011: Dempster & Hanna, 2015: Davidsen, 2013). Within this study, the influence of clinical colleagues is likely to be a major influence on the sense making of the participants, and also reflects the researchers understanding of what shapes the embedding of practice related perceptions. The CoP concept commonly utilised to frame understanding of the social nature of learning within clinical practice (Thomson et al., 2013). This concept is then amenable to investigation using the IPA methodology, and seems well suited to frame the clinical learning process as it is understood within this study.

3.13.2 NAs and the Community of Practice

The concept of the Community of Practice was identified earlier as framing the understanding of the process of student nurse engagement within the social learning environment that is the clinical placement. Hay (1993) identified however that automatic acceptance within a CoP is not guaranteed, Cope et al. (2000) explaining that for successful integration the novice's contribution must be considered authentic and valuable by the established group members. Potential barriers to student acceptance can be seen in the

accounts of the groups involved and detailed above, most frequently emerging as a perceived delineation between NA and RN roles and the differing value attributed to them in relation to student learning needs. This is concerning as students struggling with acceptance face consequential marginalisation and experience exclusion and a sense of remoteness from practice, and hence poorer placement involvement (Hay, 1993). The notional separation of the NA and RN role is common in the accounts detailed above and additionally emphasised in the study by Cope and colleagues, which clearly details their understanding of the practice CoP as being composed only of RNs. Failing to recognise NAs as members of the community that is the placement nursing team puts students in a position where they are forced to negotiate progress through key elements of the nursing organisation, with limited preparation and little understanding of the relevance of the NA role.

The exclusion of NAs from what would be understood as the placement CoP is concerning as the evidence presented above identifies them as pivotal in the acceptance and clinical education of the student. Winkelen and Ramsell (2003) advocate that for a CoP to be successful it needs to accommodate an alignment between all of its members and failing to incorporate NAs in what is considered as the placement CoP seems then to be dismissing the value of the NA contribution to care, ignoring the relevance of their skills in relation to student learning, while also placing the cohesion of the CoP at risk. If students are to successfully negotiate the process of legitimate participation, as defined by Lave and Wenger (1991), the NA role in the nursing CoP needs to be recognised and accommodated within the preparation of students embarking on practice placements.

3.13.3 Cognitive Apprenticeship

The evidence that NAs are significantly responsible for teaching student nurses essential care skills, especially early within placement experiences, is concerning. Cognitive Apprenticeship is a social constructivist framework for learning applied in the design, delivery and evaluation of student nurse learning (Cope et al., 2000). This model identifies six learning strategies designed to support the student to develop clinical, social and organisational knowledge during practice placements. The first three of these strategies,

modelling, coaching and scaffolding involve significant in- situ direction by a subject expert, as the student gradually masters the skill (Bates et al., 2012). Identification then, that NAs are responsible for much of the student learning around essential care tasks, frequently through modelling, coaching and scaffolding, highlights the lack of standardised preparation or support the NAs receive to undertake this role, and raises concern around the quality of training they provide.

The smooth delineation of progression of the novice learner through the apprenticeship process as outlined by Lave and Wenger (1991) is proving more complex in the real world than in theory. The concept of a nurturing legitimate peripheral participation for the apprentice within the supportive environment of a community of practice does not seem to work well in the absence of initiatives that foster it. Despite the CoP concept within healthcare settings being routinely considered "as a group of healthcare workers, sharing a common domain of interest…" (Seibert, 2015 P70), the available research suggests that NAs are routinely overlooked, even ignored, when nurses, student nurses, nurse educators and prospective nursing students conceptualise the nursing team and its CoP.

Exclusion of the NAs from formal involvement in the student's educational development has created a lack of awareness in NAs of the value of their contribution and a corresponding lack of confidence around the issue, which creates an unhealthy tension between them and students. The accelerating pace of development of the NA role seems likely to exacerbate these issues.

3.14 Conclusions

It is apparent that the workforce involved in healthcare delivery is developing in a manner that shifts the expectations on the established professional bodies while offering opportunities to emerging staff groups. The NA type role offers advantages to employers in terms of flexibility and cost, however, the growth of this group and overlap apparent with registered nurses has created a somewhat confused pattern of care delivery, based on local interpretation and expectation. This has created a clinical environment where the formal and informal influences on student nurse education are evolving rapidly. The extent of this

change has been tested slightly within areas such as adult nursing and in the care of older adults and this has identified a possible conflict between the expanding role of NAs and their informal involvement in student learning. While sustained studies have investigated clinical environments within the UK and Australia there are obvious gaps in the information available, strongly suggesting the need for further research. There is no current evidence around how this shift in care delivery has impacted on the development of student mental health nurses and indeed no research available exploring the role of NAs in the clinical development of such students within mental health settings. There is a need therefore to investigate this phenomenon and the previous successful use of social constructivist theory to shape similar investigation supports is appropriateness here.

3.15 The Research Questions

3.15.1 Defining the research questions

It is apparent that there is sufficient evidence to confirm that NAs have an existing role in the clinical development of student mental health nurses during the practice placement components of their programme. What is less certain however is the nature and extent of this involvement in what is a period of rapid development within UK healthcare provision, including extensive task shifting involving nurses, NAs and nurse education. The crucial impact of practice placement experiences (Dale et al., 2013) supports the need to examine and identify the nature of the relationship between NAs and student mental health nurses placed within their clinical teams. As the most accurate explanation of the relationship between different groups is likely to emerge from involvement of representatives from these groups (Rebar & Gersch, 2015), so the research needs to examine the form and degree of the influence that NAs bring from the perspective of each of the main groups involved; the nursing assistant, the student's mentors and the students themselves. The crux of this investigation is articulated within research questions detailed below;

Q1. How long do student mental health nurses spend with registered and unregulated nursing staff in a typical day, and what is the focus of these interactions?

Q2. How do NAs perceive their role in the clinical development of student mental health nurses, including the preparation and recognition they receive for any such involvement?

Q3. How do student mental health nurses view the role of NAs in developing their essential care skills whilst on clinical placement?

Q4. How do clinical mentors understand the role of NAs in the clinical preparation of student mental health nurses?

Chapter 4- Research Methodology

4.1 Chapter Overview

This chapter outlines the rationale for the research methodology used, detailing the fit of Interpretative Phenomenological Analysis within the investigation of a previously unexplored phenomenon. The chapter opens with a review of phenomenological theory as related to research, and then shifts to clarify how Interpretative Phenomenological Analysis relates to this specific study. The choice of data and narrative collection methods is explained, as is how they are connected within the study. The identification and selection of study participants is clarified, as is the analysis process and steps taken to ensure that the project is ethically sound and that participants are fully protected. The chapter closes by presenting the key quantitative information emerging from the participant diaries, using this to provide the context within which the Interpretative process of this study took place.

4.2- Research Strategy

4.2.1 Choice of strategy

Denscombe (2010) advocates that the choice of research methodology for a study should be determined through the application of three qualifying criteria; does the strategy answer the question being asked, can it be applied successfully in the specific circumstances of this study and is it ethically sound. While these are the questions that this chapter sets out to answer, it must be recognised that this is a very pragmatic conceptualisation in suggesting that the research methodology is selected on the basis that it best fits the purpose of the study. Sanders and Wilkins (2010) argue that the perspective through which the researcher understands the world, as frequently, drives the choice of strategy. Recognition of this and consideration of these factors guided the selection of research methodology for this study as described below.

The purpose of this study, as defined by the research aims and questions, centres on the exploration of the experiences of individuals training for a professional qualification, and of the people who most closely support this within the practice placement setting. As such experiences are considered to involve a combination of both emotional and cognitive aspects of understanding, answering the research questions requires the use of methods which investigate such deeply personal phenomena (Edwards & Talbot 1994). These factors are suggested by the literature review to be at least partially related in this case to the individual's previous experience and to the perceptions dominant within their wider culture (Simmons & Griffiths, 2014), as well as in the influences on both the clinical and academic settings within which this training takes place. This led to the selection of a phenomenological research design, utilising a mixed methods approach to information gathering and analysis. The reasons for this are outlined below

4.2.2 Research design

This study comprised a three- stage design to data collection which included firstly a review of relevant literature. Moore (2012) considers the quality of the review and appraisal of related literature as key in determining the quality of a research study. This was followed by completion of a diary, recording the participant's experiences of the phenomenon as it occurred within the clinical area (appendix 3), and then a subsequent review of their diaries (appendix 4) and the participants' wider views on the subject within a semi structured interview with the researcher. As the diary captured relatively immediate experience within the clinical environment, accurate detail was achieved on how the participants interpreted and understood the phenomenon in question as the events unfolded. The diary responses then shaped the semi structured questions put to the participants (appendix 5), an iterative process utilised within other qualitative methods of collecting data (Holloway & Todres 2010).

Smith et al. (2009) advocate incorporation of quantitative research methods in IPA studies if their application is relevant in investigation of the phenomenon under scrutiny and phenomenological analysis retains primacy. There is though some confusion apparent around universal understanding of terms used to describe the combining of research

methods within one study like this. The linking of research methods within one study has been described variously as multiple methods, mixed strategy and integrated methods (Denscombe, 2010). With authors such as Molina- Azorin (2009) and Driessnack, Sousa and Costa Mendes (2007) providing markedly conflicting definitions for the same term, so Denscombe's suggestion of a continuing vagueness around the use of such terms is noted.

The term mixed methods research is generally accepted as describing studies that incorporate data collection approaches from each of the main ontological paradigms (Cameron, 2011). This combination is encouraged within IPA research (Smith et al., 2009), however it has been rarely applied and any consequential results are often presented in separate publications (e.g. Newton, Landau, Smith, Monks, Shergill & Wykes, 2005: Newton, Larkin, Melhuish & Wykes, 2007). A study by Michie, Hendy, Smith and Ashead (2004), however, utilises an approach that mirrors the preparatory role of quantitative data collection informing a subsequent qualitative method applied here. Within that study General Practitioners were canvassed on the number of steps their practice group had made towards meeting specific government targets. Once this data was obtained it was incorporated with an IPA analysis of individual interviews to provide context to the influences shaping the GP's perceptions. This approach, then, is established, though has been infrequently used.

Doyle, Brady and Byrne (2009) identify typologies of mixed methods approaches presented by Cresswell and Plano Clark (2007) and Leech and Onwuegbuzie (2007). While the term sequential explanatory design most closely reflects the process used within this study, none of the variants included there considers the use of quantitative data collection solely to generate contextual information for the subsequent qualitative review that forms the basis of this research. Hasson (2012) identifies, however, that categorisation of mixed methods research is still developing, suggesting that not all combinations of methods may yet be listed. It is useful therefore to return to the literature to elicit a description more accurately reflecting this study. Sanders and Wilkins (2010) identify several combinations through which quantitative and qualitative methodologies can be applied within one study, considering convergent, divergent, sequential and parallel processes. They describe the use of one methodology to inform the subsequent use of the other as developmental, hence this research can be said to have used a sequential developmental explanatory approach.

A major criticism of combining research emerging from each of the main ontological standpoints is the articulation of common ground between them (Wagner et al., 2012). The use of phenomenology is suggested able to accommodate this (Fisher & Stenner, 2011) and Smith et al's. (2009) assertion that Hermeneutic Realism underpins IPA explains its ability to incorporate both paradigms within one study.

The research methods selected for the study came from each of the main methodological paradigms traditionally categorised within nursing research; qualitative and quantitative (Kelly & Long 2000), however it is evident that research methods emanating from the main philosophical stances are not mutually exclusive, and in fact are suggested to potentiate a more comprehensive study when combined (Robbins, Ware, dosReis, Willging, Chung & Lewis-Fernandez, 2008).

Smith et al. (2009) encourage the combination of quantitative and qualitative methods of data collection as they feel this delivers sufficient depth of exploration while providing findings and a methodology of data collection more acceptable to policy makers, and hence more likely to lead to desired practice development. Within this study, completion of the diaries informed the development of questions for the subsequent individual interviews. They also provided context around the participants' decision making, and the identification of such context is considered crucial for interpretative analysis (Smith et al., 2009). The diaries additionally focused the participant's attention on to the phenomenon under investigation. This guided intentionality then forcing those completing the document to consider and reflect upon the subject, creating a shift in their reflective state.

This study then utilised the literature review and diary content to identify the context within which the participants understood the area of investigation, while the diaries also primed the participants for their subsequent involvement in the individual interviews. The interviews provided access to the individual perspectives required of phenomenological research (Fade, 2004) and were the key process through which this investigation was completed. This process meeting the needs of IPA research as defined by Smith (2004), one of the originators of that methodology.

4.2.3 Reflective state

As Larkin, Watts and Clifton (2006) consider that IPA can only identify an individual's current relationship with a phenomenon, so the understanding of that person's reflective state gains importance. Smith et al. (2009) point out the difference between pre-reflective thought and reflective thought is that the former signifies something we are only barely conscious of, while the latter relates to a more considered and deeper analysis of the subject. Combining diary use with interviews therefore allows insight into the individual's sense making process as they move from one to the other.

The diaries used also provided quantitative data that could be subjected to descriptive statistical analysis and thereby provide another perspective from which to understand this subject (Appendix 6), adding to the information arising from the interview stage. Combining semi structured interviews and diaries has been previously used within IPA studies (Brocki & Wearden, 2006), and Smith et al. (2009) encourage this wider scope of investigation as long as the focus remains on ideographic phenomenological analysis. In addition then to shaping the subsequent individual interview question schedule, the diary also provides another route through which to understand the phenomenon in question.

To facilitate a cohesive research study requires alignment between ontology, epistemology and the questions or phenomenon the research seeks to investigate (Edwards & Talbot 1994). Denscombe (2010) conceptualises operationalising this through the application of a strategy that links the way we understand the world and the relations between features of that world (ontology), with our perceptions on if, or how, we can develop knowledge about that world (epistemology). Using these influences to shape an action plan (research design) that will successfully achieve our goal (meet the research problem). For this study the objective was to explore how those directly involved in student nurse education within the clinical setting perceive the role of the nursing assistant within that process. As suggested above experiential knowledge of this topic differs from policy guidance and existing research evidence. A research methodology was therefore required that would fully explore the reality of this phenomenon in the situation within which it occurs. Such exploration must therefore include investigation of the experience from the perspective of those individuals closest to it. Spinelli (2005) suggests that phenomenology emphasises the

individuality of human experience, and Smith (2004) advocates that Interpretative Phenomenological Analysis (IPA) is a research methodology that facilitates exploration of how people make sense of their experience. Phenomenology therefore is the worldview that guided the study, and IPA is the framework that shaped this exploration. A rationale for this is detailed below.

4.2.4 Phenomenological Underpinnings

The word phenomenology is somewhat inexplicit in that it is a term used to describe both a philosophical perspective and an approach guiding social science research (Earle 2010). Philosophically, phenomenology is understood to differ from other worldviews in that it considers understanding and verity to arise from an individual's perspective, rather than it being externally determined (Sanders & Wilkins, 2010). Holden (1991) explains this as emerging from the concept of Idealism, which postulates that reality consists only of conscious thought, therefore denying the existence of matter. This emphasises the centrality of human experience as well as recognising the individuality of that experience. Such a focus fits well with the defined research questions, and should facilitate illumination of the experiences of those involved.

While the first use of the term phenomenology is attributed to Emmanuelle Kant in 1796 (Yegdich 1999), a means of applying the concept to real life emerged later, in the 19th Century, through the work of Edmund Husserl, a German philosopher (Quinn- Patton, 2002). Husserl is suggested to have emphasised exploration and identification of the universal components of human experience as an alternative to the use of the experimental science approaches that dominated at the time (Roberts 2013). In Husserl's view humans each have a unique interpretation of the phenomena they experience, while recognising that within those experiences there are shared constituents, or eidetic structures as they are described (Flood, 2010), that can be found through examining the experience in isolation from its wider context, and in the absence of preconceived understanding of it (King & Horrocks, 2010). This process of distancing is described as phenomenological reduction, epoche or bracketing (Tuohy, Cooney, Dowling, Murphy & Sixsmith, 2013), and the aim in Husserlian focused research is to uncover these shared components, or essences of the phenomena

(Dowling & Cooney, 2012). Husserl advocated that there was one true interpretation for each experience, and that bracketing was a method through which it could be uncovered (Flood, 2010).

4.2.5- Bracketing

Any form of research requires some way of avoiding becoming a process that merely moulds the findings into fitting with the researcher's preconceptions (Pringle, Hendry & McLafferty, 2011). Within phenomenological research, strategies advocated for achieving this include encouraging the researcher to reflect on their own understanding and beliefs about the phenomenon in question, and to be open to what the emerging data is suggesting (Dawkins & May, 2002). This process allows a bracketing off of their pre-existing views of the topic and the researcher then sees it afresh, stripped of the personal and cultural complexities that obscure the essences referred to by Husserl and discussed above.

Bracketing therefore meets two needs; by encouraging the researcher to consciously separate the phenomena under investigation from their own preconceived understanding of it, bracketing should enable a more accurate description of the participant's experience, and through this be able to evidence the rigour of the study. While the importance of rigour is detailed below it is important to note that despite the apparent advantages associated with bracketing, there are some authors who debate whether it is possible to completely suppress the perceptions an individual has around a phenomenon (Finlay, 2008). Bracketing is also strongly associated with descriptive approaches to phenomenology, approaches that miss the collaborative sense-making occurring in interpretative methods (Hamill & Sinclair, 2010). IPA is considered to include elements of both these approaches (Smith, 2004) and as this study sought to determine the lived experience of those involved in student nurse education within clinical practice, and I as a former clinical nurse and current nurse educator and researcher have involvement in that process, so IPA offers a research method that incorporates recognition of my own experience, as well as that of the clinicians and students involved. The integrative focus of IPA hence strengthens its suitability for this study.

4.3 Explaining the Phenomenological variants

4.3.1 Diverging theories

Phenomenology has undergone several transitions since its inception, with Dowling and Cooney (2012) describing a divergence into three main branches; Descriptive phenomenology associated with Husserl, Hermeneutics or interpretive phenomenology associated with Gadamer and Heidegger, and what they describe as The Dutch School, which includes features from each of the others and is related to the work of theorists such as van Manen. This simple delineation of phenomenological research is not universally agreed, with authors such as Roberts (2013) and Flood (2010) providing other forms of categorisation. However, as Husserl and Heidegger are considered the most significant influences on phenomenological research (Converse 2012), and as their theories have significant relevance to the application of IPA, it does provide a background through which to review how such somewhat diverse approaches are integrated within IPA.

4.3.2 Descriptive Phenomenology

Husserl's focus is described as emphasising the importance in identifying a description of the phenomena as experienced by the individual, unadorned by any consideration of individual preconceptions or external influences (Earle, 2010). As none of these influences are recognised as sufficiently powerful in shaping the core essences of phenomena (Flood, 2010), so stripping away such considerations then leaves only the universal truths of those phenomena. Truths that Husserl felt were obscured to the participant's consciousness through the influence of the external environment (Shinebourne, 2011).

Husserl was influenced by the dualist perspective of his contemporary, Brentano (Dowling & Cooney 2012). Dualism posits a separation between the mind and the body (Holden 1991), and Husserl emphasised this differentiation through the concept of intentionality. Intentionality refers to the idea that humans relate to the world around them and to other humans through a process of consciously attending to each object and experience (Converse 2012). This understanding of consciousness considers our awareness of, and thoughts and feelings towards everything that we experience are mediated through a

process of orientation to that object or person, influenced by our interactions with the world and people around us (King & Horrocks, 2010).

As this process of intentionality was not shared by physical phenomena, so Husserl determined that identification of the key elements of this process were not amenable to empirical investigation (Dowling & Cooney 2012). Later theorists, however, determined to go beyond merely pursuing this description of human experience, and instead sought to explain it.

4.3.3 Interpretative phenomenology

Having studied under Husserl, Martin Heidegger initiated moving from the epistemological focus of Husserl's work to the ontological search for the understanding of being (Flood, 2010). This shift recognised the need to understand how humans experienced aspects of life, in the full awareness that the constituent parts that make up a person's life do not occur in a vacuum, in that they are indeed subject to the influence of the person's interaction with the wider world (Converse 2012), including the cultural, political and social environment that surrounds them. This positioning of the person within the wider context is termed Dasein (Tuohy et al., 2013).

This move from description to interpretation attracted the Hermeneutics title, as this was a term used in describing the process of understanding the relevance of ancient artefacts through reviewing them within the wider context of their era (Willis, 2007). This shift meant that those researching from a hermeneutic perspective moved from describing subjects making sense of their world, to making sense of subjects making sense of their world (Roberts, 2013). To do this involved a double hermeneutic (Clancy, 2013) in that it required the researcher to accommodate not only the preconceptions and external influences that affected the people they were studying, it also necessitated the researcher to explore and declare the impact of their own prior understanding, beliefs and values around the matter being investigated, and to consider their relationship as a researcher with the subjects involved, the phenomena being investigated and the process of investigation (King & Horrocks, 2010). The process generating understanding through the interaction between

the context, the study topic and the perspectives of the humans involved is described as a hermeneutic circle (Earle, 2010), and the practice of striving to understand one's own position in relation to the matter under investigation is called Reflexivity (Sanders & Wilkins, 2010). While hermeneutics obviously differ from the descriptive phenomenological approaches associated with Husserl, Interpretative Phenomenological Analysis is an approach that manages to integrate the two.

4.4 Interpretative Phenomenological Analysis

4.4.1 IPA as a guiding framework

Now, still less than a generation old, IPA emerged in 1996 within a paper by Smith, who has been instrumental in shaping its development since, both through subsequent publication of clarification of underpinning theory, and in providing supplementary guidance on the application of the approach. Smith (2004) also recognises the role his supervision of doctoral students has had in encouraging the selection of IPA as a research strategy, and may help explain the proliferation of IPA studies within his own Health Psychology field, especially early in its inception (Fade, 2004). IPA has since been utilised within an increasing diversity of settings, including nursing (Stewart & Rae, 2013), midwifery (Roberts, 2013) and social work (Rizq, 2012).

4.4.2 Layers of analysis

Flexibility is a term commonly found within descriptions of IPA (e.g. Brocki & Wearden, 2006). While there is a flexibility in the level of analysis available to the researcher within an IPA study, researcher capabilities and the research purpose are considered the main factors influencing the level of interpretation achieved (Smith et al., 2009), and Smith (2004) demonstrated four layers of analysis available within one study of chronic lower back pain.

The ability to move between these levels, shifting from descriptive appraisal, utilising close consideration of the text, through to interpretation guided by psychological, cognitive and

social theory, is suggested to allow sense making in a manner that expands upon and enhances explanation of the participants understanding (Larkin et al., 2006). In addition to providing levels of analysis, where connections can be made cross-sectionally, IPA also facilitates cross subject comparison, with subsequent opportunity to explore the commonalities and differences in how individuals experience the same phenomenon (Palmer, Larkin, de Visser & Fadden, 2010). The selection of participants is therefore significant.

4.4.3 Sample and transferability

The focus of IPA research is on the experience of the individual. Described as ideographic (Larkin et al., 2006), this influences the number of subjects included. While Brocki and Wearden's (2006) review of published IPA studies determined that participant numbers in the papers found varied between 1 and 30, they recognised a prevalence of small sample sizes. Smith et al. (2009) emphasise how this micro level focus allows deeper analysis, strongly encouraging consideration of single case studies, as a method for achieving this level of scrutiny.

In order to fully explore the chosen phenomenon, IPA incorporates use of what is termed a purposive and homogenous sample (Roberts, 2013). This approach is commonly used within qualitative research (Vishnevsky & Beanlands, 2004), as it facilitates engagement with those closest to the topic in question, thereby encouraging a richness of relevant experience to emerge (Denscombe, 2010). There is a fine balance required here though as concentrating on too unique a group will reduce the likelihood of findings being transferable to other settings (Pringle et al., 2011) and while this form of qualitative research doesn't seek to claim that the sample is fully representative (Wagstaff & Williams, 2014), its relatedness for others is important. Smith et al. (2009) therefore suggest that participants should be selected because they provide representation of a perspective on the topic under investigation, not because they are representative of a population. This is an important consideration here, as it would be preferable to be able to relate findings in a manner that would have relevance for other clinicians, so transferability of meaning is important. To achieve these aims this study endeavoured to recruit representatives from each of the

triumvirate of groups most closely involved in the clinical component of student mental health nurse education; student mental health nurses, mentors and nursing assistants.

Generalisability is a word often used in relation to the extent to which the findings of a study can be considered universally applicable across other similar instances of a phenomenon (Denscombe, 2010). Also referred to as external validity, this concept is more strongly associated with quantitative research methods (Sanders and Wilkins, 2010). In qualitative research, transferability of meaning replaces generalisability, as the aim is to evidence relevant understanding arising from the study that is meaningful for other similar experiences and settings (Rebar & Gersh, 2015). Smith et al. (2009) are clear in asserting that the aim of IPA studies is to produce interpretation that is contextualised, clear and rich enough to confirm relatedness for the reader in relation to wider settings and circumstances.

4.4.4 Attracting participants

Recruiting participants is considered to require the development and application of a process that facilitates access to relevant subjects, while avoiding introducing unwanted bias in doing this (King & Horrocks, 2010). To disseminate the request for participation to appropriate groups an invitation and information leaflet (Appendix 7), was emailed (appendix 8) to all nursing staff working for one large Health Board in Scotland. This approach was replicated with all three, then current, cohorts of student mental health nurses from one of the two higher education establishments who access that board for clinical placements for their student nurses. The use of the internet in research design is suggested to increase access to users of digital media (Cook, 2011). Email was used for this request as it is a common method through which to contact prospective research subjects (Cleary & Walter, 2011), it is a routinely used communication portal within the Scottish NHS (NHS Dumfries and Galloway, 2016) and is the preferred medium for student contact within the University (UWS, 2016).

Ten people initially responded; four mentors, four students and two nursing assistants. The subsequent use of an approach termed snowball (Thomas, 2009) or significant other

(Denzin, 1970) sampling, wherein other relevant individuals are accessed through their contact with existing participants (Edwards & Talbot, 1994), facilitated sufficient response to enable the inclusion of three representatives from each of the key groups. The combining of purposive and snowball sampling is an effective sampling strategy commonly used within qualitative research (Polit & Beck, 2010).

This process included a mentor replacing an individual who initially agreed to take part and who then stopped responding to communications from the researcher. No reason was given for this abrupt withdrawal and no data had been obtained from this person. Participant dropout is a recognised phenomenon within any research involving human subjects (King & Horrocks, 2010), and in this case occurred despite the best efforts of the researcher to follow the recommendations of Sanders and Wilkins (2010) in developing a working relationship with all involved.

4.4.5 Participant selection

Offredy and Vickers (2010) suggests that participant selection within qualitative research should be based on the prospective informant's ability to contribute to the development of knowledge on the topic specified, while Doody, Slevin and Taggart (2013) considers that the researchers awareness of the value of that likely contribution should guide participant selection.

The objective of IPA framed research is to identify an interpretation of the unique experiences of subjects closest to a phenomenon under investigation, while illuminating the broader context of commonalities and differences across small groups of such individuals (Wagstaff & Williams, 2014). This process enables access to interpretation that is of interest or transferable across wider populations, but is unlikely to produce theories that are generalisable (Pringle et al., 2011).

The sample selection within IPA studies needs therefore to engage with individuals able to provide that relevant scope of experiences around the one topic. Smith et al. (2009) indicate that participants within an IPA framed study should not be chosen because they are representative of a population. Their involvement should be guided by their ability to

answer the research question and to provide comprehensive representation of the topic under investigation. Inclusion criteria for study participants were determined accordingly and are detailed in Tables 1, 2 and 3 below;

Group	Inclusion requirements	Exclusion criteria
Student nurses	• Students on the mental health field programme • On placement during the data collection period • Placed in an area where NAs contributed to the delivery of care • Could complete the 2 stages of information gathering.	• On holiday or in academic settings over the period of data collection • On placement in a team without NAs

Table 1 Inclusion and exclusion criteria- students

Group	Inclusion requirements	Exclusion criteria
Mentors	• Were registered mentors or in training for mentorship • Were currently or recently (Limited at a month to aid recall and this timeframe is referred to whenever the word recent is used in the inclusion and exclusion criteria) working in a clinical area where student mental health nurses were placed and where NAs were routinely involved in care delivery • Were contributing to the students' development • Could contribute to both phases of information gathering.	• Were RNs but not mentors or mentors involved in training for the role. • Had no recent involvement in student learning • Worked in an environment with no NAs.

Table 2 Inclusion and exclusion criteria- mentors

Group	Inclusion requirements	Exclusion criteria
Nursing Assistants	• Currently employed as an NA • Working in a team which currently/ recently had a student mental health nurse on placement • Had recently been involved in supporting student mental health nurses • Could contribute to both phases of information gathering.	• Not working in an area that currently or recently supported student mental health nurses

Table 3 Inclusion and exclusion criteria- nursing assistants

Selection of participants from the pool of volunteers saw acceptance of the first three to respond from each of the staff groups as each met the requirement of frequent involvement within the phenomena under investigation and each was exposed to clinical interaction between NAs and SMHNs.

Selection then was done on the basis of the researchers understanding of the participant's likely contribution to the study and of the recommendations around sample size appropriate for IPA research. As suggested above numbers involved in such studies are small, generally composed of no larger than ten subjects (Smith, 2004). The sample selected then met the recruitment goals defined at the outset of the study planning and provided a range of perspectives that included representation from the required variety of staff groups as well as from a scope of clinical specialisms.

Clinical development for student nurses takes place within a series of placements during which they are embedded within unit teams across a variety of clinical specialisms. Comprising a mandated fifty percent of the overall programme (NMC, 2010) these placements vary in length, with their process and structure determined by the educational establishment responsible for organising them. This flexibility of design though must meet the requirements of a national guidance document (NMC, 2010), and while this guidance is updated regularly (NMC, 2015), the version relevant to these cohorts of students strongly emphasises the sharing of core skills across the various fields of nursing (NES, 2012). In regards clinical placements this has meant inclusion of placement experience out-with the students chosen field, and placement areas routinely providing educational support to students from across learning disability, adult, mental health and to a lesser extent child fields. None of the participants therefore work within an educational process that solely includes placement experience for student mental health nurses.

4.4.6 Representativeness of the sample

While Sanders and Wilkins (2010) suggest that the group investigated within a research study should be representative of a larger population, phenomenology is considered effective in exploring situations wherein pockets of human experience are known not to fit with wider perceptions (Ivey, 2013), as emerged in the earlier study of this subject authored by Hasson et al. (2012). Smith, Flowers and Larkin's (2009) recommendations therefore about the representativeness of the sample introduced above are amplified in that individuals representing a wide scope of relevant viewpoints would help shed light on this, as yet largely unexplored, phenomenon.

Student nurse placements within this programme are organised through a rota designed to facilitate a broad range of clinical experiences for the student. For placement areas this means an irregular and frequently unpredictable allocation of students. Identifying mentors and nursing assistants who would have a student allocated to their area within the study time-frame was therefore difficult. This meant that one of the mentors involved and two of the nursing assistants had no students allocated during the study. To capture their experience of student support the mentor was encouraged to diary their involvement in

supporting another mentor's student and the nursing assistants asked to record their involvement with the most recent students on placement in that area. As a purpose of the diary was to encourage participants to focus on and consider their involvement in student nurse education, this retrospective review would still meet this aim.

Pringle and colleagues (2011) caution on inclusion of too specific a focus when selecting participants within an IPA framed study, recommending a scope of relevant perspectives be used. Within this study research participants were representative of each of the core staff groups involved and provided a diverse cross section of standpoints from within those groups. For the mentors this included a mentor and a mentor in training who were supporting students mentored by others, and a mentor supporting their own student during the study. The use of a team mentoring approach is common and recognised by the relevant regulatory body (NMC, 2010). All qualified nurses are therefore expected to contribute to a students' development, whether qualified mentor or not, however one named mentor must be identified as having overall responsibility (NMC, 2010).

For student mental health nurses' the sample included one participant from each of the stages of the programme as well as from a diverse range of current clinical settings. For nursing assistants this saw representation from child and adolescent treatment teams across to older adult services. The participant group also included a range of ages in those involved and a number of nurses and student nurses who had previously, or who currently also worked as nursing assistants, a common method for augmenting bursary during student nurse training (Hasson et al., 2013a). In addition, the participants coincidentally included one representative from each staff group who were simultaneously working within the same ward area.

4.4.7 Participants and the Community of Practice

With the Community of Practice model underpinning this investigation, in providing a framework through which to understand the process of learning within a socially influenced occupational environment, there is a need to consider how the range of participants included, fit with this concept. Risling and Ferguson (2013) advocate that for a CoP to

develop participants must co-exist within an environment, have a common purpose and share both culture and language. The RCN has clearly identified NAs, student nurses and RNs as the groups combining to form the clinical nursing team (RCN, 2012). There is, therefore, a clear expectation from the largest professional nursing organisation in the UK that each of these groups will contribute to the CoPs that are clinical nursing teams.

The participants in this study provide representation from clinically diverse settings from across the range of available mental health services. Such diversity offers opportunity to investigate experiences from a range of perspectives and from across several CoPs from a variety of settings, including areas of in-patient and community care delivery. This differs markedly from previous studies investigating similar relationships, many of which focused on only one clinical specialism, examples of this being Wakefield (2000) and Melia (1981) investigating surgical care settings and Ranse and Grealish (2007) exploring older adult care placements.

The background of the study subjects is detailed in table 4 below and evidences a relevant scope of participant characteristics, including varied placement backgrounds, a gender mix that is historically representative of nursing as a whole (Whittock & Leonard, 2003) and some identifiable reasons as to why the participant is interested in taking part within this study.

In this study the two nursing assistants who have the grading dispute with their employers have what appear to be strong, if relatively unique, reasons to have their role in student nurse education formally explored. That these individuals are in dispute with their employers is somewhat unusual, however their complaints are based on what these individuals see as the lack of recognition they are receiving for the advanced clinical skills that they are currently employing in practice. As advances in the scope of the NA role and subsequent reconfiguration of the relationship they have with SMHNs is the object of this study, so the involvement of these subjects appears key in uncovering important elements of this change process. Involvement of another NA, fulfilling a more traditional role, will allow context to emerge around their experiences. Engagement with individuals undertaking advanced NA roles and representative of a range of clinical areas suggests

findings are more likely to capture current clinical experience and have relevance, and hence likely transferability, across a range of settings.

Identifier	Age 20-30 30-40 40-50 50-60	Male/ Female	Clinical area	experience	Comments
S1	20-30	F	Older adult day hospital	Year 3 student	Worked previously and currently as an NA
S2	20-30	F	Older adult admission and rehabilitation ward	Year 1 student	No NA experience
S3	30-40	F	Older adult admission and assessment ward	Year 2 student	Worked previously and currently as an NA
N1	50-60	F	Older adult admission and rehabilitation ward	25 years as an NA	
N2	50-60	F	Child and adolescent community services	18 years as a community based NA. 5 years in a similar ward based role.	Has a current grading dispute with employer.
N3	50-60	M	Child and Adolescent Community Service for LD and MH	25 years working in a variety of care settings. Ward based and community.	Has a current grading dispute with employer.
M2	20-30	F	Generic Community Mental Health Team. Under 65 population	5 years in this post. Had a student allocated during the study	Had a student allocated during the study.
M3	40-50	F	Older adult assessment in- patient unit	2 years in this role. 1 year as a mentor. No current student allocated	Previously worked as an NA
M4	40-50	F	Generic admission unit. Under 65	2 years in this role. Awaiting formal commencement on mentor programme.	Previously worked as an NA

Table 4 Participant details.

4.5 Methods of collecting accounts

4.5.1 Diary use

Smith et al. (2009) promote IPA as amenable to a flexible range of methods of collecting people's stories, and in addition to individual interviews with varying levels of flexibility they recommend the use of diaries as a possible alternative or as an adjunct to interview data. Diaries were utilised within this study for several reasons. Considered to have emerged as a method for the quantitative recording of behaviour within employment and home life as early as the seventeenth century (Chenu & Lesnard, 2006), the use of structured diaries is described as offering "the opportunity to investigate social, psychological and physiological processes within everyday situations, (while) simultaneously they recognize the contexts in which these processes unfold" (Bolger, Davis & Rafaeli, 2003, p580). Differentiated from self -driven reflective diary keeping through their solicited nature (Gill & Liamputtong, 2011), in research this approach is considered to allow the collection of aspects of experience that are not available through more traditional data collection methods (Graham, Catania, Duong & Canchola, 2003), as well as offering several other possible advantages to the prospective researcher.

The use of temporal anchoring points, which prompt recording of experience that is detailed in close proximity to the event through the use of a diary, is beneficial as the accuracy of human recall is considered to be subject to a variety of phenomenon likely to distort how the event is remembered (Townsend & Duka, 2002). Graham et al. (2003) suggest that self -report approaches used retrospectively to record human experience are prone to what they term telescoping, a process wherein events occurring out-with the measured timescale are remembered as taking place within it. Cain, Depp and Jeste (2009) advocate that without the structure a diary can provide the more mundane aspects of life are often considered unimportant and are therefore prone to being overlooked, even though these routine experiences might be key to the matter under investigation. van den Brink, Bandell-Hoekstra and Huijer Abu-Saad (2001) suggest that background factors such as age of the respondent, and the presence and severity of either physical and mental health conditions have an influence on the interpretation of events recalled. These three areas of possible

deficit; difficulties in remembering exactly what happened within a specific timeframe, the overlooking of common, though key details, and bias or error in recall related to the respondents' individual characteristics are examples of a number of factors that can all have a significant impact on the accuracy of information collected within a study.

The investigation of the interrelationship between complex phenomena is considered beyond the capability of retrospective data collection methods (Roelofs, Peters, Patijn, Schouten & Vlaeyen, 2006), however a recognised strength of diary use is its ability to explore such situations in depth, allowing meaningful interpretation of the experience as it occurs within its natural environment (Kempke et al., 2013). This frequently leads to the development of insight into the often important role of activities previously taken for granted and hitherto seen as part of the background to daily life. A study by Orban, Edberg and Erlandsson (2012) for example, identified the importance of tea and coffee breaks in the lives of Scandinavian women, an importance neither the researchers nor participants recognised beforehand.

Diary use is considered highly flexible in how it can be applied and works well when combined with other data collection methods (Bedwell, McGowan & Lavender, 2012). It is considered to provide more accurate and detailed information than retrospective methods, and is able to do this and still attract a high completion rate over several months (Graham et al., 2003). It is also amenable for use with groups considered somewhat disorganised or chaotic (Hardy & Gray 2012), therefore applicable for use by practitioners working within busy and unpredictable environments. Prior to use the diary format was trialled to gauge its applicability.

4.5.2 A Feasibility study

Performing a trial run of a planned research method with participants sharing similar characteristics to those within the intended study is likely to identify any significant design flaws, and enable the development of the strategies employed (Edwards & Talbot 1994). In this study a feasibility approach was utilised to test the applicability of the diary of practice experience. This differs from a pilot study in that it only tests the practicality of a study

component, as opposed to trialling the fit of the entire study (LaGasse, 2013). In addition to testing the applicability of the diary, this strategy also allows the researcher to develop familiarity with the process, develop the materials and process planned for use and gauge the time demanded to successfully complete the task. As inadequate planning and underestimated time commitments are considered to be common features of failed research projects (Alak et al., 2014), the use of a trial run seems essential.

With this in mind I tested the planned diary with three level two (year 2 or SCQF level 8), Adult and Mental Health nursing students, one mentor and one nursing assistant. This involved using a scaled down version of the email distribution approach for invitations, intended for the main survey, differing only in that mention of the interview planned for the full study was omitted and the invitations to participate were distributed to a smaller pool of possible respondents. This group was approached because of their relevance to the study and an ease of access to contact them. The initial email invitation however attracted only 1 response and had to be repeated. This was concerning, as even after the second email only four of the 197 students approached replied, and low response rates are associated with uncompleted research studies (McCullagh, Sanon & Cohen, 2014).

Later networking via this group of volunteers saw the number rise to 8, 4 of whom subsequently withdrew, signifying that time and patience would be needed around recruitment within the main study. The response pattern also suggested that final numbers of prospective participants may be higher than the number required, though not all may see the process through. This encouraged deeper consideration of the selection of applicants, as well as thought around sensitively informing applicants who are not required.

The trial was effective in that it highlighted issues around the clarity and influence of verbal instruction during the diary launch, it identified that written instructions needed to be clearer in parts of the student diary and it indicated that regular prompts from the researcher may influence more timeous completion. The use of such reminders is commonly seen when utilising diaries within research (e.g. Graham et al., 2003). Importantly, while overall participant feedback on the process was positive, the feasibility study had generated information that was of interest to the study as a whole (Appendix 9).

With authors such as Sanders and Wilkins (2010) emphasising that the purpose of trial runs in research is for testing the planned process and not in generating understanding of the topic being investigated, there is a danger that information relevant to the overall study may be discarded. This disconnect does not fit with calls for cohesiveness within the design of research studies (King & Horrocks, 2010). Within this trial significant information emerged in relation to different perceptions around who provided actual supervision for the student, and this was used to shape the questions planned for the individual interviews within the main study.

4.5.3 Diaries, reflective and pre-reflective thought.

Diaries are suggested to overcome the inaccuracies inherent in human recall (Standing, 2009), thereby providing a more accurate account than that arising through reflective discussion alone. In this study both approaches were employed. The use of diaries here therefore augments the information arising from the interviews, a form of triangulation posited as enhancing the accuracy and sensitivity of the research (Smith, 1999). Diaries also do this in a way that captures the participant's pre-reflective understanding of the phenomena and the transition to reflective consideration.

In explaining the importance of pre-reflective exploration, Smith et al. (2009) suggest that commencing investigation of a phenomenon before the participant begins to consciously attend to it allows identification of the phenomenon in its natural state. This in turn facilitates review of the process of sense making in the participant as they begin to consider aspects of their life previously taken for granted. Consideration of both pre-reflexive and reflective aspects is therefore considered to provide a more comprehensive analysis (The Stanford Encyclopaedia of Philosophy, 2014).

The diary content was collated and subject to descriptive statistical analysis through the use of the Microsoft Excel Statistics Package, with an example given as appendix 10. This provided basic numerical data on the amount of time each group spent undertaking a variety of clinical and administrative tasks, and identified how long the groups spent with each other, giving some indication of who provided supervision to the students within the

completion of core clinical and caring skills. A section for qualitative comments also provided some insights into the interactions between the groups and provided the foundations for a relationship that supported the subsequent individual interviews.

4.5.4 Interviews

Semi structured interviews are the most frequently employed method of collecting stories within IPA research (Palmer et al., 2010). The term semi structured means that while an outline of questions are planned for each interview (Doody & Noonan, 2005), the approach also allows a flexibility that enables the participant to move the conversation in whichever direction they feel most relevant (Sanders & Wilkins, 2010). There is also scope within this approach for the researcher to incorporate the iterative approach associated with IPA, through modification of the interview schedule in response to the data that is emerging (Wagstaff & Williams, 2014). These factors shaped the interview process employed within this study, wherein semi structured interviews were employed incorporating a flexible list of questions, the order and scope of which were developed as the series of interviews progressed.

While the use of semi structured interviews fits the purpose of this study, there have been some concerns raised that authors rarely identify the origin of questions they use within such interviews, thereby missing an opportunity to show they emerge independently of the researchers own perspective (Brocki & Wearden, 2006). The questions used in this study were initially drawn from the literature search, though the order they were asked in altered as the series of interviews progressed and they were also individualised in response to the participants' diary content. The list of questions asked also evolved in response to the researcher's subsequent reflection on each interview.

The process used when carrying out the interview is considered key in shaping the quality of the information retrieved from the participant, with Opdenakker (2006) suggesting that a planned interview protocol be used to mediate the effects of social cues introduced by the researcher, and the possible bias such cues could introduce. Such a protocol should include consideration of factors such as the interviewers listening skills, the question styles

employed, the use of silence and even the clothing worn by the interviewer, as the engagement skills of the interviewer has a significant influence on such responses (University of Leicester, n.d.). Within this study an informal approach was used and all interviews were carried out at the participant's clinical workplaces, all having selected this, having been offered a choice of possible locations beforehand. The interviews lasted between 20 and 45 minutes, fitting within the optimal timeframes suggested by Mathers, Fox and Hunn (2002).

Edwards and Talbot (1994) recommend that study participants should receive some incentive or reward for taking part, and while Nelson, Onwuegbuzie, Wines and Frels (2013) recognise the opportunity for therapeutic benefit for participants offered through being able to offload distressing emotions within an interview setting, this study stopped short of using the Family Therapy techniques they suggest facilitate this. These authors do however provide a useful list of strategies that they feel deliver a rewarding experience for the interviewer and interviewee, and their recommendations were used to guide the process in this study. These strategies include mirroring the language of the participant, empathising with the participant's experience, working to develop a rapport with the participant, being flexible about the interview time, location and content, reflecting on the process of the interview, summarising the content and ending the interview appropriately. The interviews generated over 20,000 words of relevant data for analysis.

4.6 Analysis

4.6.1 The process of analysis

Described variously as either a four (Mathias, Parry- Jones & Huws, 2014), six (Smith et al., 2009) or seven (Palmer, Larkin, de Vries & Fadden, 2010) stage process, the format guiding analysis within IPA studies is considered to allow a degree of flexibility as long as the focus remains ideographic, and the analysis multi- level and of good quality (Smith, 2004).

4.6.2 Transcribing Interviews

Richards (2015) suggests that the transcription process should be thoroughly planned beforehand including consideration of the format to be used, how the materials would be stored and significantly, who would complete the process. For this study the interviews were recorded using the "Recorder" app for iPad and digitally stored using Apple's iCloud secure storage system. As Sanders and Wilkins (2010) identify the opportunity the transcription process offers for the researcher to further their understanding of the interview content if involved, so this method was employed within this study.

While it is obviously important to transcribe the interview accurately, the depth of detail of the recording is dependent upon the form of analysis planned (King & Horrocks, 2010). Within IPA research it is less relevant to record the length of pauses and the presence of non- linguistic utterances, as the focus is on the content of the conversation (Smith et al., 2009). The written recording therefore included all of the verbal communication between both parties, recorded verbatim though did also incorporate notification of pauses and non-linguistic verbal utterances where they signified emphasis (see appendix 11 for an example of the transcribed interviews). Writing out the communication in such depth encouraged considerable familiarisation with its content and provided an initial immersion in the data.

4.6.3 Analysing the text

Commencing with a line by line consideration of what in IPA is often transcribed interview data, the process began with the researcher immersing themselves within participant's stories through reading and re-reading them (Smith et al., 2009). Cohesion of interpretation with the original meaning was strengthened at this time by simultaneous replaying of the session recordings. Developing familiarity with the transcribed data in this manner is suggested to allow content to be considered within the context of the wider discussion, thereby reducing the risk of compartmentalisation and resultant misrepresentation (King & Horrocks, 2010). The researcher's involvement within the interview process is also considered to facilitate this understanding of context (Roberts, 2013).

The next step involves initial note making (Smith, 1999), and incorporates adding comments around what is considered as the descriptive, linguistic and conceptual facets of the story (Smith et al., 2009). Further stages follow moving from a descriptive appraisal of the content of the transcripts, through to interpretative contemplation incorporating sense making by the researcher, utilising recognised theories to explain the themes emerging (Orri et al., 2014). This involves gradually introducing the sense making of the researcher in relation to the concepts found (Palmer et al., 2010), meaning a multi layered analysis of the individual's account is accomplished. This was achieved through collating the meaningful comments individually for each of the participants (see appendix 12), with this process allowing clear focus on what the participant said, while repetitive simultaneous re-reviewing ensured adherence to the original meaning of the comments.

This detailed consideration of the text allows identification of prominent (Fade, 2004) and repetitive (Ritchie, Weldon, MacPherson & Laithwaite, 2010) content, thereby informing the development of themes. The themes emerging from each transcript are identified and recorded in turn (appendix 13), and are shown to arise from the participant's perspective and not from external theory, emphasising the ideographic and interpretative focus of IPA (Smith, 1999). Following subsequent analysis at various levels of abstraction, what are termed subordinate themes (Mathias, Parry-Jones & Huws, 2014) are determined for each participant, which are then further reviewed across the group of subjects, finally arriving at shared main, or superordinate (Palmer et al., 2010), themes. While Smith et al. (2009) encourage identification of themes at individual and overall level across all participants, this study lends to clarification of themes at an intermediate level, allowing comparison across and between the members of each of the staff groups involved. This process then facilitates comparison of similarities and differences between participants as a group, as well as identifying the main points emerging from the individuals themselves, and the inductive nature of the process of theme development is demonstrated within appendix 14.

4.7 Validity and rigour

4.7.1 Assuring quality in qualitative research

Bryman (2012) identifies reliability, replication and validity as the most prominent measures through which to gauge the worth of a research study. While Berg (2009, P. 8) describes the application of some qualitative methodologies as "uncontrollable", he does identify that rigour is achievable within qualitative approaches. With the rigour or merit of a qualitative research study suggested to be identifiable by the extent to which the process illuminates the phenomenon under investigation (Vishnevsky & Beanlands, 2004), there is recognition that the parameters outlined by Bryman above relate to more positivist research designs, and that qualitative approaches are amenable to other forms of quality assurance (Maxwell, 2002).

In a review of approaches to validation of qualitative methodologies, Creswell (2013) highlights several structured methods available, including the four category framework formulated by Lincoln and Guba. This approach categorises requirements under the headings of credibility, transferability, dependability and confirmability. Together these elements are suggested to comprise the trustworthiness of the research (Bryman, 2012). Smith et al. (2009) encourage the use of a similar strategy in the appraisal of IPA research, recommending the approach developed by Yardley (2000). This framework will therefore guide consideration of the merits of the proposed study.

Shinebourne (2011) advocates that IPA meets the first of Yardley's criteria, sensitivity to context, through justifying selection of the methodology as the most relevant for exploring the phenomenon under investigation. The link between IPA and the study purpose has been clearly defined above, and the methods of sample selection, data collection and analysis have all emerged directly from this. It has therefore been strongly argued that the methods and methodology used are the most appropriate for the investigation of the phenomenon under scrutiny here.

The second criterion against which to gauge the quality of a study is rigour and commitment. Smith et al. (2009) advocate that IPA meets the former of these through diligent adherence to the model, and the latter via the attention paid to the participants within the process. An example of this is in the strategy utilised for gauging the accuracy of the interpretation of themes arising from individual testimonies. Mathias et al. (2014) advocate the involvement of research colleagues in cross checking the themes elicited from participant interviews. The goal of IPA is however identification and exploration of the beliefs of the individual participants, which can then be compared with those of the other subjects involved (Pringle et al., 2011). It was felt more appropriate therefore to ask the participants themselves to check and comment upon the accuracy of the sense made of their comments. Described as member checking, this is an approach advocated for use in qualitative research by Stanley and Nayar (2014), and in this study involved the participants being invited to review both the interview transcripts and the themes and justification for the themes identified by the researcher. None of the participants contradicted the emergent themes presented to them and indeed one of the students advised that they had shared theirs with peers, who had confirmed a similar understanding of the issues discussed. It is considered that this research adhered closely to the recommendations defined by Smith (2004) for the application of an IPA focused study and consequently met the requirements for rigour and commitment.

The penultimate criterion is transparency and coherence. Transparency is enacted via clear description of the process followed thus enabling exposing it for comprehensive scrutiny (Shinebourne, 2011). Denscombe (2010) refers to this as an audit trail and as well as detailing the research stages here the project has also been presented at national (Scottish and UK) subject specialist conferences. The use of such forums is considered to facilitate the critical review of emerging ideas (Cumbie, Weinert, Luparell, Conley & Smith, 2005). This allowed the research questions, methodology and findings to be considered by subject experts, including representatives from the Nursing and Midwifery Council. It is also planned that the study will be the subject of at least one article submitted to a peer reviewed professional journal. This would open the paper to examination by a wide range of subject specialists (Sanders & Wilkins, 2010). Coherence is the fit of the methodology with the research purpose (Smith et al., 2009) and this has been strongly argued above.

Publication and dissemination also meets the last of Yardley's requirements, impact and importance. Publication allows external scrutiny through wide dissemination of the findings and the presentation of the research through subject specialist forums such as conferences and related journals encourages maximum impact within the field itself. Highlighting the concepts involved to nurses, nurse educators, nurse regulators and nurse managers seems the most effective way to influence recognition of the current deficiencies in student mental health nurse education and subsequent accommodation of change. Smith et al. (2009) highlight the need for the study to be relevant in order to achieve importance. The importance of this study has been detailed above in relation to UK health care delivery. It has been argued that this is a pivotal time in the delivery of nurse education and for the role of nursing and the relevance of the involvement of NAs in student nurse education is emphasised throughout.

4.8 The researcher role

4.8.1 Positionality/ Reflexivity

Within interpretivist research there is recognition of the central role of the researcher in making sense of the data they are reviewing. Thomas (2009) suggests that positionality incorporates this meaningfully into qualitative studies by fore fronting the researcher's stance from the outset. Cresswell (2013) refers to this process as reflexivity and suggests a two stage method for this involving the researcher firstly explaining their previous experience in relation to the study topic, and then discussing how that shapes their understanding of it. Bryman (2012) adds another useful dimension to this, pointing out that such introspection needs to include review of the methodology employed as well. The paragraph below, written before the study commenced, provides such an exploration.

Having had twenty years' experience of working as a qualified mental health nurse and ten years in a nurse educator role, I have had significant involvement in the development of student mental health nurses and was at one time such a student myself. Having worked clinically in both ward and community settings I have mentored students within a variety of

placement areas, and supported others in contributing to student nurse development across a range of clinical specialisms. This experience has highlighted to me the importance of the nursing assistant role in student mental health nurse development, particularly within in- patient settings, where my own experience, and that of others, suggests they have a pivotal role in both the acceptance of the student within the ward team, and in the development of the student's skills. My understanding is that nursing assistants' interaction with student nurses ranges from open hostility and obvious rejection of any student support role, through to providing some of the most motivated, compassionate and skilled role modelling across a wide range of clinical skills and behaviours. These motivated nursing assistants often taking a lead role in organising the student's placement experience. There appears to me to be a reluctance from relevant regulators and educators to recognise or accept the strength of this influence, which I feel is a missed opportunity, as supporting this ongoing learning relationship is likely to enhance its effectiveness. My view is that the truth of this relationship will therefore be found through the experiences of those involved, and not through examination of policy guidance. A qualitative methodology therefore appears likely to be most effective.

By completing the statement above, I feel that I have clearly set out my own views for examination by others. Through producing it I have become more aware of how my experiences influence my current interactions and therefore more aware of how I will influence this study. Reflection in this manner is a long recognised mechanism through which to enhance (in this case research) practitioner insight. Pirsig (1974; page 156) explains this well "You look at where you're going and where you are and it never makes sense. But then you look back at where you've been and a pattern seems to emerge".

4.9 Ethical considerations

4.9.1 Potential Risks

A recent synthesis of research articles (Montalvo & Larson, 2014) suggested a lack of researcher understanding of the risks the application of their projects posed to participants, and to the veracity of their findings. Rid and Wendler (2011) identify possible

consequences for research participants ranging from the development of anxiety, through job loss and even including death. While this study is not perceived to incorporate such levels of risk, there are several areas within which difficulties may arise that could pose some threat to participants and reduce the accuracy of the information obtained. It is worth therefore considering how such risk is managed and how adherence to ethical principles ensures that any potential risk is minimised.

4.9.2 Possible risks within this study

Klatt, White and Gard (2003) express significant concern that research participants are frequently unfamiliar with the language and processes used within research studies, and they suggest that researchers should consider such possible deficits pre-study, and their effects should be mediated within the study itself. For participants in this study the diary structure could be overly complex, guidance around completion vague and its format may not elicit responses to the questions I want answered. The participants' responses may reflect what they see as acceptable in relation to their understanding of my role, or they may respond in tandem with colleagues giving a group influenced response, and not the individual views sought. They may also be reluctant to be fully frank when interviewed individually. The steps outlined below should help in order to overcome these possible difficulties. There are no foreseen long term individual consequences for participants, and in fact the research findings would hopefully influence policy change around the recognition of NA contribution towards the clinical development of student mental health nurses, and thereby enhance that experience for the individuals involved.

4.9.3 Ethical considerations

The requirement for consideration of, and adherence to ethical principles, is strongly linked to the process of social research (King & Horrocks, 2010), and the moral parameters for such a study are generally defined by the application of common ethical principles (Edwards & Talbot, 1994), and via the requirement to meet professional standards (Hek & Moule, 2006).

Denscombe (2010) identifies four major principles considered to guide ethical practice, suggesting that research studies should be conducted in a manner that:

- Complies with the law of the land
- Protects the interests of the participants
- Ensures that participation is voluntary and based on informed consent
- Avoids deception and operates with scientific integrity.

These four underpinning principles will be used to detail the ethical considerations incorporated within this project;

4.9.4 Complies with the law of the land

The Research Ethics Guidebook (TREG) (n.d.) explains that unlike for research on animals there are no specific laws governing research on human subjects within the UK, only related legislation on matters such as human rights, confidentiality and consent. This emphasises reliance upon organisations involved in such research to maintain ethical standards. Because of the setting within which this investigation took place and the occupations of the groups involved, this study was required to adhere to four different published ethical policy protocols and to successfully navigate three separate ethical approval processes. This suggests a robust and detailed scrutiny of the research project and a sound ethical underpinning throughout the study.

Nurses are at all times expected to meet the ethical standards detailed within their professional code of conduct (NMC, 2015), while involvement of NHS staff and premises necessitated adherence to that organisations ethical code (NHS Research Scotland, 2012) and review and approval from their ethical governance committees. The involvement of UWS students within a study sponsored by the University of Strathclyde (UoS) meant adherence to the ethical approval processes of each of these organisations (UWS, 2015c; UoS, 2015), as well as application for ethical approval from each. Approval for this study was subsequently granted by all three organisations (appendix 15).

The scrutiny process for each of these organisations included review of the quality of consideration of ethical concerns within the study (Appendix 16). These features are

summarised by TREG (n.d.) and include security and ownership of data, informed consent, anonymity, and privacy, appropriateness of methodology and participant selection and confidentiality. These professional and organisational requirements are designed to confirm that ethical considerations for the study exceed the minimum legal requirements, while ensuring the safety of participants and researchers and thereby protecting the organisations reputation.

This study has gone beyond meeting minimum legal standards for the protection of those taking part. This was achieved by following the ethical principles presented by UWS (2015c) as necessities underpinning any intended research; these being autonomy, beneficence, non-maleficence and justice. In doing this, any probability of harm befalling participants is avoided through respecting their rights and dignity, by completing the study with integrity and honesty as well as by meeting legal requirements (UoS, 2015). To achieve this required ensuring privacy and confidentiality for participants, avoiding deception or misconception, providing honest and accurate analyses and reporting of results and through attainment of informed consent (Denscombe, 2010).

4.9.5 Participation is voluntary and based on informed consent

Informed consent is said to entail the participant agreeing to undertake the research having full comprehension of the methods, purpose, confidentiality and risks associated with the project (Bulmer, 2001). Potential participants for this study were informed of the purpose and outline of the study with no defined timeframe set within which they needed to respond. This open timeframe allowing space for those approached to fully consider the consequences of their involvement (Gerrish & Lacey, 2010).

Invitations to participate were emailed to all nursing staff working within mental health settings in one Scottish Health Board and to all student mental health nurses studying on one campus of a Scottish University that accessed that health board for clinical placements. Attached to each email was the participant information sheet that detailed the main points of the study (Appendix 6). For potential participants seeking further information a paper copy of the information sheet was then provided to each respondent during an initial

meeting with the researcher. This is a strategy recommended by Denscombe (2007). During this meeting the study requirements were also explained verbally. This provided an opportunity for clarification of any uncertainties the participants had prior to commencement, while ongoing communication with the researcher replicated this for each subsequent stage of the study.

It is important to recognise the right for participants to change their mind (Koubel, 2013) and to adjust and indeed remove themselves from the study if requested. This was addressed within the participant information sheet and during the initial meeting with the researcher. Within both formats they were advised that they could withdraw their involvement at any time, and remove their input right up until commencement of completing the final writing up. Communications then continued with the participants up until the latter stages of the final write up, outlining the progress of the study and seeking their feedback on the progress to date. These measures conform to recommendations made by Suhonen, Stolt and Leino-Kilpi (2013), for achieving fully informed consent with research participants.

4.9.6 Protects the interests of the participants

The confidentiality inbuilt within the study process has obvious implications for the participants and King and Horrocks (2010) advocate that protection of confidentiality is a basic ethical principle. Restricted access to completed documentation and anonymity inbuilt within each component of the study ensures confidentiality for participants. Pseudonyms were used throughout the data collection, analysis and reporting stages, a strategy recommended by Gerrish and Lacey (2010). In addition, all identifying material including completed consent forms were stored securely with a promise that they would be destroyed when the study is completed. Consideration of the security of information is considered a priority for the nursing profession (Boagy, Maier & Glasper, 2013) and Richards (2015) encourages the researcher to be strongly familiar with the software used whenever data is stored electronically. For this study the commonly used Microsoft word programme provided secure, password encrypted, programme storage within a password protected personal computer.

There are concerns that the relationship the researcher has with the participants is rarely fully considered and may in some cases be detrimental to the participant and to the veracity of the study (Carpenter, 2013). Little (1999) identifies a power imbalance inherent within some research studies, fuelled through the participants' exposure to unfamiliar language and practices within the research process, and via the researchers' often elevated position within a relevant organisation. Within this study the only respondents who had previous and likely subsequent contact with the researcher were the students, who may have been concerned at the involvement of the lead researcher due to my role in lecturing and assessing on their programme. Neither the mentors nor the nursing assistants work in clinical areas related to my current academic liaison role, or to my previous nursing career. In addition, my input to the student's pre-registration programme is small, as I am currently employed mainly to teach postgraduate students hence contact with all participants out-with the study is minimal.

Mindful of the anxiety provoking nature of new experiences such as involvement in research, led to the use of reflexivity to increase my awareness of possible influence on participants' responses, a strategy recommended by King and Horrocks (2010). Reflexivity being consideration of the fusion between the environment and the researchers' interaction (Timmins, 2015). This caution made me more aware of instances where I might influence the participant's response, particularly within the interviews. As a result, I was conscious of avoiding introducing such bias, leading to shifts in how I asked the questions and a focus on developing an informal rapport with those involved.

While the participants within this study are capable of making decisions about their own involvement there is a need to ensure protection of vulnerable individuals and groups who are not so capable (Johnson & Long, 2010), and in this case the patients for whom these nurses cared for would not be in a position to grant consent. As a result, diaries and questions for the semi structured interviews were designed to relate to the clinical development of students and to the role of other staff groups in this, specifically focusing away from consideration and discussion of any individual client, or of their care. The diary in fact contains direction around avoiding the inclusion of client details, imprinted on each page.

As this study is partially set within a healthcare environment particular attention must be paid to any possible actions that may be detrimental to care delivery. The use of diaries will assist this as the other major prospective data recording approach available, observation, is likely to influence a change in the behaviour of those being observed (Denscombe, 2010). Use of observation therefore could result in substandard care delivery or alternatively an over inflated impression of the care normally delivered. Adherence to ethical guidance will also minimise any potential risks.

4.9.7 Avoids deception and operates with scientific integrity

To ensure that the study process clearly met expectations for transparency and methodological integrity required being open and honest with participants from the outset as evidenced within the participants' information leaflet and through utilising a robust approach to research. This entailed using recognised and relevant research methodology and utilising methods of analysis in an accurate and comprehensive manner, thereby recognising the importance of all study findings, not just those conforming to the researcher's preconceptions. This was strengthened through the inclusion of participants within reviews of the data analysis process. Described as member checking, the involvement of study participants in confirming the accuracy of interpretations of their contributions is considered to be a widely used strategy in the pursuit of rigour within qualitative research studies (Stanley & Nayar, 2014). The additional involvement of research supervisors and programme assessors added a layer of scrutiny to ensure this happened, and as recommended by Nieswiadomy (2008) the study will be summarised and sent to peer reviewed scientific journals for consideration for publication.

4.10 Diary Results

4.10.1 Background

It is important to situate the experiences of the participants within the work that they do, and in order to capture a sense of this across the wide variety of clinical environments that

they spend their time in each participant completed a diary over a working week that detailed their activity and interactions. The diary recorded half hourly summaries of their working experience and was designed to identify the facets of their work most closely linked to the purpose of this study; where they spent their time, the tasks they were engaged in and their understanding of the support that was being given to student nurses at the time. The collated results, which were fed back prior to their interviews (appendix 4), help identify the determinants influencing the sense making of participants that emerges in the qualitative results generated by the analysis of the individual interviews that is presented within the next chapter. The diaries are summarised below, ordered by staff grouping, and in addition to the tabled results, comments are included explaining the more significant findings. The data below represents only part of the information collected as it concerns only the specific facets that related directly to the discussion around the themes that emerged via the individual interviews. The full range of data obtained is presented within appendix 6.

The inclusion of the tables below is important for the study as they provide information on aspects of student education that have not previously been investigated within the mental health setting. This prior lack of understanding creates a vacuum in relation to our ability to fully realise the context within which the participants have developed their beliefs, opinions and values around the topics under investigation here. As authors such as Hasson et al. (2012) have done previously, there is a need to forefront the realities of the working relationship between each of the groups involved. The use of diaries here allows comparison of similar or even the same phenomena, from a number of perspectives, and in turn illuminates any inconsistencies or contradictions that may arise within the subsequent interview findings.

4.10.2 Student mental health nurse diary content (by 30 minute segments over 1 working week)

Table 5. Who the student was working with

Who the student was working with	Student sessions/ (%) S1- total= 80	S2- total= 73 sessions	S3- total= 100 sessions
No answer	9 (11%)	4 (5%)	2 (2%)
Registered nurse	20 (25%)	14 (19%)	25 (25%)
NA	18 (23%)	15 (21%)	67 (67%)
Other professional	5 (6%)	17 (23%)	4 (4%)
No one	23 (29%)	7 (10%)	2 (2%)
other	5 (6%)	16 (22%)	0 (0%)

The location within which the students' placement occurs is strongly influential on the relationship between the NA and the student, as is the stage of their training and their own personal preferences. With all of the students working with the same client group S1 and S3 spent the same percentage of their time working with registered nurses, however the time spent with NAs was markedly different, with S3 (a stage 2 student) working alongside this group for over two thirds of the time covered, while this occurred for only a quarter of the time the more senior S1 recorded. S2 (a stage 1 student) showed a more even spread in working with people from a variety of backgrounds despite working in the same clinical specialism as S3. As this was in a different hospital and ward from S3 it appears that factors other than specialism shape this phenomenon. A study by Gillespie (2013) found that while a group of student nurses in Scotland identified undertaking tasks they saw as NA related, as the most concerning issue for them during the first week of their programme, such concern was not unanimously held. That individuals vary between acceptance and avoidance of association with the NA role, from the very commencement of their programme, suggests variance in student engagement with NAs is likely, and at least partially shaped by individual student preference.

Table 6. Who supervised the student

Who the student was supervised by	Student sessions/ (%) S1- total= 80	S2- total= 73 sessions	S3- total= 100 sessions
None identified	9 (11%)	5 (7%)	4 (4%)
Nurse direct	20 (25%)	32 (44%)	22 (22%)
Nurse indirect	20 (25%)	12 (16%)	3 (3%)
No one	5 (6%)	5 (7%)	0 (0%)
NA	20 (25%)	18 (25%)	66 (66%)
Other professionals	3 (4%)	2 (3%)	6 (6%)
Activities when NA was main supervisor (in descending order); **S1**= Diet and fluids, Patient escort, Patient activity (Quiz/ dominos), Personal Hygiene. **S2**= Patient activity (talking to and calming patients), Diet and fluids, Personal hygiene. **S3**=Diet and fluids, personal hygiene, Patient activities (Quiz, painting, relaxing with patients, General tidying			

Table 6 above confirms a substantial percentage of time recognised by students wherein their practice is supervised by NAs. In the case of S3 this covered two thirds of the timeframe investigated and for the other students a quarter of their placement time. For one of these students (S3) the duration over which they believe they are supervised by NAs exceeds the maximum determined by the NMC during which non-mentors are able to take responsibility for guiding student learning (NMC, 2010). These students therefore consider NAs as significant contributors towards their clinical learning.

There was also a clear connection between NA supervision and the delivery of direct care, including the application of essential care tasks, especially the meeting of nutrition, hydration and hygiene needs. Several other authors (for example Gillespie, 2013: Grealish & Henderson, 2016) have commented on the connection between the NA role and the completion of these skills, and the lack of relevance in learning these skills seen by some student nurses. These diaries have additionally shown that NAs are the main guides for student mental health nurses during the application of a wider range of tasks requiring skills

in group-work, de-escalation, communication and socialisation. This would suggest that student nurses recognise NA involvement in guiding student nurse learning in a far more significant scope of competencies than previously identified.

4.10.3 NA diary content (by 30 minute segments over 1 working week)

Table 7 Activity the NA was involved in

Activity involved in	NA sessions/ (%) N1- total= 73	N2- total= 8 sessions	N3- total= 15 sessions
Care planning	7 (10%)	3 (38%)	3 (20%)
Meetings with other professionals	0 (0%)	0 (0%)	0 (0%)
Diet and fluids	13 (18%)	0 (0%)	0 (0%)
Hygiene	7 (10%)	0 (0%)	0 (0%)
Medicines	0 (0%)	0 (0%)	0 (0%)
Other interventions*	29 (40%)	4 (50%)	8 (53%)
Student administration	0 (0%)	1 (13%)	4 (27%)
Other	0 (0%)	0 (0%)	0 (0%)
Other activities	16 (22%)	0 (0%)	0 (0%)
*Other interventions include; N1- Crosswords, word searches, bingo, art groups and talking with patients. N2- use of counselling/ CBT, School assessment. N3- Use of communication activities, IT development, school assessment, using visual aids.			

Table 7 emphasises the rapid expansion of the responsibilities available to those working within the NA grade job role, or at least opens up recognition of the wide scope of that role as it currently stands. Being responsible for personal hygiene is no longer the main purpose of that group and the specialism influenced outline of the NA role can be seen in the results presented. Because of their relatively unique role N2 and N3 had no responsibility at all for assisting clients with hygiene or nutritional needs while N1 spent a fifth of their week engaged in such tasks. The interventions NAs were involved in were diverse and often appeared to require complex skills while attracting a significant level of responsibility. Fitting with the ethos of task shifting, wherein care is provided to a wider pool of patients

through up-skilling lower grade staff (McPake & Mensah, 2008), the range of skills required in order to complete the tasks the NAs were carrying out, are considerable.

Involvement in assessment, communication with highly disturbed individuals, providing counselling, applying cognitive behavioural techniques, organising social activities and educating clients, carers and other professionals in the use of visual communication aids adds to the already recognised association NAs have with key patient facing responsibilities. This could provide confirmation of a burgeoning role for this group, though as N2 and N3 report involvement in these activities over a number of years, there is a possibility that the role hasn't changed that much for some, but the recognition of their contribution has.

Table 8 Who NAs considered were supervising students

Time NA spent as the students main guide	NA sessions/ (%) N1- total= 73	N2- total= 8 sessions	N3- total= 17 sessions
Direct guide	25 (34%)	6 (75%)	13 (76%)
Not direct guide	30 (41%)	2 (25%)	2 (12%)
No answer	18 (25%)	0 (0%)	2 (12%)
Activities when NA was main supervisor (in descending order); N1- Patient activities (Crossword/ quiz/ talking to patients), Diet and fluids, Personal Hygiene. N2- Communication (writing case files/ reporting back to team), Education (teaching staff, teaching relatives). N3- Patient activities (assessment/ carer contact/ teaching student communication interventions), Student induction, Communication (feedback to own team, feedback in wider review).			

Table 8 suggests that NAs saw themselves as being the main student guide over a period ranging from 34 to 76% of the time recorded. The main activities they engaged in at the time included recreational pursuits with patients, clinical skills including patient assessment, family educational programmes and support, as well as the delivery of essential care skills within in-patient settings. In addition then to identification of involvement in, and responsibility for, a wide range of skilled tasks, the NAs here recognise that during the times where they have a student allocated to work with them, they are carrying out a broad range of therapeutic tasks; tasks which require a significant level of competency and which are

highly relevant to the students' development. The lack of recognition of this in the current NMC (2010) guidance around student nurse education, is therefore concerning.

4.10.4 Mentors diary content (by 30 minute segments over 1 working week)

Table 9. Activity the mentor was involved in

Activity mentor was involved in	Mentor sessions/ (%) M2- total= 80	M3- total= 76 sessions	M4- total= 78 sessions
Care planning	14 (18%)	26 (34%)	13 (17%)
Meetings with other professionals	9 (11%)	2 (3%)	15 (19%)
Diet and fluids	0 (0%)	7 (9%)	1 (1%)
Hygiene	0 (0%)	4 (5%)	0 (0%)
Medicines	3 (4%)	8 (11%)	13 (17%)
Other interventions*	27 (34%)	13 (17%)	12 (15%)
Student administration	7 (11%)	0 (0%)	0 (0%)
No answer/ other admin	16 (20%)	16 (21%)	13 (17%)
*Other interventions include; M1- Various therapeutic interventions- e.g. counselling, CBT approaches. Also client assessment. M4- Security checks and financial checks M3- Assessment and client interaction.			

Table 9 identifies that Mentors recorded a work pattern that was almost diametrically opposite the NAs. Within this little mentor time was spent carrying out hygiene and nutrition tasks, between zero and ten percent only, whilst around half of each mentor's time was taken up in administrative responsibilities. Direct client contact involved activities related to the clinical area and client group served; for example, assessment focused within assessment wards and security focused within the forensic setting. These findings echo the thoughts of Stokes and Warden (2004) who argue for the use of NAs in filling the void in patient care resulting from the movement of RNs into the delivery of what they term "technical care".

Table 10. Time mentors spent with students

Time spent with own student	Mentor sessions/ (%) M2- total= 80	M3- total= 76 sessions	M4- total= 78 sessions
With own student	54 (68%)	0 (0%)	0 (0%)
Not with own student	10 (13%)	76 (100%)	78 (100%)
No answer	16 (20%)	0 (0%)	0 (0%)

Only one mentor (M2) had their own student allocated within the timeframe of the study, the others provide feedback from the team mentoring perspective. It is interesting to note in table 7 the difference between the almost 70% of time M2 identified as spending with their student to the far lower figures recognised by the students over the same timeframe. That each human interprets their experiences uniquely, through a lens clouded by their earlier experience, current mental state and individuality (Simmons & Griffiths, 2014) suggests that full consensus is unlikely to be achieved around such a fluid phenomenon.

Table 11. The time mentors provided direct support to students

Time spent providing direct support to the student	Mentor sessions/ (%) M2- total= 80	M3- total= 76 sessions	M4- total= 78 sessions
Providing direct support	23 (29%)	41 (54%)	51 (65%)
Not providing direct support	39 (49%)	19 (25%)	16 (21%)
No Answer	18 (23%)	16 (21%)	11 (14%)

Mentors see mentors as spending large volumes of time directly supporting students, between a third and two thirds of that available according to M2 and M4. The high figures given however identifying the volume of time within which students are not supervised by mentors is notable as the influence of role models in the development of student nurse practice is well recognised (Felstead & Springett, 2015). For students to be guided through their development by non- mentors over large swathes of their programme would support the notion that other groups, including NAs, are contributing significantly to student mental health nurse education.

Mentors recognise that between 10 and 20% of the student's direct supervision is allocated to NAs, and within that the NAs are showing students how to complete tasks as diverse as security checks, personal hygiene and graded exposure.

4.10.5 Summary of diary content

It is apparent that student mental health nurses, mentors and NAs operate in an environment wherein tensions exist for the students in relation to attainment of a professional nursing identity. Mentors believe that they are largely responsible for the professional socialisation and clinical development of the students', however both the students and NAs' describe a far more extensive contribution from NAs' within this process. The expanding role of the NA, identified here, further complicates this as previous studies have identified a common, though not unanimous, reluctance from students to engage in work that they see falling within the realm of responsibility associated with NAs'.

Chapter 5 Findings

Chapter Overview

This chapter provides interpretative analysis of the participant narratives generated through the individual interviews that formed the core of the research study. Presenting the themes identified at individual, staff grouping and overarching levels enables understanding of themes that are commonly held and those that are individual or specific to one or more groups. The analysis identified three superordinate themes associated with expectations round NA involvement in student education and the esprit de corps supporting that involvement. It was also apparent that this involvement changed as the student progressed through their programme. These themes are considered in relation to the expanding role of the NA and explanation sought in terms of social constructivist learning theories as well as established sociological concepts.

5.1 Results

5.1.1 Superordinate themes

Three superordinate themes were identified and it is interesting to note the overall pattern of responses across each of the participants and between each of the work roles as the two groups who are presently, or who have previously, undergone student nurse training (the students and the RNs), both recognised the complexity of influences that shape student nurse learning and a developing sense of control associated with the programme. Similarly, the two groups who form the permanent nursing component of the clinical teams, the NAs and RNs, both identified a sense of teamwork as driving their expectations around work roles. This sense of duty considered a reason for NAs to contribute to student nurse education. All of the work groupings agreed on the final of the themes; that NAs were

expected to contribute to student nurse development during clinical placements. The findings are detailed below.

Table 12 Participant agreement on overall theme

Theme	S1	S2	S3	M2	M3	M4	N1	N2	N3
Obligation drives involvement **The concept of team connects and motivates each of the groups involved in delivering nursing care**	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes
Presumed participation **NAs contribute crucial and assumed skills and support to student nurse development**	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Progressive mastery **Students learn to manage the complexity of influences on their clinical development**	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No

5.2 Identifying the meaning of the themes

5.2.1 Obligation drives involvement-The concept of team connects and motivates each of the groups involved in delivering nursing care

The perception of being part of a team was considered significant by the participants belonging to the staff groups who were permanent members of the clinical team; the mentors and nursing assistants. This sense of belonging provided motivation for nurses and nursing assistants, who saw differences between their roles, but considered these differences as offering a more comprehensive and cohesive skill set, that when combined enhanced the care offered by the clinical team. This team ethos also justified working beyond traditional boundaries, and for NAs even included undertaking tasks normally perceived as falling within the remit of nurses.

Table 13 Obligation drives involvement- The concept of team connects and motivates each of the groups involved in delivering nursing care.

Super ordinate theme	Group theme	Group	Emergent theme	Participant
Obligation drives involvement **The concept of team connects and motivates each of the groups involved in delivering nursing care**	M Working together, as a team	M	There is a difference between the roles	M2
			The roles differ though crossover is important	M3
			Working together for student development	M4
	N Being part of a team drives NA input within student education	N	Feeling NAs have a role in embedding student within the team (awareness of both roles)	N1
			NAs have an orientation role with all students	N1
			Team membership is why NAs help students	N2
			I have a role as part of a team (and my role in teaching students is controlled by others)	N3

5.2.2 Difference between the roles

There appeared to be a generally accepted delineation of responsibilities between the NAs and RNs and a clear understanding by participants of the tasks that fell within the remit of each group. This proved true across both in-patient and community settings and was accompanied by clear identification of two distinct groups. As M3 stated;

"I think it's very them and us, it can be very nursing assistants/ nurse" (M3/ box 41).

This separation was very deeply embedded, even to the extent that the groups were considered to exhibit mindsets different enough to be noticeable to students placed there. As S2 suggests;

"…like I was saying, there is a different, I suppose perspective, in the nursing assistants outlook and the role of the trained staff, their outlook" (S2 / box 42).

The most clearly articulated difference between the role of NA and that of nurse was in the widely held recognition of essential care tasks as falling within the remit of the NA. The provision of care in the domains of personal hygiene, diet and hydration were almost universally recognised as an NA task. This was true for all in-patient areas represented within the study, but not for community services, for which these were not identified as tasks or responsibilities expected to be provided by the service. The student nurses interviewed recognised this within their placement areas. S2 commented;

"in terms of personal care and feeding a lot of the times the nurses weren't around with those sort of aspects, it was the nursing assistants who were taking the lead" (S2/ box 17).

Indeed, NAs were identified by each of the student participants as not only being largely responsible for the delivery of these essential care skills, their role was seen to go beyond this. S2 above identifying that nurses frequently absent themselves from such tasks, and with "leading" being a description strongly associated with the NA contribution to these aspects of care. S1 describes this as;

"I think my perception of the role within this specific settings that they do a lot of things that I would imagine shouldn't be expected of them, emm they are very direct patient, like and I do expect that direct patient contact but they are almost on a day to day basis solely

responsible for the care of the patients., emm they are also, have administrat…, administrative tasks within the ward so one of the girls is also allocated to deal with food fluid and nutrition" (S1/ box 17).

This understanding of NAs being involved in significantly more direct contact with clients and carers was accepted across most of the participants, and especially, though not exclusively, in those working in in-patient or clinic facilities. This phenomenon appears accentuated through the requirement for RNs to be involved in shaping the organisation of care for their clients. This meant RNs were seen as being involved in administrative, often paper driven tasks, multi professional discussions and meetings, most of which took the nurse away from direct contact with the client. This is clearly illustrated in the comment from M4 who describes how the NAs engage within a physical checking process within the clients' rooms, and how the RNs then take responsibility for any administrative follow up that leads to;

"they (NAs) do like mattress audits to make sure there's no leaks or anything like that so the nursing assistants would do that, they would, they complete the paperwork and we then, if there is anything needing actioned, we action that" (M4/ box 10).

The NAs were also aware of a defining of expectations around their role, determined via a loose split of responsibilities for undertaking tasks required within the practice area. This was clearly identified within the involvement they had with students. N1 describes this here;

"basically what we're doing (with students) is the day to day sort of, how would you put it, the sort of personal care, like the little things, like as you say they get on and on, there they start to get more involved in the nursing side of it" (N1/ box 17).

It is interesting to note that N1 describes the personal care that they engage in, and which they involve student nurses in, as somehow separate from the "nursing side" of care. Wider responses from this participant and from the others involved would suggest a general acceptance of the practical application of personal care as falling within the remit of the NA, while organisation of that workload is often delegated by an RN. This delineation of tasks has a subsequent influence on what is expected of each of the groups, on where each of

these groups spend their time whilst on duty and on the skills that they are likely to demonstrate to student nurses who are placed with them. These factors are discussed in depth below.

5.2.3 But the crossover is important

While it was considered that there was clear differentiation between the roles and responsibilities associated with NAs and RNs, mainly related to their status and qualifications, the combination of the two groups were thought to create a cohesive team able to meet the wide scope of needs of the clinical area, and of the client groups served. The value of being able to develop skills and understanding within the realms of both roles was understood as beneficial for students. Mentor 2 puts this clearly;

"I think sometimes having a student involved with a nursing assistant can be good in a way because they've got their nurse training behind them, but there is also experience in the nursing assistant side of things" (M2/ box 23).

This exposure to tasks associated with both NAs and RNs was considered beneficial in that the relevance of the links between them were accepted and the delineation seen as a practical approach to workload allocation. Student nurses, and consequently qualified nurses, were understood to require developing knowledge of the basic (or essential) care skills, because of their connection to more advanced clinical decision making. The shift from the NA domain towards the RN province was considered by all as associated with the student's stage of training; the initial stage requiring mastery of skills associated with NAs, with students expected to gradually undertake tasks more associated with RNs, and by third year this role was expected to be dominant. M2 gives the mentors view on this process;

"Within first year, especially the introduction placement you know they (the NAs) play a big part of the basic needs and care given, personal care, toileting, the right incontinence pads, dietary intake, recording details, admission you know client weight and urine samples and things so the nursing assistants play a big part there. They tend not to play such a major role as the student progresses and becomes more confident, and more able within the student life". (M2/ box 12).

The opportunity available to students from working with both RNs and NAs was therefore considered to facilitate the development of a practitioner exposed to a more rounded experience and consequently more aware of how the roles complimented each other. It was also interesting to note that NAs were considered more involved in the early, more impressionable stages of the student's programme.

5.2.4 Working together for student development

It was accepted that in order to support students through the development of the broad range of skills identified above required the involvement of all constituents of the clinical nursing team. The delivery of a good quality learning experience was considered a shared goal and the NAs questioned very clearly saw that they were working collaboratively with their RN colleagues towards the delivery of this service. From a mentor perspective this acceptance from NAs to undertake a supportive role with students placed within their clinical area was clearly expected, even if it had apparently never been formally confirmed. M4 comments on this and their repeated uncertainty around the issue, especially in relation to formal recognition of the NA role with students, suggests it is a topic that is accepted, if not formally agreed;

"I kind of guess it's as if it's just a role that's been assumed. Our nursing assistants here they will welcome the students and they will just take on their, their role they have done it so many times, we have students all the time so, we've got nursing assistants that have been in forensics for maybe fifteen years or maybe came down from (Hospital name removed) even longer than that like years and years and years, if you're a student they just take on that role,…and I suppose, I suppose everybody supports each other, I don't know if its staff nurses supporting nursing assistants but it's also the other way around as well I think". (M4/ box 15).

Despite their being no formally agreed role for NAs in supporting the student nurses placed within their teams, the NAs themselves had not previously considered this as being a barrier to their involvement. They also, generally unquestioningly accepted that it was their responsibility to work with the RNs in developing a supportive, educational environment for

the students. The motivation pushing the NAs to get involved in student nurse education seemed related to their sense of shared purpose. This in turn was influenced through their connection to the clinical team and this sense of shared enterprise clearly fits with the Community of Practice theories that underpin this study.

5.2.5 Team ethos drives involvement with students

Nursing assistants were clear in identifying that working with students was a team responsibility that they felt compelled to engage with, mainly through a sense of contributing to the greater team effort. Contributing to the students learning was accepted as a goal important for the nursing team as a whole and therefore when nurses were otherwise engaged, or when circumstances supported it, NAs understood that they were in a position to take temporary responsibility to ensure that students were supported and were offered appropriate learning opportunities. N3 shows this sense of unquestioning camaraderie when asked about the NA role in the orientation process;

"…a mentor usually probably …would deal with that initially, but eh…obviously you know when some students come they might have appointments, they might have various things, and so they would ask you to…you know, could you show them round the team, then I'll go through some things with them2". (N3/ box 10).

In addition to simply filling in for mentors and other nurses, NAs were clear that they became involved in student learning because they felt able to provide the more rounded experience for the student, the importance of which is detailed above. They therefore considered themselves as offering the opportunity for students to gain more effective learning within the placement experience. The enhancement of the learning offered was considered beneficial for the team, and therefore accepted as a goal of all of the team members, including the NAs. This level of involvement was reliant upon a reciprocal acceptance of the value of the NA as a skilled and effective team member. N2 explains this;

"It was never when I started in this team, you're no trained and we are, we were a team and that's the way it worked, so …, that is why that I've always taken students". (N2/ box 14).

It is evident that the role of the NA in placement based student education is encouraged via a general recognition of their contribution within the clinical team as a whole, and not solely around expectations of input towards the wider team's approach to student development. Rather unsurprisingly, for NAs, making students feel valued seems more relevant when the NAs are feeling valued themselves and the development of a team ethos based on mutual respect is a key contributor to this.

5.2.6 Embedding

There was strong recognition of the importance of inclusion of newly placed student nurses within the care team. Developing this sense of belonging and overcoming the danger of what was perceived as an initial experience of isolation for students was considered an important aspect of the NA role. For at least one of the NAs this went beyond the realms of an expectation associated with teamwork. When asked about the high volume of time her diary had suggested she spent assisting students, N1 emphasised the importance she felt in this;

"…but if I'm on yeah, kind of tend to make sure because there's nothing worse. I remember one wee girl that started, and she stood there and I went there's nothing worse your first day and your hands are behind your back and you just don't know where to go. So I was like that, come on I'll show you. Showed her different things about and…you just make them feel part of the team". (N1/ box 15).

Acceptance within the clinical team is recognised as significant in shaping both the students sense of wellbeing and in encouraging team members to go out of their way to offer learning support. With NAs already identified as having closer ties to students during the initial stages of their placement, especially within the earlier parts of their programme, they seem to be well positioned to influence, and even control, the student's entry into the team. The power of the NAs in facilitating the student's entry into the clinical team is emphasised within this comment made by a mentor who was discussing their own experience of the impact on students when NAs do not facilitate this, in fact when they seemed to purposely obstruct this process;

"but on the negative side there was nursing assistants that would exclude you, not talk to you, you know you go in to a new placement and sit there and try and join in a conversation and they totally blank you, that's not nice at all you know, it's difficult enough going in to a new area, new patients and you've never been in that environment before, without the staff not including you". (M3 / box 37).

Students benefit greatly from feeling that they are embedded within the clinical team. NAs are recognised as being in a position to smooth the student's entry into that team and for some NAs this role is driven by a sense of concern based on understanding the uncertainty of joining a new workplace. It is also understood that at times NAs are passive around the support given to students within this process, and that some may at times even obstruct it. NAs therefore occupy a key, almost gate keeping role in transitioning student nurses from the role of outsider in to recognised members of the clinical team.

5.2.7 Orientation

As well as commencing the process through which the student is incorporated into the clinical team, NAs also see themselves as having an expected, if not formally recognised role, in orientating the newly arrived students to the clinical environment. Like any workplace there is a requirement to familiarise new staff to, in particular, the health and safety aspects associated with the location and the tasks the employee will undertake. Within the mental healthcare setting this could be considered to have an additional importance due to the nature of the vulnerable and at times aggressive and unpredictable client group being cared for.

The NAs interviewed were clear that they were expected to participate within this orientation process, there was a common belief amongst them however, that their unique relationship with clients provided them with a significant advantage over RNs in familiarising newly arriving students with both the clients being cared for and the processes undertaken by the team. Because of their more comprehensive understanding of the nuances of the clients, and the responsibilities they had in ensuring that ward processes flowed smoothly, the NAs took it for granted that they would provide effective orientation for students, and

this was a view apparently shared by the RNs they worked with. How this process unfolds within the practice setting is explained by N1;

"...whoever is in charge of the nurses will say (to the student) you work with N1 and I'll take him or her round, show them basically where everything is, how to approach the patients, take them in to a bay and help them set up. Everything, and then they'll stick by me all day, and I'll show them how to fill in all the forms like the dietary, the boards, the check boards and just give them a wee bit information about each patient and certain things". (N1 / box 7).

For student nurses, entering a new placement is an uncertain and frequently anxiety provoking experience. The environment is unfamiliar; the clients bring a novel set of presenting problems and the workload expectations are unclear. Within this period the students seek guidance and support; there is a need for them to understand what is expected of them and they require familiarisation with their colleagues and with the clients they will be working with. That support is frequently left within the domain of the nursing assistants. The reality of this is described by S2;

"Like the first time I went on that placement, cos it's my base placement, so my very first four week block then it was the nursing assistants that really in the end showed me about and where everything was". (S2/ box 23).

NAs were identified as key then in the introduction of students to the placement environment, providing significant input for the students during their early experiences within each placement, a time when students are recognised as feeling vulnerable and at times isolated. Students are subject to repeated instances of placement change. In the programme governing the students within this study this occurs between three and four times each year. This then is a recurring phenomenon that the students are likely to become familiar with, and one which their responses suggest attracts a level of resigned acceptance, and recognition of the benefits of early engagement with a supportive and knowledgeable NA.

5.3 Presumed participation- NAs contribute crucial and assumed skills and support to student nurse development

5.3.1 NA contribution to student nurse learning.

NAs are expected to contribute to the learning experience offered to student nurses placed within their clinical teams. Their involvement with students is an everyday occurrence within practice settings and is an assumed facet of their job. Despite this there is little evidence of any sustained planning or consideration of their involvement and their input varies markedly and is shaped by their own individual skills as well as by the attitudes of the nurses and students they are working with. NAs are often able to model the application of high level interpersonal skills as well as the delivery of complex individual and group interventions. This level of expertise often jars with official recognition of their role and like their involvement with student nurses appears accepted, even expected, but not fully recognised. Participants recognised that by focusing their attention on this area they uncovered a realisation of a mismatch between these official expectations and the reality of clinical practice.

Table 14 Presumed participation- NAs contribute crucial and assumed skills and support to student nurse development

Super ordinate theme	Group theme	Group	Emergent theme	Participant
Presumed participation **NAs contribute crucial and assumed skills and support to student nurse development**	There is limited recognition of NA skills	N	NA role is expanding and skilled	N1
			NAs skills are recognised only within the clinical team	N2
			Some people recognise my skills and some don't	N3
	NAs have informal responsibility for much of the clinical development of student MH nurses	N	After nurses allocate NAs are left to shape student learning (though informally)	N1
			Expanding NA role involves teaching students	N2
			NAs teach students complex interventions and professional and interpersonal skills	N3
			NAs keep students in touch with clients and their families	N3
	NAs are influential to students, but recognition could enhance this	S	NA involvement with students could improve, if they wanted it.	S1
			Ignoring the value of the NA role development	S1
			NAs are influential, though not always in a positive way	S2
			More recognition of the NA role would help student learning	S3
			NAs proximity to clients has significant advantages for care delivery	S3
	The NA role with students is valuable though not always recognised as such	M	The NA role is undervalued	M2
			Feeling pressure to retain the status quo	M2
			Feeling powerless in updating recognition	M2
			NA influence is variable though worthwhile	M3
			The importance of the NA role	M4
			NAs contribute to student nurse development	M4
			Reflection uncovers acceptance	M4

5.3.2 The NA role is expanding and skilled.

The essential care tasks of attending to client's personal hygiene and meeting their nutrition and hydration needs were recognised as firmly situated within the remit of NAs. Within some locations NAs were also understood to hold responsibility for specific administration requirements for the clinical area or for organising and facilitating specific clinics or tasks relevant to that care environment. There was however evidence of an understanding of NA involvement in, and responsibility for, the application of more complex interventions across the scope of care settings studied.

Within the older adult in-patient admission environment, where the emphasis is on the application of an admission and assessment process, which is employed frequently if unpredictably, the NAs and RNs each have their own defined and complimentary roles within the admission process. The NA contribution to this entails aspects such as recording and storage of clothing and belongings. Within the out- patient setting catering for a similar client group NAs were identified as responsible for coordinating and running memory clinics, wherein newly presenting probable cases are offered assessment, information and emotional support. In adult community settings NAs fulfil a similar coordinating role in regards to clinics, this time for administration of depot neuroleptics (which are administered by nurses), and for phlebotomy, where bloods are taken, generally for the purpose of medication related health monitoring (a task completed by either group as long as the individual has negotiated the required Health Board training programme). The importance of the flexibility of the NA role in the delivery of healthcare is identified by M2;

"they do anything that anybody asks them to do, they run the clinics, we will go in and do injections and take bloods, you know, ask us to run the clinic and we won't have a clue what to do, 'cos the nursing assistants control the diaries and the system and so the place sort of falls apart if there is not a nursing assistant in the clinic", (M2/ box 20).

In addition to the organisational and care process skills detailed above, NAs are seen as responsible for the delivery of structured therapeutic interventions, and for employing a wide range of complex skills including specific communication approaches, de-escalation and other interpersonal skills. These responsibilities are shaped by the needs of the clinical

environment and suggest a significant reliance on the NAs in contributing to meeting the needs for that specific area.

The community based services for children and adolescents saw the NAs deliver some of the more notable interventions. One NA was responsible for applying picture based communication aids with children experiencing a variety of developmental disorders. This role also included easing the child's family and schoolteachers into accommodating the approach within their interactions with the child. The other NA working with this client group identified responsibility for monitoring clients' height, weight and blood pressure, completing individual assessment components of larger ADHD assessments and responsibility for formulating appropriate therapeutic interventions such as sleep hygiene and anxiety management. The adult community team expected their NAs to take responsibility for graded exposure and social skills development and older adult settings saw them run activity groups and coordinate social activities. Within in-patient forensic services the NAs were seen to be responsible for security checks, health and safety checks, organising recreational activity for clients and were recognised as demonstrating highly effective interpersonal skills that contributed to the de-escalation of aggression that was considered a threat commonly associated with this environment. M4 describes this well in relation to the general skills of NAs within their environment, and then relates it more specifically to one NA.

"we've got nursing assistants that have got fantastic interpersonal skills, they can change how they approach our patients because our patients are so different and they recognise that one method of communication works with one patient and within minutes they will change that when they are dealing with another patient, but they assess the situation very quickly and they know how to…their de-escalation techniques are fantastic, and I for one rely on our nursing assistants if there is a challenging situation, there is a couple of nursing assistants I will always approach and ask to accompany me to deal with that because they're excellent, excellent at de-escalation". (M4 /box 36).

"It's fantastic the way one nursing assistant in particular who in challenging situations, he can have that turned around within minutes and his body language, his tone of voice, his approach, but it's also about the relationship that he builds up with our patients, they

know him really well, and they know, they know that…he's not…I don't know, I'm trying to think what the right word is like…they know if he's intervening to sort the situation out, that that's it, they just need to let it go and then they come and talk about it later on…and it's excellent how he does it and I would say the students must pick up on that because its, I find the nursing assistant, we have a patient in here who's very difficult to manage at times and I've picked on the skills from this nursing assistant how to deal with this particular patient and it works, it works and he has it down to a T". (M4 / box 38).

There is recognition therefore of NAs providing some of the key therapeutic interventions delivered to clients across a range of clinical specialisms and providing them with an impressive level of interpersonal and organisational skill. This recognition is shared across each of the staff groups studied here and incorporates NAs taking a coordination and facilitation role as well as applying what is often complex and highly skilled communication and interpersonal skills. Inherent within the interviews, and highlighted within the examples from mentors provided immediately above, there is a strong reliance on NAs in order for the clinical area to achieve its aims and to meet its purpose.

5.3.3 NA skills are recognised only by some

The expansion of the NA role and the consequential encroachment into student nurse education has proven contentious to some and as a result has generated significant frustration for those involved. Two of the NAs participating in the study were concerned in disputes with their employers that had spanned periods of several years and had both considering seeking alternative employment. The reason for this unhappiness was a perceived lack of recognition of their abilities. The skills of the NAs were considered by participants as being generally well understood within the clinical team they were part of, and this meant that the tasks allocated to them and responsibilities understood as theirs were viewed as often reflective of their abilities. The NAs however considered that managers beyond their immediate team level influenced a lack of wider recognition. N2 describes her concerns that this jarred with her understanding of the ethos of teamwork;

"I think everybody has got a skill set, whether you wash the floor, or wash the dishes or you deliver the mail, and this is the way this team's always been, but its not now and, and no just this team, maybe other places are starting to, but people I think, my grade, have to be recognised. They have to be recognised and they have to say do you want the opportunity to go and do this, you know, would you like that". (N2/ box 17).

The most obvious consequence of being recognised as working at a level less demanding and less responsible than you actually are fulfilling, would be the lower remuneration likely associated with positions accepted as less skilled. Interestingly none of the NAs mentioned this and when expressing dissatisfaction at how they were recognised, their main concern centred on the unfairness of them working beyond what was required of them in order to benefit the team, only to find that the extension of their role was at odds with either their colleagues expectations or the wider organisations job grading and pay agreements, and therefore their extended roles were under threat, or not fully utilised. N3 explains how the working relationship with team colleagues shaped an inconsistency in the level she was able to practice to and expresses a sense of hurt that her abilities were ignored because of the absence of a particular form of qualification;

"It depends who you are working with you know, like I say I've got, I think your own working relationships with, because you are multi-disciplinary in your processes…some people might feel…Because you're not, because you're not a trained clinician, some people get to think you can't do certain, because you're under supervision they think you know that you shouldn't be supervising somebody else, whereas others take the point that, take the, I would say take the, take the line that they know what you're capable of. And they know that you can pass that on to somebody else". (N3/ box 25).

While the NAs cited above generally recognised barriers to full recognition of their abilities, their ward based counterpart identified no such concern. N1 felt that any such reluctance from students to engage with NAs was historical, largely made redundant as a consequence of the expansion of the NA role. This was not a view shared with the student on placement within the same clinical area. For them tasks associated with NAs were continually referred to as "basic", a description suggesting a low value placed on their role and of the learning opportunities it offered. They summarise this succinctly;

"I spent a lot of time with the nursing assistants, just when there wasn't much else going on." (S2/ box 5).

There is no uniformity then in the expectations held around the role of the NA. Within some care environments the clinical team is seen to foster the development of NAs, encouraging them to undertake skills and interventions that carry a level of prestige and help increase the NAs confidence and sense of purpose. This recognition is however not always shared beyond that service, and in some instances may in fact conflict with the regulations and perceived remit of the wider organisation. Even within the NAs own service, it is felt that some of the colleagues they work alongside may have reservations around the extent of the NAs abilities and of the level of responsibility they are able to undertake.

5.3.4 NAs are left to shape student learning

It was clear from each of the groups approached that NAs are expected to provide significant support to students during their clinical placements. While mentors and other RNs are acknowledged as having responsibility to shape, plan and organise such support, it was apparent that there is an implicit understanding that NAs would take this role on when mentors and other RNs were otherwise occupied. For some of the NAs interviewed this was accepted as a common sense component of showing students how to successfully complete tasks, the tasks having been allocated by RNs. At other times however there was a perception that, when the opportunities arose, they were prepared to take responsibility to identify learning opportunities for students, and to guide the students through them. N1 suggests this arises as a consequence of NAs working in a closer proximity with both students and the clients they are caring for;

"…because you're more or less on the floor with them and showing, maybe taking them to see, maybe somebody feeling a bit down, you know. You'll take them along and you'll tell them all about, try and sit down and you'll encourage them and get involved with things around the ward as, as I think the students' progress they are getting more in to the more paperwork stuff, the more medications, doctors rounds, eh kardexes, so it's just even with

first years, but you try, even here you go, Kardex is on, go in, or so and so is doing that down in the ward, dressing, away you go and see, keep them up to date". (N1/ box 21).

This would suggest that NAs are identifying learning needs for students associated strongly in the realm of skills associated with the RN role, not just those relevant to what NAs are doing. Kardexes is the term given to the information sharing and planning session nurses engage in at the commencement of each shift, and wound dressing is not a role normally undertaken by an NA, particularly if a prescribed treatment is included.

5.3.5 The expanding NA role includes student development

It is interesting to note that while the NA role with students lacked formal recognition, the expanding repertoire of skills that NAs offered increased their attractiveness as a learning resource. While much of the contact student nurses had with NAs in clinical settings was shaped around the application of the essential skills discussed earlier, it was obvious that the NAs involvement in more advanced techniques was an asset that both mentors and student nurses were keen to exploit, and that this development strengthened the expectation that they would take responsibility for student education.

It was obvious from each of the NAs questioned that they shared an understanding that the development of their role was something that would be helpful for students, and they took it for granted that they would be expected to contribute this expanded level of knowledge to the students learning during their placement experience. Having discussed taking responsibility for the delivery of a wide range of advanced therapeutic skills, N2 is pragmatic in their understanding of why their contribution to student learning is more than just convenient;

"I think part of it (is for convenience) but…part of it probably was but part of cos they'd learn from me". (N2/ box 43).

The developing NA role was also seen by mentors as an unquestionable opportunity for students to learn a variety of, often advanced, therapeutic, interpersonal and organisational skills, from the NAs that they knew were routinely applying them in practice. M2 indicates a

referral process to their teams NAs who are expected to deliver important interventions to clients who are chronically and severely mentally unwell and sees that this as strongly advantageous for students placed there;

"…the students tend to spend a good bit of time with the nursing assistants because they've got a lot of really unwell people on their caseloads just now". (M2/ box 15).

It seems then that the expansion of the NA role is understood to add to the learning opportunities available to the students, and as a consequence it was generally assumed that NAs would accept responsibility for exposing the students to any specific task or skill that they were seen to have developed.

5.3.6 NAs teach students complex interpersonal and therapeutic skills and professionalism

In addition to being recognised as delivering highly skilled interventions and providing general support to students placed within their clinical teams, there is a general acceptance that NAs are also teaching students advanced therapeutic and interpersonal skills, and professionalism. NAs themselves are well aware of the tasks they teach, and generally recognise taking responsibility to teach less obvious clinical skills such as risk awareness, even if they are not always cognisant of the value of these skills. N3 provides an example of the application of these clinical skills and explains here the need to teach students risk assessment and tact during a home visit to the family of a client;

"there might be other people in the house who you've no seen before, again you can make people, you know you can make students aware just to be, be careful and tactful about what they're saying or they might encounter somebody who's a wee bit, I'll no say aggressive but you never know eh…just a wee bit…oppositional to what to what you might be doing". (N3/ box 9).

Mentors were also aware of the value of linking students to NAs in order to learn specific skills or therapeutic approaches, M4 identified that NAs were best equipped to teach students security and drug testing processes within a forensic setting and M2 explained the advantages that NAs offered in teaching students how to carry out graded exposure. This is

a cognitive behavioural intervention used in the treatment of phobias, and NAs appear to undertake the facilitator role in it on the basis of having sufficient time allocated for it and being recognised within clinical teams as well placed to carry it out. This was M2's response when asked if there were skills or interventions that they would routinely allocate students to work with NAs to learn;

"Graded exposure for one, the nursing assistants do a lot of that, community integration, and I think one of the students commented to me before who wasn't my student commented that everyone always talks about graded exposure but I don't know what it is and any nurses I have been with don't actually do it, so had sais so and so is going to do graded exposure with patient X, go out and see what they do". (M2/ box 22).

Somewhat surprisingly one student even identified that NAs proved to be role models that promoted professionalism more than their registered counterparts. This was based on the student's opinion that prioritising direct patient contact over paperwork was a more professional approach to care delivery. S3 identified the aspects of the NA role that so impressed her;

"…they know the dislikes and likes, they know what can make them (clients) become agitated, so I find that they have a better relationship with the patients and that's my aim, to have a more, to understand the patient better rather than knowing the care plan system or whatever. I know that's important but I think the patients should be the priority". (S3/ Box 11).

When asked to describe this relationship NAs develop with clients she was clear around what it meant to her;

"… (It) Appears more professional". (S3/ Box 12).

It was apparent then that the general up-skilling seen across the health system is reflected in the educational relationship that exists between NAs and student mental health nurses. The opportunities offered through NAs undertaking tasks that are more skilled than those traditionally associated with the role are seen as advantageous to student development, and both mentors and students are keen to take advantage of this development. In addition to providing access to the more advanced skills on offer, NAs are also seen as providing

important role modelling in how some students at least consider professionals should prioritise their workload.

5.3.7 NAs connect students to clients and carers

One of the most frequently discussed concepts across each group of participants was the advantages associated with the closeness NAs were considered to have with clients and carers. The nature of the NA role; regularly involved in delivering hands-on care while spending more time than any other healthcare worker sharing the same physical environment as the clients, was seen as facilitating enhanced care delivery and providing opportunity for student nurses to understand their clients better and to observe, learn and develop practical and interpersonal skills.

Within clinical areas the physical environment was understood to be split into areas associated with either RNs or NAs. Client areas; dormitories, toilets, dining areas and social environments were seen as where NAs would spend the majority of their time, and expectations were that RNs would complete the bulk of their tasks within either the clinical office or in the treatment room. None of the areas involved in the study contained what is termed a nurses' station, which often provides an interface between the ward office and the client areas. Where staff spent their time was both a reflection of the work they were engaged in, and in turn, further influenced the forms of interaction they had with the clients in their care. The hierarchical underpinnings associated with this were obvious, with increased responsibility attached to the work taking place within the office and treatment room. Clients and student nurses were not immune to this form of categorisation. The NAs proximity to clients was considered to suggest a more equal relationship, while there seemed to be more flexibility and choice around how student nurses fitted within this hierarchy. M4 explains here the mentors view on this and interestingly uses the common term "floor" when referring to client areas. This term is used across groups and placement areas and suggests comparison with factory work where more cerebral skills are needed for the office based work, and more menial tasks are carried out within the factory floor. This metaphor relating the areas falling under the floor description as the lowest level of both the clinical environment and of the tasks carried out within them;

"…if the student is spending more time with the nursing assistant, they are probably more likely to be on the floor with the patients, either sitting in there or in here. And it is definitely more formal stuff that the students will spend more time with the staff nurses because we sit and do one to one sessions with our patients, the student has came in to those, but when it's just kind of informal parts of the day they're with the nursing assistants". (M4/ box 35).

The difference in the client/ practitioner relationship between NAs and RNs is clear to the students placed within clinical teams. The apparently less formal responsibilities of the NA role are seen as engendering a different quality of association with clients than can be achieved by the RNs. This closer bond is expected to facilitate a better understanding of the client, and in particular a clearer awareness of the progress of the health condition they are being treated for. S1 explains the difference;

"nurses are seen as like the enforcers of maybe things the patients don't like, whereas the healthcare assistants have got an out like "oh I can't make that decision, you would need to ask a nurse", so they can be more, maybe a wee bit more friendly and empathetic with them whereas a nurse would have to be a bit more disciplined with a patient, so it's like maybe a wee barrier to a relationship there just because its "you have to do this" or "you are not allowed to do that" whereas the healthcare assistant will say "oh I can't make that decision, I'll just sit and chat to you and speak up on your behalf kind of thing". (S1/ box 26).

The NAs were considered to have more time to spend in direct contact with clients and carers, as RNs were perceived to have more of a remit for intermittent interaction with these groups. Even in community settings, the tasks allocated to NAs were generally those that required the highest levels of face to face contact, often over a sustained period of time. M2 for example identifies the practical aspects of graded exposure and supported socialisation as falling within the remit of NAs within their community mental health service, both time intensive and client facing interventions. N3 also explains the belief that commonalities in experience and language are advantageous for NAs in developing a rapport with clients and carers;

"...over the years I think I've noticed that there is a lot more, that some of the senior nurses, who are more likely to be the mentor, are more administrative, rather than being, in the practical, down to earth patient interaction kind of thing…and maybe even going in to…how could I put it…their language is a lot more jargon and things... I just tend to talk in normal, common everyday terms and even I'm out with families I eh…eh…I'm trying to talk to them on a level, kind of eye to eye…I'm you know I'm trying to understand your son or your daughter having behavioural problems but I can also understand where you're coming from, whereas I do think sometimes…some people are talking…more technical terms and things like that, and I don't always think that…families appreciate it". (N3/ box 21).

The NA is considered closer to clients and carers across a range of treatment settings in regards to the physical space they occupy, the activities they share, the language they use and in the social hierarchy of the clinical environment. This proximity facilitates the opportunity for care improvement through enhanced relationships and offers student nurses entry into the world of the client and carer through exposure to NAs modelling the development of a therapeutic rapport.

5.3.8 The NA role in student education could improve, if wanted.

There was strong recognition of the opportunity to develop and improve the contribution of NAs to the clinical development of student mental health nurses, assuming that is, that NAs would want such added responsibility. The role of the NA in the clinical development of student mental health nurses is presently considered to be an implicit though limited responsibility to support the student through the development of essential care skills and in formulating an understanding of the routine of the clinical area. This involvement is generally considered ad hoc and included allocation of the student to work alongside the NA, often to observe a particular skill being applied or task being completed. The NA would receive little explanation or direction and they would only occasionally be asked to provide informal feedback on the student's performance. This exclusion from the formal processes framing the students learning is considered to leave the NA blind to the students actual learning needs and to allow them only a markedly limited snapshot of understanding of the

student's overall programme. When asked how this role could be better supported N2 suggests a common sense initiative that confirms recognition of NA contribution with the student's programme provider;

"…if they get a sort of guidance to follow when they go to placement, ... I think that would be helpful for them... Well I suppose if it's something that could be put into the mentor that you know, I suppose they would need to give me time and what they are looking for me to do... I think it would be good if there was something that they would spend a week or whatever…depending how long they are here". (N2 / boxes 21/ 36 / 38).

To improve the quality of contribution the NAs make to the student's development is therefore considered to require no more than ring- fenced time for this purpose and inclusion of NAs within the formal processes shaping the students learning within the practice placement. While each of the NAs questioned were keen to see such a development some of the students were dubious about the attractiveness of the role for NAs, particularly if there was no accompanying recognition which included some form of reward. S1 is clear about this;

"I think it would be just be seen as an additional responsibility they're probably not rewarded for within their job role or financially or anything so I think that would be just seen as another, another sort of burden on their workload". (S1 / box 37).

From the outside then, there is doubt as to whether NAs would undertake an official role within student education, unless the responsibilities that this brought were appropriately recognised and remunerated. For the NAs however their immediate thoughts around this concept suggest that this would help them place their input more effectively in relation to the students overall learning needs and allow them to provide meaningful feedback on the student's performance.

5.3.9 NA role development is ignored

There was a general consensus that NAs were recognised as being skilled practitioners by their own team members. This was in the main borne out in the trust shown around the

level of tasks they were asked to take responsibility for, and by recognition of their abilities in their interactions with colleagues. There was an undercurrent of uncertainty around this for NAs though, and there were notable aspects of their working life that did not always attract such acknowledgment, for example there was concern raised around whether the responsibilities attributed to them in some areas was appropriately rewarded. S1 explains this;

"…definitely, emm I think the nursing assistants within this setting are (pause) potentially working at a level that's much more than what their banding is responsible for". (S1/ box 18).

This mismatch between the level of responsibility NAs were given and the recognition this attracted beyond the boundaries of their own team was of significant concern to the two NAs who were involved in the protracted dispute with their employers. Both felt that their employers had taken steps to restrict the scope of their roles rather than celebrate and take advantage of their unique development. In many ways this had made them question their effort and led to them feeling it necessary to repeatedly justify their claims as advanced NA practitioners.

In addition to feeling their skills were at times unrecognised by their employing organisation, beyond the level of their immediate team, there was also some conflict recognised with their direct colleagues. It was suggested that there was a variance between limitations associated with the NA job and the actual role these NAs fulfilled. The reaction of colleagues was felt to be variable and considered dependent upon their individual interpretation of the NA role and the level of trust they had in the NA themselves. N3 explains this;

"…because you're under supervision they think you know they you shouldn't be supervising somebody else, whereas others take the point that … that they know what you're capable of. And they know that you can pass that on to somebody else and I think that, but there are other people who feel that because your supervised you shouldn't really be imparting, you can do a certain extent but they would limit that and no let you know, because of what they feel the limitations, but there are other people in a team who are quite happy to, because they know the work you do with them, and they give you

more autonomy in doing that work, and trust you in being able to go and do things like that without thinking Oh I need to be supervising that person at every level". (N3/ box 25).

NAs were therefore in a vulnerable position; the up-skilling that was available to them, and was at times expected of them, wasn't always matched in terms of the expectations of their colleagues or in the recognition of their employers. To compound this uncertainty, the student nurses they were able to support weren't uniform in their acceptance of the value of the contribution of NAs to their clinical development. The value attributed at times to the NA role is succinctly captured by S2, whose response to the question "what did you learn from the NAs" drew this brief though telling response;

"just a lot of the basic care" (S2/ box 23).

5.3.10 NAs have an influence on students, though not always a positive one.

The NA role provides an additional, alternative, on site, practical support for student nurses that entails what are perceived as both advantages and disadvantages for the student. On the positive side, the NAs exclusion from the mandated learning and assessment process, associated with the student's placement, reduces the sense of a power imbalance between them. This is seen as an advantage by NAs in developing a working relationship with students. As N3 suggests;

"Well it, I think, I think in a sense there is because maybe they don't see me, or they don't see a support worker…as being a superior…or as being independent or somebody, they seem to more basically a kind of hands on at a level that they're (at)" (N3/ 19).

As a counterbalance to this each of the groups identified concerns around NAs proving to be negative role models at times, both in terms of engagement with students and in the application of poor practice. The NAs questioned each referred to such colleagues in historical terms, advocating that such individuals no longer existed. N1 gives their opinion of students reporting such experiences;

"…cos I've heard students sort of say they went to a ward and this one was like that , well you shouldn't let her away with it because you know you're here to learn, you're a team as much as she is, but that's all changed". (N1/ box 28).

For student's fluctuations in the helpfulness of all clinical staff were a feature that they seemed to learn to accommodate. As discussed elsewhere in this paper the students modified their behaviour to smooth their acceptance within the clinical team, including the NAs. Students learned who to approach and when, even recognising poor practice when it was demonstrated by NAs. Such recognition helped the student understand what didn't work and why. S2 explains this from the perspective of a year 1 student;

"I think I've seen a lot of what to do and what not to do, and sometimes what they are doing is not how I would have handled some situations". (S1/ box 25).

5.3.11 Recognition of the NA role would make it more effective

There was agreement across each of the groups that formalising the role of the NA in student nurse training would enhance what is already considered to be an important and effective relationship. The ad-hoc nature of utilising NA support and expertise was seen as having considerable advantages as well; the flexibility and ease of access to a staff group who could provide good quality learning experiences for students with little or no notice, made them attractive to busy mentors, while the informal nature of their involvement made them less threatening to students.

Despite their close involvement with students NAs were rarely involved in review or planning of the students learning, or indeed any goal setting arising from this process. NAs then were providing compartmentalised learning for students shaped around individual tasks, with no real understanding of how this fit with past or future learning. Each of the mentors recognised this to some extent and M1 identifies here where they believed the blame lay for this.

"I think were probably the ones that are kind of failing them on that a bit, cos more often than not we'll ask them if they can take students out, but maybe not discuss with them

what they could be showing them or what they could maybe be doing with the student as well, so I think that maybe we kind of expect quite a bit of them". (M1/ box 27).

While mentors may feel that they could include NAs more effectively within the students learning, there was recognition that this involvement is not supported in the documentation accompanying the student that outlines the expectations of the programme providers and maintains a record of the student's progress. M3 encapsulates the mentor's views on this;

"I think it's all labelled on the trained nurses on the ward. You're filling out the documents and you're signing the documents, but a lot of the time, you know especially in the morning there's a lot of personal care going on so… know you can get additional comments in the OAR for people to fill out, and maybe if there was a specific document for nursing assistants who've worked alongside to complete after that shift then that might be a way for (improving the process)…". (M3/ box 30).

There was agreement amongst all interviewed that inclusion of a component within the student's programme documentation for the NA to complete would be beneficial in a number of ways; it would encourage NA involvement within the educational process, providing them with recognition for their input and offering a structure outlining the expectations for it on them. Such documentation would also facilitate their understanding of the students learning beyond the current placement and would allow them to contribute useful feedback on the student's performance.

5.3.12 The NA/ client relationship facilitates enhanced care delivery

The provision of good quality care is the ultimate goal for the clinical teams where students are placed in order to learn their trade. Learning how to achieve this goal then should be the overarching ambition of the students themselves. One of the factors that regularly arose within this study was the difference in the perceived quality of relationship the NAs had with clients and their carers, with a perception that in many ways, this enhanced rapport facilitated the delivery of a better standard of care.

Each of the groups involved believed that the NA role generated a closer bond with clients, this was considered a consequence of NAs spending more time in their company, being more frequently involved in intimate care tasks and because the informality associated with

the NA role meant that they were distanced from the decisions the clients found restrictive. These closer links meant that the NAs were considered to have a more intimate knowledge of the client, and therefore were more able to deliver individualised care. S3 describes how this appears to a student on placement;

"Well because they know the patients or client…because they know the dislikes and likes, they know what can make them become agitated, so I find that they have a better relationship with the patients and that's my aim". (S3/ box 11).

This seems somewhat of a paradox because to develop such a relationship means that in order to become a better nurse it was perceived that the student should behave more like an NA.

5.3.13 The NA role with students is undervalued

In addition to a consensus around the important contribution that NAs make to the clinical development of student mental health nurses, there was matching agreement that their role in this was expected, though very much taken for granted. For the NAs, two had very obvious qualms around the tenuous nature of recognition of their skills and the other shared some of their doubts about being seen to be a valued part of the student's educational experience. While each of the NAs felt that their teams were supportive of their input, even relied on it at times, they were aware that not all of their colleagues either trusted their level of expertise or felt fully comfortable in having a nursing assistant teach students. This generated a level of uncertainty as there were no hard and fast rules around what the NAs could contribute. The extent of their input with students was likely to vary depending upon the beliefs of the individual RN responsible for the student on that day, and this was unlikely to be made clear to the NAs, who were left to accept the unpredictability of whatever was asked of them. N3 explains what this is like in practice.

"…but there are other people who feel that because your supervised you shouldn't really be imparting, you can do a certain extent but they would limit that and no let you know, because of what they feel the limitations". (N3/ box 25).

As the accepted role for NAs in student learning in placements is guided by expectations that the NA will rarely be part of the planned programme process; they will not be involved in determining learning goals, they will generally work with the student on an opportunistic basis and they will rarely contribute anything formal to the student's performance review, so the sense of importance attributed to their input seems low. This informal role is accepted by NAs though each of the NAs were clear that more formal recognition of their participation would enhance the students experience, and in turn would likely lead to increased satisfaction for the NAs involved.

Both the RNs and the students were also clear that they felt the lack of recognition of the NAs input to the student's development belied the importance of their contribution. When asked what impact formalising the NAs role would have for NAs, M4 suggests that the recognition it brings may be the remedy to the impact on NAs of the underrated nature of their input;

"Thinking about it now I think it would be a great idea. I think the nursing assistants would probably feel more valued". (M4/ box 20).

5.3.14 There is pressure to retain the status quo around recognition of the NA role with students

Despite the role of the NA being subject to considerable development over recent years, attempts to match the reality of the capabilities of this group of practitioners, with the responsibilities recognised for them by employing organisations are considered to face significant impediments. It was felt that it was not seen as being in the interests of the employing organisation, or necessarily a priority for the educational establishment responsible for the student's programme, to recognise any alterations in how NAs interact with students on placement.

One of the NAs questioned had found that the recognition of their abilities had actually diminished at a managerial level despite their continuing development and involvement in student education and in the delivery of advanced therapeutic skills. The NA was very clear

in whom they attributed this change to, as it coincided with a new clinical manager being appointed. N2 responds to a statement pointing out the skills and experience they have;

"But I don't according to my clinical services manager". (N2/ box 25).

Pressure to continue to retain the current understanding of the NA role in student nurse education also arises as a consequence of the level of unquestioned acceptance of this as how it should be. Each of the participants recognised that until they had been guided to consider this specific subject they had been content to fit within the accepted paradigm.

5.3.15 Practitioners feel powerless in changing recognition of NA involvement in student nurse education

M2 emphasised the need for mentors to adhere to the requirements set out for them by the NMC, several times they refer to meeting the targets set for them in their role as mentor. With control over managing the rules governing student education and the remit of NAs set at an organisational level, and in part by an organisation that is not the mentor's employer, so the mentor is distant for the decision making process around this. M2 highlights this when looking at how the NA role could be more fully recognised;

"we maybe don't do that as much with the nursing assistants, we just take them out and show them what you do and that's fine, so we probably don't involve them as much as we should, how we change that I don't know". (M2/ box 27).

It may be that uncertainty around making changes to the NA input to student nurse development is fuelled by a lack of consideration previously directed towards that role as much as it is generated via influences external to the local clinical service. The comment by the mentor above suggests significant vagueness around the specifics of the NA role, and around how it may be improved.

5.3.16 The NA role in student nurse development is important though variable

The lack of formal recognition of the NA role in student development may have contributed to what was recognised as a variance in both the expectations set around their input, and in the actual form their assistance took. The fact that NAs would be involved in supporting the student's training was generally accepted, though the shape and extent of this involvement seemed to be dependent upon the culture of the clinical team and the motivation and organisational skills of the RNs and NAs involved. Often the NA would be approached to support a student in an opportunistic manner by a mentor or the student themselves, either when the mentor would be busy elsewhere or when the NA was undertaking a specific role, task or skill that was felt would be of use to the student. Recognition of the importance of the NA contribution to student nurse learning has been established elsewhere in this paper and the variability emerging comes across strongly in the markedly mixed form of interactions reported between the two groups by the participants within this study.

The NAs themselves were seen as influential in shaping the extent of their involvement in student education. If an NA didn't want to get involved, then there was a belief that they could in effect opt out to a degree. M3 explains what they feel is a major influence on this;

"Some, you still have that, they don't want to get involved, some, I think the older generation they don't want to emm, still don't want to have anything to do with students". (M3/ box 20).

The NAs also indicated some uncertainty over what was expected of them with students, recognising that both their organisations and some of their colleagues seemed to have ideas around the limitations of the NA role, and that these limitations were not always clearly defined.

"I say the team meets, …something would be passed to me and they would say Oh (NAs name) is working on this particular case and …they probably say to the student, right that's part of your learning project, go along with (NAs name), …or they'll ask me and say can you instruct the student on the Board maker because it's all part of the communication eh aspect of their training". (N3/ box 29).

Some of the variability then is within the NAs control, however much of it is generated through the lack of systematic involvement of the NA and because of the individuality of opinion in colleagues who shape the student nurses learning experience.

5.3.17 Reflection uncovers dissonance around the NA role

The process of reflection, driven through participation within the study, was suggested to have uncovered an awareness of both a prior lack of consideration of the NA role with student nurses and a level of dissonance between what had previously been assumed about the extent of their involvement and what the participant had uncovered. Completion of the practice diary and subsequent consideration of the topic in preparation for the research interview was identified as something of a revelation, especially to the mentors involved. M2 points out what this process has uncovered;

"think I mean I can't rate them highly enough and neither do the students, but you have made me think a wee bit now about how much we maybe do utilise them but don't include them as such or maybe don't give them the recognition that they should be getting, but yeah definitely they do have an active and significant role to play, but I'm questioning my own, I guess I'm questioning a wee bit how I do kind of, off you go with the healthcare assistant without discussing too much with the healthcare assistant". (M2 / box 28).

Some of the student nurses also seemed surprised that focusing their attention on the subject had made them realise that what they had taken for granted around the input from NAs in their programme didn't fit with reality. In particular it didn't fit with the reality of how important contributions to their programme are normally fore-fronted and supported. S1 identifies such a contradiction here;

"…well I suppose I'd never really thought about it before but when you said is there any recognition for it, and there's not, and I think especially in the earlier parts of your training, they are really influential". (S1/ box 47).

The taken for granted nature of the perception of the NA role then appears detrimental for both the student and the NA. There seems to be a benefit in bringing this relationship to the attention of those involved in order that a more accurate understanding be reached.

5.4 Progressive mastery-Students learn to manage the complexity of influences on their clinical development

5.4.1 Student nurses develop mastery over a complex learning environment

Student nurse learning is a complex process complicated by the need to frequently fit within established clinical teams. The capability of the student to manage these recurring transitions is influential on the quality of the learning experience and their sense of control over their learning is considered to develop as they progress through the programme. This sense of control includes the development of strategies to manage the need to incorporate themselves successfully within those teams and the evolution of their engagement with NAs is considered part of this process.

Table 15. Progressive Mastery

Super ordinate theme	Group theme	Group	Emergent theme	Participant
Progressive mastery **Students learn to manage the complexity of influences on their clinical development**	Students need to drive their own learning, and this gets easier with experience	S	Autonomy in learning comes with experience	S1
			Workload allocation has multiple drivers	S2
			Left to create own learning- abandonment and a need for structure	S2
			Students shape their own learning (and NAs are valuable resources)	S3
	There are varied factors contributing to student nurse learning	M	Student seniority shapes learning need	M2
			Student learning is complex and controlled by nurses	M2
			Students can impede learning	M3

5.4.2 Autonomy in learning comes with experience

It was clear from each of the students involved that they expected a gradual burgeoning of autonomy in shaping their learning as their programme progressed. The year one student saw this as something to aspire to, while the final year student was able to reflect on how this emerged from an increased understanding of healthcare delivery and a growing confidence in their own abilities. This growing capability is facilitated by the clinical area through a reduction in direct monitoring and an encouragement for the student to practice more independently. S1 explains how this is understood by a final year student;

"I would say I was a lot more independent this time of being there, because it was our base the previous times I would have been much more closely supervised, sort of on a decreasing scale from my first time there to my last time there, emm but I would say this was, this was the most independent that I had been practicing". (S1 / box 12).

It wasn't only the students who considered a need to recognise the importance of accommodating their developing abilities. There was a consensus across all groups that expectations of students related to the year group to which they belonged. As a consequence, it was understood that their progressive independence as practitioners should be facilitated through a matching reduction in the extent of the supervision and direction they would be given. While this was accompanied by what was seen as a shift away from NA influence, this was not a complete disconnection. Even for more senior students who have responsibility to manage their own caseload and to an extent schedule their own workload, NAs appear to provide significant direction in the practicalities of this. N2 describes how they guide more independent students to schedule workload in a way that enhances their learning;

"I think see that you know you're saying they need to be prepared, they need to be organised, don't just say to that person in there I'll join you because I know you want to get as much as experience but you need to give yourself a break in between patients. Because then you'll be like that when you go to the next one you're not taking it in, you're not taking it in (emphasis), so I'm very, I'm quite eh…don't just say aye I'll do that, I'll do that because you won't be taking it in, you're not learning properly". (N2 / box 37).

While the burgeoning autonomy of students is recognised then, and indeed expected as the student's progress through the years of their programme, there is still a role for NAs to contribute to their clinical development. From N2's comments above it is apparent that interested NAs continue to guide students even in the more independent stages of their training.

5.4.3 Workload allocation has multiple drivers

There was an interesting scope of influences shaping the students' workload, both that allocated to them and that seen by them as having importance. The nature of the clinical area obviously shaped the learning opportunities available and for S2, who was placed within an older adult admission and assessment setting, some days involved repeated exposure to admission assessments. This is described as;

"…the week that I did my diary we had about 7 new admissions that one week, so it was a much busier week in terms of paperwork than the rest of my placement had been". (S2/ box 3).

The needs of the clinical area then shaped the learning experiences for the student and where possible they married this to their agreed learning plan. While this provided the overt influence on the students work there appears to be a less obvious, though still significant concept that shaped the emphasis placed on the activities students were expected to undertake; the importance of hard work in direct patient care.

Each of the groups made reference to the areas of the clinical environment associated with clients as "the floor". This was noticeably separate from the domain of the RN; "the office". This metaphorical association with industry (factory floor), or even simply the demarcation between manual workers and office staff within such a setting, sees students understand an emphasis on evidencing that they are working industriously and directly with clients in order to gain acceptance. Working hard was linked with the physical tasks involving direct patient contact seen as in the main the responsibility of the NA, and was considered as something to strive for. S3 identifies here why the NA role appears more attractive;

"…they know more about the patients as well because they're kind of never really in the office too much, whereas the trained staff are in the office doing care plans and updates, so the NAs are on the floor constant, so they do know more kind of what the patients like, if they are feeling a wee bit agitated, what calms them down, so I find that useful. I like to one to one, I actually quite like the NAs job better than the staff nurses job, well that's how it appears to me, like you're on the floor, your with the patients, being a trained you're in the office more". (S3/ box 9).

It could be argued that, as students, the need to evidence industry and graft should be secondary to the development of the practical understanding of the application of theory within the practice setting. To a staff group excluded from discussions around the students' programme however, the obvious indicator of the worth of a student is in their observable performance. Students understood that, for NAs, the student's worth to the team seems related to their motivation to muck in and support their colleagues, and that this was an influence on the level of acceptance the student achieved within the team. S1 describes how this has influenced this senior student's practice whilst on placement;

"…I think they definitely enhance your sort of emm, like work ethic on the ward, I would say like there's always a kind of gripe among healthcare assistants that they do all the dirty work kind of thing and I think like knowing that as I said before would influence my practice in future, you know like when you've got time you pitch in". (S1/ Box 24).

Interestingly, while still using the same language to describe the breakdown of the clinical environment, the NAs did not express the limited understanding of the students' educational goals that was ascribed to them. The NAs here showed strong recognition of the need for students to learn and develop their practice, and were very keen that this entailed the skills and tasks associated with the RN role.

5.4.4 Left to create learning; abandonment and a need for structure

The placement learning process left the student nurses feeling vulnerable as they were repeatedly allocated to clinical environments where both the resident team members and the local processes were new and unfamiliar to them. The early stages then of novel

placements generated significant uncertainty on the part of the student. In some cases, this seemed to arise as a result of dual priorities that created a dissonance that generated insecurity. Students felt compelled to contribute to the work associated with the area through the completion of routine tasks, and at the same time knew they were expected to undertake the role of learner. S3 describes the experience of one such placement;

"I went on community which was very alien to me, and I was really "what will I do, what would you like me to do?" And maybe because it's not so quite hands on, I felt like I hadn't been to work, I usually feel like I'd been to work, whereas its, …I feel more…a hindrance because I don't really know what I've to do, it's not their fault, like they say "no, no you're not meant to be doing anything, you're here just to watch, you're here to learn". (S3/ box 57).

This level of alienation referred to by S3 was identified by another student as well, and both placed significant emphasis on this feeling, suggesting that it in many ways was influenced by the level of acceptance they received from the clinical staff within the placement area, particularly the NAs. S2 describes both the balance believed to exist between acceptance and abandonment, and the fine line students tread in order to fit in;

"…as a student its difficult going in and em, like you don't want to upset, rock the boat and tread on people's toes…". (S2/ Box 18).

The same student was clear of the consequences of failing to fit in with the clinical team, with the NAs in particular;

"…because a lot of my time in the lounge was spent with them, if they had kind of cut me out then it would have been very difficult, very difficult". (S2/ Box 37).

Believing that they were often left isolated, including by their mentors, and particularly at the start of placements in areas new and unfamiliar to them, students' were then driven by a need to engage with the team, as well as to achieve their defined learning goals. These objectives then encouraged the students themselves to take responsibility for their own learning.

5.4.5 Students shape their own learning

Far from being only passive recipients of an educational process over which they have no influence, student nurses recognised the need to actively shape their own development within clinical settings, and this includes how they work to incorporate NAs within that process. There were several reasons given by the students as driving this; feeling abandoned, lacking external direction and even experiencing a sort of passive resistance to their involvement were all mentioned. S2 comments on one notable example, emphasising why there was a need for students to grasp the nettle and take control over their learning within the clinical environment;

"what I found difficult sometimes was though was if they (NAs) were managing themselves, they would sometimes, for example like with personal care in the mornings they would pair up and they would go to this patient, and me wanting to learn would want to go with some of them and well say can I come and do this with you, and they are like, "we are fine with just the two of us" and it wasn't so much that I didn't think they could do it with just 2 of them, it was just, it was just that I needed to be with someone to learn how to do it, but quite often it would be a case of "no we don't need you here", "we don't need you here" so I'd spend the morning just trying to find someone that would say "yeah, come with me and I will show you"." (S2/ box 17).

Other students had a more confident sense of control within the clinical learning environment. This manifests in a strong sense of purpose and a drive to find what needs done and do it. This perspective though suggests a more receptive response from the practitioners approached for help.

"so I'll go in and just get started with what I know needs done and then once the patients are all organised and X's (Name of practitioner removed) there, that's her time, I'll go and see the mentor, if he wants me to do anything I'll do it, if he doesn't I'll go in with X, so it's just kind of sussing out what you think needs done ". (S3/ Box 55).

This enhanced sureness about self is possibly due to that student's more advanced stage on the programme, to their prior experience as an NA or even because of their age (the more confident response was given by a student around 10 years older than S2). The

development of experience therefore seems influential in bolstering the student to feel confident about taking control over their learning.

5.4.6 Student seniority shapes control over learning.

The students questioned suggested a developing autonomy associated with their stage of training. As the student progressed from year to year so the programme guidance for clinical placements set out expectations detailing requirements for the student to become an increasingly independent practitioner, and this included taking control over their learning experience. This sense of independence is strongly evident in this comment made by S1;

"…although I was with nurses it wasn't really like I was being supervised by them. We were just, maybe writing our notes together or, you know so that's who I was with at the time, it wasn't necessarily that they were supervising my practice or anything". (S1/ Box 5).

This shift of control over the organisation of the students learning is also recognised by mentors who are tasked with facilitating the growth of student independence while remaining within the guidelines governing their involvement. M2 is keen to emphasise adhering to these rules while explaining that their student had taken on responsibility for organising the shape of their own placement learning;

"She is a third year student, she is in her last placement, you can give her a bit of leeway and let her sort of plan her own, do her own thing, as long as I thought I was hitting where I should be with the targets around meeting my time with her". (M2/ Box 13).

This increasing sense of student control impacted on NAs as it was closely linked to a move for students from focusing on practising the skills associated with NAs, towards an emphasis on learning the role of an RN. Each of the groups recognised this progressive change, and there was an understanding that as the students developed this autonomy there was also a need for them to work less frequently with NAs and for mentors to increase their contribution to the student's development through more indirect support.

5.4.7 Student learning is complex and controlled by nurses

While the importance of the NA role in student nurse education was acknowledged across each of the groups questioned, it was also evident that control over that learning experience was very much seen as residing within the domain of the RN. For mentors the coordination required to organise educational experiences that meet the students learning needs was considered complex and best served through the pivotal mentor role. Mentors saw themselves as responsible for utilising their NA colleagues, and others, within this process. M2 explains their immediate decision making routine for this;

"A lot of the times they (students) have identified in their learning outcomes as well, I still need to do X, Y and Z or want to do more of X, Y and Z and you can see right away well the nursing assistant does that, or I don't have anybody on my caseload who does that but the nursing assistant does". (M2/ box 23).

Mentors were not the only group who accepted their prominence in student education. NAs made no claims of ownership for student experience, frequently seeing themselves as contributing to a team effort to support the student. While they appeared content to be directed in their involvement with students in relation to the formal programme requirements, they did often take the initiative to guide students informally when they saw them at a loose end. Official control however was accepted as the mentors.

5.4.8 Students can impede learning.

It could be assumed that as individuals who have voluntarily undertaken a programme of study, student nurses would show a consistent and committed motivation to engage with learning opportunities offered, particularly those identified as key for their progression. The participants within this study identified that this was not always the case, and that for some students what they saw as a dichotomy existed between the roles and responsibilities of NAs and RNs, and this at times could negatively impact on the students learning. The NAs approached recognised a general acceptance and willingness from students to engage with them during placements where the NAs saw themselves as contributing to the students understanding of a wide scope of clinical, organisational and interpersonal skills. There was

a smaller number of students however, identified by each of the groups as having a reluctance to accept NA input, and often this was because they did not appear to identify the tasks associated with NAs as being relevant to them, or to their learning needs. This group was sufficiently small in number to make those within it noticeable and indeed memorable to their mentors. M4 recalls one such individual;

"we've had some students that aren't even receptive to learning from staff nurses so…and we have, oh there was one student a couple of years ago who…who emm…she made a comment and the comment was "a but they're just a nursing assistant"…and that alienated herself from all of our nursing assistants, and they didn't feel they wanted to support that student". (M4/ box 43.

Students themselves recognised that some of their peers gravitated more strongly towards what they perceived to be the nursing role. As described above this was most frequently associated with administrative tasks including care planning and the completion of necessary documentation, the administration of medicines and the coordination of multi-professional communication, often within multi-disciplinary meetings. Interestingly there was a geographical aspect to this, with the nursing role perceived as taking place most frequently within the nursing office, and to a lesser extent the treatment room. This meant an absence from client areas, or as it was often termed; "the floor". S3 described one such student that she had worked with, questioning her values and educational goals;

"She spent the whole three weeks watching me, not actually doing anything, and I thought well…it maybe isn't a good thing, not being part of the NA system, because she's kind of, in my head she's there to do the paperwork, she's there to do the medications, she's there to maybe be a psychiatrist". (S3/ box 42).

The NAs were the least vociferous of the groups to express dissatisfaction around student attitudes to their contribution towards the students learning, indeed they frequently described the response from students as exemplary. There was some recognition from them though of the perception of a separation of roles between NAs and RNs, and a consequential reluctance from some students to engage with them, or in tasks they associated with NAs. N3 describes this;

"Well you do sometimes get students who, who are maybe quite ambitious to get…you know their perception of the job is maybe more that the… that it is, became more administrative, and their more keen to learn that particular kind of…maybe I would call it getting up the ladder kind of, kind of thing, you maybe eh whereas there is other students who are very good. They see the role, they see the role that you want to play as being hands on kind of things". (N3/ box 22).

N3 obviously then seeing the administrative focus as representative of a promoted role or of a motivation from the student to attain what could be seen as an elevated position within the organisation. It could be extrapolated from this that N3 may understand the role NAs fulfil, and the tasks they are responsible for as less important in the eyes of the organisation.

In light of these comments it seems reasonable to expect that a variable number of student nurses will show a lack of enthusiasm to take full advantage of all learning opportunities offered within their clinical placements. A hopefully small number of them will be, as described by M4 above, as being unwilling to learn from even the RNs mentoring them, the reasons for this being open to further study. A more significant number however, are likely to see the NA as undertaking tasks that are out-with the expectations they have around the skills required to qualify as an RN, or may see NAs as lacking the qualifications that would confirm their acceptability in contributing towards the student's clinical development, and would be therefore, less likely to engage with them whilst on placement.

Chapter 6 Discussion and conclusions

6.1 Introduction

The findings chapter identified the key perspectives around the role of NAs in the clinical development of student mental health nurses as understood by the NAs, mentors and student mental health nurses who participated in the study. In addition, patterns emerging from those perspectives enabled clarification of differences and similarities across the individuals and groups involved. Developing from that, this chapter will explore those findings, considering them in relation to relevant literature in seeking explanation for the generation of the themes that emerged and of the influences on the sense making of the study participants that shaped those themes. Core to this critical review will be a reconsideration of the research questions presented in chapter 3, ensuring that they have been sufficiently addressed.

The research questions were set out to identify both the nature and form of the influence that NAs bring to the clinical development of student mental health nurses, and how this is understood by people in the roles most closely associated with that relationship; nurse mentors, nursing assistants and the students themselves. This chapter could follow that order in addressing the findings, responding to each of the research questions in turn and providing a critical discussion around each. This approach would however negate the wider perspective facilitated through the involvement of participants from each of the groups, by compartmentalising the responses obtained.

The use of Interpretative Phenomenological Analysis as the guiding methodological framework for this research encourages consideration of a phenomenon from the perspective of the individual and from the groups who share their experiences (Palmer et al, 2010). This recognition of the interplay between individual and group is also core to the social constructivist viewpoint (Knowles, 1984) that frames the epistemological underpinnings of the study, and to the sociological concepts of figurations (Quintaneiro, 2006), sociogenesis and psychogenesis (van Krieken, 1998) that help guide the exploration of the findings. These sociological theories are elements of the relational approach to the

study of society postulated by Nobert Elias (Hughes, 2013), who's work emphasised the relationships between individuals and groups, and the impact this interaction has on the generation of change within societies (Heinich, 2013). Elias argued that as societal change was continuous, sociological investigation should move from consideration of the notion of fixed societal structures, and focus instead on the changes within power relations between individuals and social groupings that occurred within the change process (van Krieken, 1998). This chapter will therefore be framed via the themes that emerged from across the wider pool of participants, and through both the diaries they completed and the comments they made within the subsequent individual interviews. Each of the themes that emerged will therefore be discussed in turn before a cross theme summary draws them together. This chapter will close with a review of the efficacy of the research methodology applied and consideration of the outcomes off this study in relation to practice development and further research.

6.2 Obligation drives involvement

In addition to confirming the findings of earlier research, which recognised that NAs provided significant input to the clinical development of student nurses, this study also identified the reasons driving this contribution within mental health settings, in the support of student mental health nurses on placement. The initial theme emerging indicated that there was an expectation for nurses and NAs around involvement in supporting students on placement within their clinical team. This expectation was linked to a sense of team responsibility; a belongingness, with the shared goal of successful student development driving this sense of obligation to contribute towards the student's educational progress.

6.2.1 Working together, as a team

Modern Western healthcare is increasingly delivered via a variety of professions and other staff groups working collaboratively to provide comprehensive care through the formation of cohesive and productive teams (The Scottish Government, 2014). In recognition of this the regulatory body for nursing in the UK clearly stipulates the need for nurses to work

effectively within clinical teams (NMC, 2015) and mandates the attainment of the ability to perform as a team player within the standards of education set for nurse registration (NMC, 2010). Learning to work effectively as part of a team is therefore instilled at an early stage of a nurses' career and remains a priority throughout.

The influence of individuals on team efficacy well established (Adair, 1983) and team efficacy in healthcare is associated with the quality of care delivered (Aase, Aase & Dieckmann, 2013), including nursing care (Watson, 2015), and is linked to job satisfaction and retention rates for staff as well as the likelihood of staff burnout (Kalisch, Lee & Rochman, 2010). Burnout is described as a condition presenting as reduced individual performance, emotional fatigue and depersonalisation, and is globally considered a significant problem affecting clinicians and the quality of healthcare provision (Henson, 2016). There is an obvious symbiosis therefore between the wellbeing of the individual team member and the efficacy of the team, and the study participants who were permanent members of their clinical teams confirmed a grass roots understanding of the crucial nature of teamwork. While both the mentors and NAs questioned in the study strongly emphasised the differences between them and the other group, they also emphasised the benefits and importance of the fit between both, and its relevance to the performance of their clinical team.

Teamwork is emphasised as a core contributor to good quality healthcare by the organisation that shapes the strategic direction of nursing and nurse education in Scotland; NHS Education Scotland (NES) (NES, 2016). Defined as a Special Health Board, NES have responsibility for meeting the educational needs of developing health priorities (NES, n.d.a), and they accomplish this via their links with Health Boards and with the institutions providing nurse education in Scotland. The message transmitted to health board staff via their employers, and to student nurses via their programme content, routinely then emphasises the importance of teamwork, with many of the performance indicators used in the sector including this as a measured variable of performance, (for example the Scottish Government's Clinical Quality Indicators (2008)). The value of teamwork is therefore a message that is continually promoted to NHS teams in Scotland by the organisation with recognised responsibility for quality assurance and is an obvious priority for all NHS staff (NES, 2016), and for the students whose placement experience frequently sits within the

NHS environs. This is however only one of the influences promoting teamwork within the healthcare setting.

The social science theorist, Norbert Elias, emphasised the social nature of humanity, postulating that our very existence is defined through our relationships with others (van Krieken, 1998). In nursing this is strongly apparent in the importance attributed to fitting in with the clinical team, and specifically with the nursing team, a concept referred to as belongingness (Vinales, 2015). Belongingness is a context influenced and individually interpreted sense of acceptance and relatedness to a group that involves sharing the core values, beliefs and behaviours of that group (Levett-Jones & Lathlean, 2009).

The strength of a sense of belongingness is associated with individual well- being, and its absence linked to reduced self-esteem and increased anxiety and distress (Mohamed, Newton & McKenna, 2014). Belongingness manifests in a sense of recognition from colleagues, connectedness with the work environment, positive relationships with co-workers (Mohamed et al., 2014) and a sense of self efficacy (Vinales, 2015). Nurses have been shown to attribute more importance to fitting in than members of other healthcare professions (Hood et al., 2014) and NAs most frequently report a lower sense of feeling valued, a key component of belongingness, than RNs (Watson, 2015).

It has been suggested that this reduced sense of worth in NAs may be attributable to what Goosen (2015) describes as a lower occupational ranking. Starting from what is perceived to be a lower status position than RNs, NAs are associated with less occupational influence and power (Kalisch et al., 2010). It could be expected that it would be more difficult to develop a shared sense of overall purpose in a sub- group of workers who are noticeably disadvantaged in this way. NAs could understandably therefore feel less connected and be less engaged with tasks not readily seen as falling within their domain of responsibility, such as contributing to student nurse education. Such reluctance was not the usual experience of the study subjects.

That the NAs in this study were unquestioningly committed to the educational advancement of the student nurses placed within their clinical service suggests a well- developed sense of belongingness, and this came across in their interviews, as did the ongoing impact on this of practice change. This developed sense of shared purpose was not seen as a completely

universal position however, and there was recognition of reluctance in some NAs to get involved in student nurse education. Such individuals were referred to by participants as old fashioned and not representative of their clinical teams, or of the wider workforce. This lack of motivation was recognised across various staff groups and in fact examples were given of RNs who were reluctant to engage in student support or education and of student nurses who appeared reluctant to learn while placed within clinical settings. Kalisch, Lee and Rochman (2010) suggest that a lack of attachment to their clinical team has a negative effect on a nurses' engagement in the achievement of team goals and may provide a rationale for this, at least partially self-driven, disenfranchisement.

To provide some context for this lack of engagement, RNs are expected to routinely undertake the mentorship role including completion of the required post-registration qualification (NMC, 2008) and unlike comparable professions such as occupational therapy, will do this without financial reward and often without workload reconfiguration to accommodate study or student support time. NAs in comparison are corralled into involvement without full inclusion within the process or any significant preparation or support for the role (Hasson et al, 2012). As for students, the quality of student nurse learning within the placement setting is dependent upon their need for a sense of safety and security, factors that they don't always perceive as present (Levett-Jones & Lathlean, 2009). In fact, each of the groups referred to here, requires a belongingness to the team and to the educational process in order to become fully engaged within it, and impediments to their sense of belonging are likely to impact on their involvement in student nurse learning (Levett-Jones & Lathlean, 2009).

For nurses to feel they belong within a clinical team they require a sense of acceptance, an understanding of shared interests and recognition of the value of their place within the team (Mohamed et al., 2014). To achieve this level of cohesion requires training, education and team processes that include and combine each of the staff groups involved (Kalisch et al., 2010). This process is supported through clearly identified roles and responsibilities and the understanding of a common purpose (Watson, 2015).

In addition to the role of training and education in fostering the conditions amenable to the generation of this sense of belonging, clinical leadership has an obvious importance. Defined as a high priority in the development of services delivering high quality healthcare,

NHS Scotland has identified the need for clinical leaders to be motivated, talented and enthusiastic nurses (NES, n.d.b). Theories of leadership associate the qualities of the team leader with the generation of a sense of worth in team members and a consequential enhancement in the achievement of the team's goals. Adair (1983) promotes a tri-pronged approach to leadership that involved fostering development of the individual and their sense of team membership in order to achieve the intended task, which in this case includes the delivery of good quality care and the provision of a receptive learning environment for student nurses. Adair considers the fostering of a common goal as key within this process.

The understanding of a common goal of producing a good quality learning experience for students was a recurring theme emanating from the NAs questioned, and was given frequently by them as the reason they contribute to student nurse education. While this belief was also voiced by the RNs, who shared the expectation that the NAs would routinely participate in this process, the other of the conditions for the generation of a sense of belongingness, clear role definition (Watson, 2015) was less predictable or precisely defined. The delineation of responsibilities between the NAs and RNs was often referred to in a way that suggested confidence and clarity about differentiating who was expected to do what. When examined the reality of this however was far from clear cut and its application was not always immediately justifiable.

6.2.2 Different roles

Management consultant John Adair (1986) describes the essential requirements for the formation of a team to be common purpose and complimentary contribution from its members, adding that effective teams utilise these constituent components to achieve their aims in an efficient manner. The complementary nature of the relationship between different staff groups would therefore be significant in the delivery of comprehensive, high quality healthcare and this is reflected in the current project driving the development of patient care in Scotland; The Scottish Patient Safety Programme. This programme promotes cohesive collaboration between all groups contributing to multidisciplinary mental health care (Healthcare Improvement Scotland, 2016), recognising that care is most effectively

provided by combining the talents of practitioners from a variety of clinical and ancillary backgrounds.

The participants in this study were confident in describing a generally clear delineation of responsibilities between the NAs and the RNs working within the same clinical teams. This common perception of well-defined roles was accepted across the variety of clinical specialisms and can be loosely categorised into more overtly manual or patient facing tasks associated with the NAs and more complex responsibilities that fell within the domain of the RN. This work pattern was recognised as early as 1996 when Workman described an association emerging between the RN role and paperwork completion, creating a distancing of RNs from patients. This perception however jars with a recent report compiled on behalf of the RCN, which while differentiating between the roles on the basis of responsibility and decision making, clearly sets out expectations that both groups would share involvement in the hands on delivery of nursing care (Hand et al., 2013). The difference in levels of assumed responsibility critical here, in that they contribute significantly to the justification of the different career trajectory available and to the levels of pay allocated, to each of the roles (NHS Employers, 2015). The impact of this change in work practices however extends beyond pay and promotion, and has significant consequences for student nurse education.

As the NMC also determines that student nurses must acquire competencies in all common aspects of essential care (NMC, 2010), so the assumption is clear that as qualified RNs they are expected to take responsibility for the assessment, planning and evaluation of nursing care, whilst also engaging in the implementation of that care. The participants within this study suggest that such engagement was often the exception rather than the rule, especially around completion of the routine essential car tasks. There is evidence that such change commenced with the introduction of NAs into the UK nursing workforce.

The introduction of NAs into clinical teams was accompanied by an associated reconfiguration of work practices in the RNs working there (Chang, 1995) and is considered to have engendered an unsettled response from the RNs they worked with (Atwal, Tattersall, Caldwell & Craik, 2005). This adjustment included a reduction in the number of nursing tasks completed by RNs (Chang, Lam & Lam, 1998) and while RNs have voiced disquiet that this process has resulted in a reduction in the quality of care delivered (McGillis- Hall, 2003), the impact was seen beyond the constraints of the clinical

environment. Public concern was raised over these issues in the media furore around the "Too posh to wash" debate that took place at the RCN conference in 2004 (Scott, 2004), and while this motion was voted down at that conference, dissenting perspectives were outlined in print almost immediately afterwards (Hancock, 2005), and have continued since (Allan & Smith, 2009: Griggs, 2011).

These concerns are not without merit as ninety percent of NAs in one study reported they were delivering nursing care through the completion of clinical care tasks (Thornley, 2000), leading authors like Fowler (2003) to speculate that the roles of NAs and RNs were diverging. Such developments are considered to have contributed to a sense of role uncertainty associated with increased anxiety and decreased attainment in RNs (Workman, 1996). This phenomenon attributed to the concept of role ambiguity (Atwal et al., 2005).

Role ambiguity in nursing is a situation that occurs when employing organisations provide vague, ill- defined, and illogical role expectations for employees, often without reflecting their actual capabilities and current duties (Tunc & Kutanis, 2009). As employees are more satisfied with their work practices when these are clearly defined, this uncertainty can contribute to the generation of what has been termed role conflict, which involves a competing crossover of expectations across individuals and groups (Fain, 1987).

Both role ambiguity and role conflict are suggested to be detrimental to the individuals experiencing them (Shead, 1991) and to the organisations employing those individuals (Tunc & Kutanis, 2009). For individuals this manifests as low levels of job satisfaction, increased anxiety and distress (Fain, 1987), loss of motivation, a curbing of ambition (Tunc & Kutanis, 2009), burnout and increased intent to leave the profession (Shead, 1991). For employers the consequences are dissatisfied employees and the likelihood of higher staff turnover rates (Murray, 1983).

While role uncertainty and ambiguity in nursing is recognised as arising as a result of the interaction nursing has with other healthcare professions (Atwal et al., 2005), it is evident that it also emerges from within nursing itself. McGillis- Hall (2003) identifies role conflict arising within groups comprised solely of RNs, while Harmer (2010) raises concerns about the effect on the role of registered nurses of what she describes as the drive to delegate elements of the nursing role to NAs, a move associated with the academically orientated

hunt for professionalism that nursing has engaged in since the 1970s (Wilson- Thomas, 1995). With Murray (1983) identifying that public perceptions of what actually constitutes nursing as composed of images of a hands on carer, and the role of the RN gradually moving away from this, so the dissonance arising around the expectations for student nurses is clear. Murray's study identified this very conflict as a major cause of distress for student nurses.

The conditions defined for the generation of a sense of belongingness and outlined above include a need for role acceptance for buy in to a shared purpose or goal (Levett- Jones & Lathlean, 2009). With the RN role seen as generally shifting to a more managerial, coordination focused position (Harmer, 2010) so concerns must be raised that it is growing ever distant from the idealised image presented by Murray as common amongst prospective and neophyte nursing students. With the preconceived image of nursing an important influence on how, and indeed whether student nurses negotiate the complexities of their programme (Hamshire et al., 2012: Gillespie, 2013), this change has significant consequences for student nurse education, and for those undertaking and those delivering that process. This shift in who delivers face to face support is not unique to nursing and may reflect a wider trend in the delivery of public services.

The results of this study confirm that NAs are frequently involved in more of the delivery of hands on, face to face care, than the registered nurses who are the most qualified for it. This mirrors concerns raised around the role of the teaching assistant within the school setting in England and Wales, whose introduction saw them replace qualified teachers in providing most contact to the more vulnerable children in the class, the opposite of the original intention of the initiative (Rubie-Davis et al., 2010). In nursing this can either be seen as an evolution of registered nurses into a managerial coordination and specialist role, or as a devolution of responsibility for the delivery of hands on care to a group who are less well prepared for the role (Harmer, 2010).

This perception of occupational recognition based on the level of qualification, skill and responsibility associated with job roles in the NHS is encompassed within the knowledge and skills framework, the structure that informs pay and conditions within that organisation (NHS Employers, 2015). Thornley (2000) suggests that the extent of the role fulfilled by NAs is under-reported and frequently largely invisible to employers, so official recognition of

their abilities is missed by both their employers and in relation to student nurse education (Hasson et al., 2012). This hidden responsibility for care delivery complicates clinical practice for student nurses on placement.

Within this study the difference in expectations between NAs and RNs was so clear that each of the groups participating defined the different areas of the clinical environment in relation to the group they associated with working there. NAs were seen as responsible for patient facing areas such as dining rooms, patient's bedrooms and patient leisure areas and RNs were associated with clinical areas such as treatment rooms and offices. This association relating to both the amount of time the group was expected to spend within the area and to the tasks they would undertake whilst there. Students were then faced with the dilemma of choosing which group to spend their time with. The location impacting on the tasks the student would then be most likely to engage in. The participants in this study seeing this delineation of tasks, location and responsibilities however, as generally complementary for the provision of team focused care.

6.2.3 Cohesive differences

Conflict is not a state conducive to the provision of a productive and enjoyable working environment and Kalisch et al. (2010) have identified an association between group cohesion and employee satisfaction within nursing teams. The evolution of the expectations around the roles of RNs and NAs discussed above, highlights that conditions likely to produce such conflict are routinely present within clinical nursing teams. The experiences of the nurses participating within this study suggest that any such conflicts are however largely negated by the importance attributed to their sense of team membership and shared team purpose. This is important as the extent of the sense of collective endeavour within clinical groups has consequences for both the psychological health of individual team members and for the quality of the care they deliver (Watson, 2015).

Despite the concerns raised around role conflict and role ambiguity in the paragraphs above, there is no evidence of any conscious competitiveness amongst the participants within this study. This is important as rank related disagreements are considered common within nursing (Goosen, 2015). The developmental opportunities available to both RNs and

NAs within the study were seen as ultimately beneficial for the team as a whole, and would consequently contribute towards general improvements in care delivery. These altruistic sentiments have been echoed elsewhere.

The initial expansion of the NA role within the NHS occurred in order to support the major step towards professionalism for RNs that was the shift of nurse education into the higher education environment (Bach et al., 2005). More recent developments for both groups are considered to have been responses to wider developments in healthcare delivery (Matthews 7 Bedson, 2014) initiated for the purpose of enhancing the quality of care available (Hancock et al., 2005). The forces driving these changes are discussed below however there is evidence of an ongoing dynamic of progress amongst all of the groups involved in healthcare provision in the UK and beyond (Brannigan, 2010). Within this movement each group is seen to respond to advancement in the others by furthering their own development and the NA developments appears to be filling gaps left as RNs upskill or take on more managerial responsibilities (Hancock & Campbell, 2006). The ongoing collaboration between these groups is crucial as these changes are currently set against utilisation of a multi- agency, multidisciplinary mode of healthcare delivery (Scottish Government, 2010).

Stark, Skidmore, Warne and Stronach (2002) advocate that multidisciplinary teamwork has developed to be the preferred form of service organisation within mental health care in the UK. While nurse education includes significant focus on developing practitioners capable of fitting within this model of teamwork (Hood, Cant, Leech, Baulch & Gilbee, 2014), similar preparation is not a current requirement of the NA role (Hayes, 2014). Despite this the importance of the NA contribution within multidisciplinary services is well established (Stonehouse, 2013) and their importance to multi- agency care strongly recognised (Cavendish, 2013). Some authors even ascribe them a position as the most important contributors to multidisciplinary care due to their prominence in the delivery of face to face nursing (Oeseburg, Hilberts & Roodbol, 2015).

Research studies investigating the motivation of NAs undertaking development programmes have consistently identified practice development as the driving force behind their involvement (for example Carr, 2015: Keeney et al., 2005). This suggests that the purpose of these developments is complementary and compensatory in the delivery of modern

healthcare, not competitive with other relevant groups. In fact, Stokes and Warden (2004) advocate that as opportunities for such role enhancement have arisen as a natural response to similar progress in other healthcare professions, therefore adequate support is required in order for this group to fulfil their potential as a key component of a comprehensive health delivery system. Clear and robust cohesion between the expectations of NAs and RNs is of significant importance to the students who spend significant periods of time learning from both groups. As nursing roles continue to evolve so understanding is required of the contribution of both groups towards meeting the students learning needs, including identification of the reasons that NAs involve themselves within this process.

6.2.4 Collaborating to help the student

The consensus in team acceptance of the need to support student education can be attributed to a concept strongly associated with the sense of belongingness explained above. Social Capital is a theory applied in settings as diverse as municipal government (Jacobson & Sowa, 2015), community participation (Araten- Bergman & Stein, 2014), suicide rates (Recker & Moore, 2016) and healthcare (Brown, 2015). It is based on the understanding that communities and smaller groups have social resources in the same way they have physical resources like buildings and equipment (Sheingold & Sheingold, 2013). These social resources relate to the extent of mutuality, or connectedness between community or group members, such relationships providing resources through which the community develops, achieves its goals or faces adversity (Read, 2014). In this case supporting students during their practice placements meets those requirements as it is suggested to be believed beneficial by team members because of local cultural beliefs around valuing what students bring to the team and as a medium through which to promote recruitment (Hegenbarth, Rawe, Murray, Arnaert & Chambers-Evans, 2015). Brown (2015) details the required conditions for the generation of social capital as trust, sanctions, reciprocity, obligations and shared expectations and understandings. In nursing social capital is associated with positive outcomes for patients, healthcare providers and nurses (Read, 2014).

Grootart, Narayan, Jones and Woolcock (2004) identify three interrelated phenomena through which social capital can be measured; bonding, bridging and linking. With the first two of these features relating to the ties that connect a group and the connections between group members of similar status (Sheingold & Sheingold, 2013), it is the third that is of most interest in relation to this study. Linking considers the cohesion between group members and factions across different strata's in rank, power and status (Grootart et al., 2004). With social capital considered influential on knowledge sharing in nursing (Chang, Huang, Chiang, HSU & Chang, 2011), the influence of the relationship between RNs and NAs then seems crucial for fostering a clinical environment supportive of student nurse education. The participants within this study advocated that such a sense of shared enterprise currently exists, although the NAs in particular were cognisant of frictions arising as a result of changes in their levels of responsibility, and the mixed acceptance of that. It is worth considering then, the forces that support NA involvement within student nurse education.

6.2.5 Being part of a team drives NA input within student education

It was clear that each of the participants believed that NAs were expected to contribute to the clinical development of student mental health nurses during their clinical placements. Refusal of this role was recognised as occurring in only a small number of what was seen as out of sync, unrepresentative and isolated individuals. The NAs questioned readily accepted this responsibility, seeing it as their contribution towards the achievement of one of the team's goals, just as they would with the goal of delivering good quality patient care. As this expectation of involvement was shared by each of the groups studied, it is important to explore the reasons behind this presumed participation.

6.3 Presumed participation

NAs contribute significantly to the clinical development of student mental health nurses during the students practice placement experiences. Their involvement with students includes self -driven efforts to ease the student's transition into the placement team as well

as fulfilling team expectations around student support. The expectations around their involvement includes taking responsibility to support and supervise the students learning for large spells of the working day and role modelling and supporting the student through delivery of an array of caring, clinical and interpersonal skills. Changes in the NA role mean that this scope of skills is expanding.

6.3.1 The developing NA role

Developments since the publication of the Cavendish (2013) and Francis (2013) reports have substantially altered the occupational dynamic within nursing in the UK. The consequential formalising of recognition of the NA role through the application of nationally set minimum standards of preparation, and the accompanying government commitment to develop the NA role (DH, 2014), has seen an acceleration of the emerging independence of nurse clinicians who have not qualified through the traditional professional route. Importantly there is also now acceptance of the ability of the NAs moving in to the advanced practitioner (Hand et al., 2013) or nursing associate (UK Government, 2015) roles to undertake care more independently. This is a seismic shift that seems to facilitate empowerment of the NA workforce while undermining the traditional professional power base of registered nurses. This process sees parallel means of educational development emerging for those delivering nursing care, with the impending removal of bursary for those in nurse training in England and Wales (UK Government, 2016) making the apprenticeship based NA route increasingly more financially attractive there.

Public perceptions strongly influence trends in healthcare delivery (van Bekkum & Hilton, 2013) and media responses to the ongoing development of the NA role suggest shifting acceptance of this process. The furore driven by the “Too Posh to Wash” headlines that even made the broadsheets just over a decade ago (for example The Telegraph, 2004) focused on fears over the removal of trained nurses from essential care. Recent media reporting however has transformed the underlying message generated, with the emphasis now on the opportunities offered for the advancement of healthcare arising as a result of similar changes. The BBC headline “Train NHS staff” to plug doctor gaps, bosses say” (BBC,

2016) is an example of this change of emphasis and evidences a shift towards acceptance, even promotion, of this process.

In earlier studies NAs were credited with responsibility for the application of a wide range of often advanced physical care skills including the monitoring of temperature, pulse respirations and blood pressure (Bach et al., 2005). More recently they have been associated with undertaking more complex tasks such as glucose monitoring, wound care, specimen testing and the application of electrocardiography, as well as providing emotional support to patients (Hasson et al., 2012). With the Hasson study also suggesting that the NAs were teaching those skills to student nurses within physical care settings, there is an obvious need to understand the current scope of the NA role in order to ascertain the areas of influence they are likely to have on the development of student mental health nurses, a specialism previously missed within studies of this phenomenon. The participation of two NAs, who could be considered to be at the cutting edge of their occupation's role development, has provided this study with valuable insight into how such change is impacting on clinical care and student nurse preparation.

The findings of the current study show that individual NAs in mental health care have been working as advanced practitioners for some years, delivering highly complex interventions and consultancy to families and other agencies with what they considered minimal oversight from "senior" practitioners. NAs have been identified as routinely taking responsibility for managing administrative processes including admissions and security reviews, and are recognised as demonstrating expert interpersonal skills suitable for the successful management of crisis situations within high risk environments, while also meeting the bulk of the essential care needs of the clients and clinical teams they serve. Their role in the transmission of understanding of these skills to student mental health nurses is generally well recognised by their peers, though less so by relevant policy guidance. Recent legislative changes around the NA role seem to be providing belated formal recognition of their skills and may now lead to similar acceptance of their role in student nurse education.

This recent shift in role responsibility is being supported by a modification in perceptions around the acceptability of the changes, with this alteration evidenced via the tone of associated media coverage, within emerging policy guidance and through the motivation of individual practitioners to embrace the emerging roles. Elias's theories of societal

development provide a guide as to why this is occurring, and why the process is developing as a series of related processes and not in one defining coordinated movement.

Elias considered societal change a continuous phenomenon driven by an innate human drive for survival in the face of shifting environmental conditions (Goudsblom, 1994). With increasing recognition of the limitations inherent in the acceptance of traditional professional boundaries in the delivery of Western healthcare, it is obvious that any change that accommodates wider application of good quality healthcare is likely to enhance survival and recovery rates for common health concerns across the globe (McPake & Mensah, 2008). The phenomenon of task shifting sees an extensive attempt to spread the standardisation of effective, evidence based, Western healthcare, through the upskilling of workers in areas where there are insufficient staff trained via traditional routes (WHO, 2007). This development is mirrored in the current evolution of the NA role in the UK and is part of a modern worldwide movement towards enhancing health delivery that has been evident since the inception of the WHO in 1948 (WHO, 2016). This global shift fits well with Elias theories around survival driven change, and in particular that of civilising processes.

Elias identified two significant processes shaping societal change; civilising processes and civilising offensives (Mennell, 2015). Elias considered that change was guided through "civilising processes", which are unpremeditated cross generational changes in social understanding occurring over a sustained duration (Goudsblom, 1994). He also suggested that societal change was pushed by what he termed "civilising offensives" which are by contrast organised, planned and intentional (Goudsblom, 1994). In this case the changes in health delivery identified can be contextualised as both a civilising process and a civilising offensive. The process can be identified as being the long- term, sustained movement to implement Western culture across the globe; in this instance via the dissemination of the Western industrialised model of healthcare delivery, the offensive being the current task shifting phenomenon. Civilising offensives are said to have both intended and unintended consequences and are often initiated in order to enhance the status of less powerful elements of society (Mennell, 2015). The intended outcome of the offensive would be the increased availability of practitioners able to deliver well evidenced healthcare to a high standard. One unintended consequence would be the consequential reconfiguration of occupational hierarchies and the impact on established healthcare professions, especially

nursing. It is important therefore to consider the impact of such threat to the professional status of nursing.

Burford, Morrow, Rothwell, Carter and Illing (2014) consider that sociologically, professionalism is understood to be a historically shaped and commonly accepted status bestowed upon an occupational group that can often be used to defend that group's power and position. The rise of the phenomenon of professionalism occurred in the 19th and 20th centuries (Burke, 2012) and the professionalism of nursing is perceived associated with the work of Florence Nightingale, who was considered instrumental in the development of defined and enhanced standards of behaviour and performance (Gokenbach, 2012). Professionalism is seen as beneficial for those accepted within the group as it generates higher status for them within society (Mennell, 2015), doing this through the creation of a monopoly of knowledge and skills, and via self-perpetuation of the importance of the profession through control of access to that knowledge (Burke, 2012). Over the last half century nursing has engaged in an escalating effort to attain and subsequently sustain professional recognition that has incorporated developments in the fields of education, research and practice (Wilson-Thomas, 1995). Most recently this has incorporated the defining of a minimum standard of degree level qualification (NMC, 2010). Traditionally in nursing the concept of professionalism been linked to accountability, the ability to self-regulate and an understanding of an underpinning desire to provide a public service (Keeling & Templeman, 2013). This status is presently however, under threat.

The obvious recognition of the weakening of the monopoly of registered nurses in controlling the delivery of nursing care is evidenced in the description of professionalism contained within the Scottish Government commissioned report on the subject published in 2012. Importantly considering the concept of professionalism from the perspective of developments within the interactions of related individuals, and not as social structures, the report recognises professionalism as a fluid construct related to the actions and behaviours of all staff involved in the delivery of care, not just those whose qualifications, registration and professional affiliation demand it. NAs are currently striving towards recognition as professionals and Stonehouse (2015) advocates that this is something that will develop over time, with the foundation stones of central registration and the publication of defined codes of conduct already in place. NAs are therefore acknowledged as shifting towards

professional recognition themselves and through this creating a new landscape in the delivery of nursing care in the UK. The impact of this on the professional status of nurses is yet to be fully determined.

This change has considerable significance for student nurses, who have identified the role modelling of behaviours of registered nurses as crucial in their own development of a sense of professional identity (Keeling & Templeman, 2013). Elias believed that change in society was generated through the dynamics of interdependencies, or "figurations", between individuals and between groups (Quintaneiro, 2006), where alteration in one area creates a tension that forces reconsideration and change in others. If student nurses rely on their relationship with trained nurses in order to identify and assimilate the essence of the professional nurse role, and there is strong evidence that this relationship has a significant influence in this process (Keeling & Templeman, 2013), then changes within this relationship will have future consequences for the professional identity of nursing, and for the direction of the educational processes that shape nursing. Much of this discussion so far has centred on developments that are still unfolding and as yet the outcomes are only hazily defined, if at all. There is no doubt however that acceptance and understanding of these changes if far from universally agreed.

6.3.2 Variance in recognition of the NA role

Despite the plethora of recent legislation outlining the UK government's vision for the structuring of the delivery of nursing care, and in particular around the shaping of the NA role, there seems to be no strongly shared agreement of current expectations of the parameters within which NAs are expected to work. This is apparent at a national level, where comparison of each of the home countries shows a variance of interpretation (RCN, 2015) and is also highlighted by the study participants as occurring in their experience at both an individual and organisational level. With the lack of workplace recognition or acceptance felt to impede team cohesion and lead to increased distress for the employee (Mohamed et al., 2014), so it is important to understand possible reasons behind this lack of a defined collective understanding.

Norbert Elias was a German Jew who fled his homeland to escape Nazi persecution and consequently spent his career theorising about societal change from the perspective of a member of a marginalised group (Heinich, 2013). This background is important as it contextualises his focus on the dynamics of what he saw as established, more powerful groups and their relationships with what he termed outsider, less prestigious groups (Mennell, 2015). The development of professionalism, discussed above, facilitated aspects of habitus, or socially constructed schema through which individuals perceive their world (Sweetman, 2003), to become used by established groups as a sign of superiority, and these features then become markers for attainment within that society (Mennell, 2015). Competition between established groups and outsiders then creates an interaction, or in Elias's terms a figuration (Quintaneiro, 2006), as the established group endeavours to retain their status and power, and the outsiders strive to attain these lofty ideals, the resulting tensions driving forward scientific and societal development (Burke, 2012).

In postulating that such societal change is a continual process, Elias pointed out that this progression does not arise from planned consideration, nor are the outcomes specifically intended (Quintaneiro, 2006). He suggests that the ongoing development of society emerges as a consequence of the shifting psychological growth of the individuals who form that society (van Kreiken, 1998). This occurs through changes to the norms and habitus understood by individuals and inculcated to them via the groups they belong to (psychogenesis), and the impact of this change on the groups and society they relate to (sociogenesis) (van Krieken, 1998). In effect, societal change is not generated via ordered long-term planning or organisation. It is instead driven through social manifestation of alterations in the collective perceptions of the individuals within a society, such alterations influenced by the social groups relevant to those individuals. If this hypothesis is accurate then the diversity of responses to NA role development could be explained if there was evidence that differences of understanding were palpable within key groups associated with the provision of nursing care, and a resulting fragmented and uncoordinated pattern of change was apparent. This evidence is available.

It would be reassuring to consider that the ongoing changes in healthcare delivery are part of a cohesive, coordinated and planned strategy, designed to lead the development of nursing care in the UK to meet the evolving health demands over the next decade and

beyond. Indeed, both the Scottish (2013) and UK (DH, 2015) governments have published documents outlining their visions for the provision of sustainable and cost effective care delivery. That both differ on the support for nurses in training, and around the shape of the NA role, suggests a lack of consensus in key areas. The current lack of recognition for the NA role within NMC guidance on the educational development of student nurses (NMC, 2010) would also support the understanding of a less organised process at play. Difference is even evident in the conviction of the wording used to describe the development of upskilling of health workers at a global level; task shifting (WHO, 2007) and that applied to the similar process occurring within nursing in the UK, described by Hasson et al. (2012) as role drift. Elias's theories around societal change provide explanation for this phenomenon.

The NAs involved in this study highlighted the variance in recognition they perceived from within their clinical team and beyond. Internally to their teams, other healthcare professionals and even team managers were seen as holding variable of levels of expectation, and for some of these individuals this was seen to fluctuate over time. Externally there were conflicting messages seen as arising from Health Board level manifestations of emerging policy guidance, with the positive messages of growing opportunity matched by increasing constraints placed on what had been instances of long-term autonomous practice. This lack of uniformity would support Elias's theories of uncoordinated and inconsistent change arising through the influence of alteration within one part of society leading to modification within another part.

Elias's work would suggest that as part of the normal process of societal change, individuals interact within their social groupings and generate transformation. In this case the tensions between registered nurses and the group of as yet unregistered NAs can illuminate the dynamic at play here, with the attainment of professional recognition for NAs fulfilling what Mennell (2015) describes as the aspirational marker. With nursing involved in a series of figurations with other health and social care groupings, it has been forced to develop in order to support its place as a profession (Wilson-Thomas, 1995). Such development continually raising the bar for attainment of this aspirational goal and in turn sparking movement in the reciprocal relationship between RNs and the other group of workers who provide nursing care; NAs. The NA role then developing in tandem, both as a response to, and as a trigger for, ongoing development of the RN role. The individual nature of the

perceptions around the developing NA role would explain the patchy nature of the change process, and indeed the fragmented response to it evidenced within this study. If accurate, expectations should then accommodate an ongoing evolution of care delivery, including nursing care, with staggered and patchy, though related innovations that will continue to see changes to the role of nurses, and to the process of educational preparation for nursing. This will incorporate a need to review the involvement of those fulfilling the NA role within student nurse practice development.

6.3.3 NA responsibility for student learning

The studies by Hasson et al. (2012) and Robinson et al. (2005) both confirm an extensive role for NA grade staff in the clinical development of student nurses within the students practice placement experiences. This developmental relationship was seen to occur on a daily basis (Hasson et al., 2012) and was suggested to account for, in some cases, almost 20% of the supervision the student received on placement (Robinson et al., 2005). The equivalent then of almost one full day each working week was spent with these student nurses learning a spectrum of skills from assistant grade care staff. This occurred across a broad range of adult and older adult care settings, catering for patients with predominantly physical care needs. The students in the current study recorded themselves as being supervised solely by NAs within mental health placements for between a similar 20%, right up to almost 70% of the placement time covered within the study. Hardly likely then that this relationship would be unrecognised, and accordingly each of the staff groups questioned within this study accepted NA involvement in the educational process as a matter of course.

While the mentors in this study each recognised and commented favourably on the role NAs play in the clinical development of student mental health nurses, their understanding of who provided the students supervision differed significantly from the other groups. Mentors attributed on average 80-90% of the students' direct supervision as being competed by mentors within the clinical area. This contrasts markedly with the figures given by the students above and with the 35-76% of student time NAs reported as being the students' main supervisor themselves. There appears therefore to be multiple perspectives

on what actually constitutes the supervision of students and how this fits with who is actually teaching the student during these times. How we make sense of our world and the depth of attention we pay to it seems influential in supporting these multiple realities.

The process of reflexivity has been employed within this study. It is a longstanding and accepted technique in common use to support the rigour of qualitative research (Koch & Harrington, 1998). In addition to positioning the researcher in relation to the phenomenon studied, reflexivity also encourages transparency in the sense making process the researcher negotiates as they strive to accommodate a deeper appraisal of a subject (Walker, Read & Priest, 2013). This suggests differences between our readily accessed conscious understanding of a subject, and our deeper analysis triggered through focused attention.

Emanating from the field of psychology, IPA encourages exploration of this sense making process as part of the research study (Wagstaff & Williams, 2013). Smith et al. (2009) explain this as an importance in understanding the assumed, taken for granted, pre-reflective perspective an individual holds on a subject, as well as the considered, prompted, reflective understanding they reach when given reason to consciously focus on the topic. The process of the shift between the two is also of relevance, as are the influences seen as shaping these beliefs. This double hermeneutic is considered key within the IPA process (Smith, 2004).

Within this study it was obvious that there was a taken for granted understanding of the role of NAs, including the expectation that they would assist with student nurse education in the practice setting. Several of the participants commented on that perception being out of sync with the more considered contemplation they were being encouraged to engage in as a consequence of their involvement in the study. Recognition of this dissonance often started along the lines of "now that I think of it…" The mentors questioned within this study each believed then that they, or fellow RNs, were providing the bulk of the supervision offered to student nurses placed within their clinical environment during the duration of the research. The reflective nature of the research process therefore facilitated awareness of a more extensive role in this process being undertaken by NAs.

NA involvement in student nurse education therefore presents as a commonly accepted though superficially considered expectation. It is obvious from the participants here that NAs shoulder considerable responsibility for taking on a major supporting role in student nurse mental health nurse education, especially within the early years of the student's programme and within the early stages of placements throughout the programme. Such responsibility includes taking the lead role in role modelling and supporting the student through the application of a wide array of nursing skills, ranging from essential care tasks though to complex interpersonal interactions and advanced clinical skills. The prevalence of NA input to student nurse development in both the early stages of their programme, and in the early parts of the series of placements the student engages is of real significance as Annear et al. (2014) identify that reluctance on the part of the student is the most significant threat to this relationship. With authors such as Hamshire, Willgoss and Wibberley, (2012) associating early clinical placement experience with high drop-out rates, it is important to understand the impact of the early impressions of practice a student forms on the generation of an intent to leave the profession. Gillespie (2013) identifies that student nurses enter their training with a preconceived image of the student nurse role, including expectations of the demands that will be made of them, the role of the NA frequently not fitting well with this image. It is important therefore to understand the impact of NAs on student nurses in relation to the developing stages of the student's programme.

6.4 Progressive mastery

Far from being passive recipients of information selected and generated by others, student nurses recognise that their programme incorporates a developmental progression in their ability to control their own learning. The growing ability to identify their own learning needs is accompanied by a similarly progressive ability to target and access learning that they feel fits their individual and programme needs. This developing mastery is accompanied by a shift in focus from patient facing skills towards the enhancement of organisational

capabilities, and a perceived reduction in the salience of the NA within this process. The shift from one to the other may be easier for some students to negotiate than others.

6.4.1 Students need to drive their own learning, and this gets easier with experience

The evidence presented here confirms findings proffered in earlier studies of the influence of NAs in the clinical development of student nurses within related clinical environments. It is clear that within NHS mental health settings, student nurses frequently spend a significant proportion of their placement time working alongside NA colleagues. Their collaboration includes involvement across a spectrum of care skills and frequently occurs without the direct involvement of the student's mentors, or indeed registered nurses in general. Being co-present however does not confirm that knowledge transfer takes place between these groups and there is a need to clarify whether this does indeed occur and, if so, the mechanisms and processes though which it takes place.

The general pattern of contact with NAs was suggested by students to commence through sustained and intensive involvement, which then tailored off as the students moved to work more closely with RNs or indeed more independently. This pattern was understood to occur across the programme as a whole and at a micro level within each placement experience, the focus of the students learning across placements then developing in tandem with, and as a result of their growing shift into the RN role. Social constructivist theories of learning emphasise the interactional nature of knowledge development (Bates et al., 2012) and theories associated with this epistemology provide significant insight into the pattern of development evidenced here, and explain the knowledge transfer relationship between NAs and student mental health nurses.

Constructivist learning theories consider learning to be an active process within which the learner engages with their social environment, generating high level knowledge and understanding that they use to advance their capabilities (Brandon & All, 2010). Concepts such as situated learning, Communities of Practice and Legitimate Peripheral Participation all fit within this perspective on how humans learn (Bates et al., 2012) and advocate the use of techniques such as collaboration, coaching (Gieselman, Stark & Farruggia, 2000), scaffolding and modelling (Cope et al., 2000), for the generation of knowledge transfer.

With these processes strongly reliant on the generation of knowledge through the very forms of interaction identified as occurring by the participants within this study, it seems clear that this study and previous research confirms that NAs are significantly involved within such processes. In this case the influence of NAs on the clinical development of student mental health nurses is recognised by all participants. The process through which this occurs is explained below.

Ousey (2009) emphasises the social nature of the clinical development of student nurses, especially during their practice placement experiences. As a profession situated within clinical practice there is little point in students developing theoretical competence if they are unable to successfully transfer that knowledge into practical application within the practice setting. It is key therefore to understand the processes through which this practical manifestation of theory occurs. Situated learning is such a concept, and the related theory of Legitimate Peripheral Participation is strongly resonant with the experiences voiced by the participants within the study.

Expert practice is considered to require both a significant depth of theoretical knowledge and a situational dexterity of understanding that guides the correct choice of action across the broad range of experiences the practitioner will face (Cope et al., 2000). This form of expertise is developed through exposure to social and practical experiences taking place within the workplace setting (Vis, 2014), and for nurses and student nurses this occurs within the practice area (Perry & Paterson, 2005). It could be suggested then that "the what" of nursing knowledge is delivered to student nurses via the academic aspects of their programme content and "the how" inculcated via their gradual familiarisation into the social and practical role of the registered mental health nurse within practice placements. Lave and Wenger (1991) describe this process as acculturation, though the journey student nurses face in order to achieve this has altered considerably over recent years. This is because of the shift from the apprenticeship form of nurse training to the more academic emphasis of the current higher education based delivery (Cope et al., 2000).

Lave and Wenger (1991) suggested that the situated learning process took place within what they termed communities of practice. These communities are identified as groups within which social learning processes are pivotal in the generation of practice development, and they are evident across a range of settings including healthcare, industry

and business (Thomson et al., 2013). Wenger and Snyder (2000; p 139) define them as "groups of people informally bound together by shared expertise and a passion for joint enterprise". The three conditions considered to define such a community are mutual engagement, a collaboration of individuals working together, joint enterprise which is an agreed purpose and finally a shared repertoire, a common use of and understanding of language, artefacts and behaviours that define the group (Wenger, 1998). The relatedness of this to nurse training is obvious with student nurses spending half of their programme time placed within clinical nursing teams, a grouping that fits this definition of an occupationally focused social learning environment.

With their original work investigating occupations as varied as tailors, butchers and midwives, Lave and Wenger (1991) theorised that the general process of developing expert occupational skills required negotiation of a training format akin to that associated with traditional apprenticeships (Li et al., 2009). This transition involving novice practitioners gradually developing practical expertise through interaction with, and feedback from, established practitioners of the craft. These interactions taking place within the real life, occupational environment, and not within isolated centres of education, the importance of this being the contextual nature of the learning that is taking place (Gieselman, Stark & Farrugia, 2000). Lave and Wenger described this gradual introduction of occupational expertise as Legitimate Peripheral Participation.

Legitimate peripheral participation is the theory postulated by Lave and Wenger (1991) explaining how novice practitioners transform into experts within a community of practice, participation within the process being accepted by the novice and the group members, who also accommodate supporting the novices' gradual development as part of their own role (Risling and Ferguson, 2013). Assuming that the traditional NA role constitutes the periphery of the community of practice of the nursing team for each clinical area, and the registered nurse is considered as the expert practitioner, the expected progression of clinical development of student nurses then mirrors the general experience of the students within this study. It does not however reflect the level of skills undertaken by the NAs nor the current trend towards enhanced NA capability and responsibility.

Other than the conditions of practice, domain and community defined by Wenger, McDermott and Snyder (2001) as determining what constitutes a community of practice,

there is no uniform understanding of how such a community is comprised and no commonly accepted process of how they function (Li et al., 2009). The amalgamation of nurses and NAs, working together within clinical teams certainly meets the criteria defined by Wenger and colleagues, however the changing role of the NA has led to significant overlap between their role and that of the RNs they work with (Rhaeume et al., 2015). This is a concern as Goodwin et al. (2005) advocate that the lack of clear boundaries within multi- professional communities of practice are problematic, in that some groups lack the recognised legitimacy needed to accommodate their involvement in the process. Student nurses who participated within this study experienced this uncertainty in relation to a fear of isolation, at times finding they were caught in a space between the NA and RN role, both of which were influential on their development. This sense of not sitting fully within either of the nursing roles while expecting to master both was problematic for the students and Li and colleagues (2009) caution that lack of full engagement within communities of practice can lead to groups being stuck on the periphery of participation. With Ryberg and Larsen (2008) also suggesting caution around the extent to which the relevance of boundary crossover has been addressed within pedagogical research on the concept of Communities of Practice, there is a need to consider the relevance of the related concept of legitimate peripheral participation in regards the current and future development of student nurses.

Changes to the responsibilities associated with the NA role have resulted in reconfiguration of the delivery of nursing care within the UK (Harmer, 2010), changes that consequently impact upon the processes through which student nurses negotiate their practice learning experiences (Ousey, 2015). The traditional training of student nurses fitted well with the original concepts of Communities of Practice and Legitimate peripheral participation, as these theories referred to the apprenticeship form of expertise development that was used within nurse education. The shift from apprentice to supernumerary student status however, means that student nurses are no longer part of the clinical service, and instead they are required to form partnerships with it (Gillett, 2010). This was a significant shift within the dynamic of practice based learning, and as part of an ongoing process that has now been complicated by the move to an all degree nursing profession (Willis, 2015) and the expansion of the NA role to a position where they are now estimated as providing 60% of hands on care within the NHS (Ousey, 2015). Nursing is considered to be prone to

unquestioning acceptance of new initiatives (Wright, 2012) and these developments suggest that the role for which student nurses are being trained is different from the one their mentors were directed towards in their own programmes of registration and their relationship with practice is also different from that their mentors experienced. It also suggests that the ramifications of such change have not been fully accommodated within student nurse education, especially that taking place within the clinical setting.

Student nurses enter their training with clear expectations around the role they expect to undertake, and are strongly dismissive of their learning being associated with nursing assistants (Gillespie, 2013: Annear et al., 2014). Within the present study, students recognised connections between their stage of training, their reliance upon NAs to guide that learning and the form of tasks they were expected to master. They also felt more in control of their learning as they moved through their training. This is likely due to increased familiarity of expectation and confidence in what they are doing. It also coincides with a move towards the domains of nursing most associated with the role they expected to perform. With authors such as Harmer (2010) suggesting that nursing has now developed into a more specialist role, including increased responsibility for directing care delivered by others, and in particular by NAs, there is cause to question the alignment of the role student nurses are prepared for, and the one they will undertake as registered practitioners.

6.4.2 There are varied factors contributing to student nurse learning

Qualification as a nurse requires successful negotiation of a training programme that contains substantially more content, and is arguably more demanding than most degree level courses. In addition to attaining the same volume of academic credits defined by the SCQF and equivalents for degree level qualification (SCQF, 2012), nurses must also complete a minimum of 2300 practice hours (NMC, 2010) within a series of assessed clinical placements. The programme itself therefore demands development and capability across two different domains, where students must master related though at times competing skill sets; academic competency and the ability to deliver safe and effective healthcare as part of a multi-agency team (Rolfe, 1993).

6.4.3 Student seniority shapes learning need

The concept of Legitimate Peripheral Participation incorporates an understanding of learners gradually developing expertise as they are supported through increasing levels of expectation (Gieselman et al., 2000). In nurse education in the UK this is accommodated through the identification of three stages generally reflecting each of the three years of the programme (NMC, 2010) and this developmental progression has been enacted in practice through the inclusion of frameworks such as Benner's Stages of Clinical Competence (Benner, 1984) within programme design. Such frameworks providing a mapping of expectations related to developments in clinical competence. Recognition then exists of the increasing levels of expertise as the students' progress, which in turn creates a requirement for advancement in the levels and complexity of knowledge and skills they are presented with and are expected to master.

The students participating within this study clearly articulated recognition of experiencing this progressive complexity of programme demands, finding that the increasing confidence they developed as they negotiated this process coincided with exposure to the roles and tasks they more strongly associated with nursing. The shifts in emphasis occurring as this unfolded, at times however creating uncertainty, even dissonance, for the students

For student mental health nurses this pathway to qualification is becoming ever more complex, at times often markedly different from their preconceived expectations of nursing (Murray, 1983), incorporating initiation into an environment that is subject to rapid change and ongoing development. Early programme experience frequently incorporates exposure to demands for engagement with tasks students often associate with NAs (Gillespie, 2013). The role of the RN is also expanding to incorporate responsibilities that were once in the domain of doctors (Norman and Ryrie, 2013), or shifting towards a managerial supervisory focus (Hasson et al., 2013b), and NAs are now developing as skilled and responsible practitioners including the incorporation of tasks previously carried out by nurses (Stokes & Warden, 2004). The use then of the traditional apprenticeship model as a guide to the processes student nurses will negotiate on their pathway to registration seems to lack recognition of the complexity of the modern healthcare environment and the changing tensions influencing it. Understanding such complexity would help shape recognition of the supports required by current and future student mental health nurses.

Elias' theories around societal change included observation around a trend of Informalisation (Mennell, 2015). This concept involves a gradual lessening of the formality held within the expectations of society and includes changes in manners, clothing styles, language and behaviours (Collins, 2014). This concept fits well with the current changes occurring within healthcare delivery in general, and within nursing in particular. Nursing and nurse education has worked to develop as a profession (Wilson- Thomas, 1995), professionalism providing a sense of recognition and power (Burford, Morrow, Rothwell, Carter & Illing, 2014). The general upskilling of tasks and responsibilities falling under the descriptions of either task shifting or role drift, suggest a process wherein the traditional domains of professional structures are altering, and in many cases weakening. In nursing NAs are increasingly able to fill RN roles without having needed to negotiate that group's formal registration route or experiencing exposure to the traditions associated with that process. This is concerning as the introduction to a professional identity is suggested to be a crucial focus of student nurse education (Harmer, 2010) and NAs are considered to be subject to a different socialisation process from RNs (Hasson et al., 2013a). Additionally, taking account of the likelihood that the students mentors have themselves not been educationally prepared to undertake the emerging roles now required of RNs (Hasson et a., 2013a), highlights variance in the influences available to student nurses on which to model a professional identity reflective of the current demands of the role. Little wonder then that the student nearing completion of training within this study expressed relief that their role was clearer, more defined and more controllable. Expressions of satisfaction around this emerging RN role were not universal though.

6.4.4 Students can impede learning

Both Murray (1983) and Harmer (2010) identify studies showing that student nurse dissonance around their role expectations increased as they progressed through their studies. In this study the student in the middle of their training expressed more uncertainty than those at the beginning or end of their programmes. Their concerns surrounding the shift they saw as occurring from their involvement in NA driven, traditional hands on care, towards the RN domain of the professional and its association with organisation, planning and documentation. Such a shift recognised as providing mixed messages to nursing

students (Wilson- Thomas, 1995). To put this in context Haberstein and Christ (1963) are cited as defining three types of nurses (Murray, 1983); the professional, whose focus was the development of specialist skills and knowledge, the traditional, who espoused the primacy of care and compassion, and the utilitarian who saw it as merely a job and a way to earn a living. The first two of these perspectives reflect a longstanding debate about the direction mental health nursing should take, with arguments presented as to whether it should follow a scientific/ professional focus, or accept itself as an art of caring (Norman & Ryrie, 2013). With such philosophical queries seen to occur on a daily basis through RNs delivering scientific, evidence based nursing (Stokes & Warden, 2004) and NAs significantly responsible for the patient facing care (Chang & Lam, 1998), it is little wonder that students rail against involvement in whichever domain least fits their expectations.

6.4.5 Training is complex and controlled by nurses

The complexity of the demands of their training programme is clear to the students undertaking that process, as is who they see as controlling the requirements of their clinical experience. Despite the widespread recognition of the NA role in student nurse education within clinical teams, this recognition rarely moves beyond the expectation that this group will contribute towards student nurse learning, with RNs accepted as holding responsibility for student development. The mentor role is considered crucial in providing a developmental relationship supporting student nurses during their practice placements (Felstead & Springett, 2015). This role suggested key in providing the direction and guidance students require (Lloyd- Jones, Walters & Akehurst, 2001) while translating the theoretical demands of the student's programme into practical terms (Ousey, 2009). NAs are recognised as being ignored in the formal application of the students learning (Hasson et al., 2012) with some expressing alarm that such a relationship should exist at all (Kendall-Raynor & Duffin, 2008).

In order to support the efficacy of the mentor role the NMC commenced a series of practice developments in 2008 which included mandated educational preparation and updating for mentors and the commencement of a registration process to record those able to fulfil this role (NMC, 2008). This initiative formalised a process that had previously incorporated a far

looser recognition of who could be involved in student nurse education. Involvement in student nurse education therefore now incorporates clear regulation around responsibilities as well as a narrowing of the parameters of those qualified to undertake the role. This defining of responsibility for student learning then providing the impetus for enhanced mentor preparation (NMC, 2008), however at the same time clearly contributing to the exclusion of NAs from formal involvement.

6.5 Summary of themes

NAs contribute significantly to the clinical development of student mental health nurses during the practice placement components of the students' programmes and it is likely that this contribution has existed since the inception of formalised nurse training. At present it incorporates NAs leading students in the development of many of the essential care skills required in modern healthcare, as well as in the application of increasingly complex technical and interpersonal competencies. This contribution from NAs is expected across all of the groups involved in student nurse education, although largely devoid of any formal recognition. The goodwill shown by NAs in providing support for student nurses is compromised by this lack of recognition and the ongoing expansion of the NA role is further complicating this.

The use of IPA facilitated access to the deeply held perceptions of individual practitioners and across the range of participants through the development of shared or superordinate themes. This is a strength of IPA (Smith et al., 2009). This study however added a participant layer through the recruitment of individuals from the three groups closely involved with the subject under scrutiny. This allowed identification and comparison of themes common within and across groups, and those shared only by some. As a result, it is evident that both student nurses and mentors understand the developing competence of students and how this influences their ability to control their own learning. Both mentors and NAs understood the importance of teamwork in motivating them to undertake tasks seen to enhance the team, while all of the groups accepted there was a presumed participation of the NAs being involved in student education. From this it could be argued

that the mentors within the study replicated their role within student education through their answers, by being a constant that holds the component parts together.

The success of the socialisation of student nurses into the occupational role expected of them is reliant upon cohesion between the groups that constitute the clinical nursing team and that relationship is currently in a state of flux. Progression through the Community of Practice is no longer clearly signposted. This leaves students uncertain of what they are required to achieve in terms of a professional identity. Madsen, McAllister, Godden, Greenhill and Reed (2009) identify such a group as nursing's orphans, describing their lack of professional attachment as resulting in insecure and isolated workers without understanding of the history of their role. Successful clinical development for students then needs to be closely matched to a considered acceptance of the skills, experience and knowledge available to them from their NA colleagues and a clearly defined pathway to a professional nursing role.

6.6 Post study Reflection

The importance of reflection in maintaining care standards has been well established, however, Edwards and Talbot (1994) advocate that such reflection is not a one off event and in fact the process requires reflection during practice as well as subsequent reflection following practice. Completion of the study therefore requires a revisiting of my own position, now including review of the research process applied. This reflection is detailed below.

My previous experience had influenced me to consider the NA role as significant though largely unrecognised within the clinical development of student mental health nurses. Interactions with the participants during the study exposed me to individuals from a wider range of clinical settings than I had previously known, and updated my contact with clinical practice, a setting I had not actually worked in for over a decade. This exposure led to recognition of considerable advancements in the complexity of tasks some NAs were responsible for, awareness of the growing complexities of both the RN and NA role, and

confirmation that the extensive contribution NAs made to student nurse learning was subject to sporadic and limited recognition.

Webber and Newby (2015) describe the development of reasoning in nursing to be a multi-faceted and complex process that progresses over time. The development of understanding of the theory and application of research proved such a journey for me during this study. Previous involvement in research and feedback from conference presentations relating to this study confirmed for me the dominance of the positivist paradigm within healthcare related research and reluctance within nursing to engage with the topic that is the focus of this investigation. Qualitative approaches seemingly expected to try harder to prove their relevance including the validity of the methodology and the findings generated. Conference organisers were also reluctant to even combine the words nursing assistant, student nurse and education, giving the impression that parity of standing between RNs and NAs was an anathema to some.

The use of IPA did allow me to engage more with the perspectives held by individuals than other qualitative methods of data collection and analysis. The utilisation of individual interviews and the participant centred analysis process associated with IPA (Smith et al., 2009) felt more sensitive to exploring the unique understandings of the topic than focus groups and thematic analysis I had used before. Pringle et al. (2011) indeed suggest that thematic analysis fails to elicit individual perspectives to the extent required by IPA structured research. The individual interviews also stretched my awareness of managing to maintain a similar process across a number of interpersonal interactions, and in fact I believe that my ability to carry out the interviews developed as I became increasingly accustomed to them. The use of IPA in general becoming more comfortable the more experience I developed in its application.

The importance of reflexivity in evidencing a robust qualitative research process has been strongly argued above and has significant relevance in relation to the utilisation of social learning theories within this study. Lave and Wenger's (1991) concept of the CoP was employed to contextualise social learning in relation to clinical practice. While this framework proved useful, it was necessary to engage in an analysis process that purposely detached from this concept to prevent fitting the participants' experiences into a

preconceived set of findings. It is believed that this process added to the validity of interpretation in reflecting the participants' experiences.

One aspect of IPA I struggled with initially was fitting with the analytical perspective promoted by the originators of the methodology. Smith et al. (2009) provide instruction in the process of applying IPA, and this unsurprisingly, given their occupational backgrounds, is strongly influenced by the field of psychology. I found this alien to me and somewhat restrictive. During supervision I was prompted to consider the value of the double hermeneutic associated with interpretative research and through this I realised that awareness of my own perspective was needed. Brocki and Wearden (2006) argue the necessity of interaction between the analyst and the emerging information and Smith (1999) confirms the flexibility of IPA in accommodating such individual experience within the methodology. Utilising a range of theories from a wider range of perspectives therefore enabled what I felt was a more comprehensive analysis of the participant's experiences. The insights I gained within the process of the study generated ideas for practice development that are presented below.

6.7 Conclusions and recommendations

It is believed that the process and application of this research project generated knowledge that is of importance to the development of our understanding of nurse education and the evolving role of nurses, NAs and student nurses. Application of the research methodology and methods of data collection employed within the study have also identified relevant learning emerging as a consequence of their use. As a major objective of research within healthcare settings is the dissemination of knowledge (Rebar & Gersh, 2015) these findings are detailed below.

6.7.1 Theoretical conclusions

Applicability of the CoP concept to explain the topic

Application of the CoP framework is poorly understood in relation to healthcare (Li et al., 2009) and this generates concern around its ability to appropriately frame student nurse learning within the practice setting. The tendency to conceptualise CoPs in relation to singular professions as described by Cornes et al. (2014) has been confirmed within nursing literature (Cope et al., 2000) and illuminated within this study. The frequent identification of a lack of relevance attributed by student nurses to engagement within NA related duties identifies a perception of an irrelevance of the NA role in the students' progression towards mastery of their craft. The dissonance created by encouragement to progress via involvement in aspects of both roles is likely to impede student motivation. Low student motivation is considered a factor that prevents their progress within a CoP (Bates et al., 2012).

The CoP model and related social learning theories do serve as useful frameworks through which to link the issues and conclusions emerging from this study. Recognition of the social emphasis of learning within an organisational setting is key in underpinning the CoP theory (Lave & Wenger, 1991) and is strongly evident within the concepts interpreted as explaining the themes emerging here from the participants' experiences. Belongingness, role conflict, role clarity, role confusion, teamwork and leadership clearly emerge, and are representative of what is obviously an experience for each of the participants that is strongly embedded within an environment where social integration is a significant influence. The model itself, however, seems less attuned to incorporating the ongoing organisational change that has been evident in the delivery of nursing care, or in using such change to frame planning for practice and educational development. Within the study a different set of theories emerged, that when combined with the CoP concept, facilitates incorporation of organisational evolution. These theories are associated with the social scientist Norbert Elias.

Elias and change in nursing

Norbert Elias postulated that societal development is a continuous process (van Krieken, 1998) and as a consequence change is something we should expect and prepare for. Modern nursing has evolved considerably since a move to professionalism was triggered by

pioneers such as Florence Nightingale, and visionaries such as Annie Altschul and Jack Lyttle have helped drive mental health nursing forward as a specialism. Authors including Harmer (2010) have however expressed caution around the unfolding role that nursing seems to be moving towards, with especial concern focused on the influence of NAs on the clinical preparation of student nurses (Kendall-Raynor & Duffin, 2008).

It is apparent that such development of health delivery structures and processes is ongoing, and far from stopping, seems to be accelerating in pace since the publication of the Francis Report (2013). To date, recognition of the contribution of NAs towards student nurse development has yet to be formalised, and as such ignores obvious opportunity to embrace and enhance that relationship. It is only within isolated pockets, like older adult care in Australia (Grealish & Henderson, 2016), where practical need has driven acceptance that this should be seen as something to engage with. Nurse education seems blinded to incorporation of structures that fall out-with what fits within the sense of professionalism that nursing strives for, and as a consequence actively fights against accommodation of that phenomenon. This reluctance is complicating student nurse education as it hinders the creation of a route to development of a professional identity for student nurses. Nurse education must therefore work to predict and lead change, as opposed to waiting until it is forced upon them, or even worse trying to ignore it is happening. Utilisation of Elias's theories of societal change would help accommodate this.

6.7.2 Methodological conclusions

Use of Interpretative Phenomenological Analysis

IPA is described as a research methodology that offers insights into ideographic perspectives in areas that are previously unexplored (Smith et al., 2009). Its use here, as a guiding methodology, provided access to individual viewpoints within this study and identified commonalities and differences within and across the occupational groups involved. It has been used previously within nursing research however it is considered a relatively new methodological approach, still in the process of evolving (Pringle et al., 2011). The

originators of the IPA advocate a flexible, adaptable and non-prescriptive consideration of the choice of methods employed, as long as the outcome enables good quality interpretative analysis of participant narratives (Smith et al., 2009). This study utilised a sequential developmental explanatory mixed methods framework to achieve this, and as a consequence adds to the understanding of IPA as a research methodology in healthcare research. Key learning from this included innovation in the methods of data collection used, in the tiers of participant analysis and in the quality assurance process employed. These initiatives are detailed below.

Combining methods of data collection has been apparent in IPA research since its early application (Smith, 1999). Despite this, more recent reviews of published IPA studies (Brocki & Wearden, 2006: Smith et al., 2009) identify little inclusion of quantitative approaches in this process. This study is ground-breaking then, in that it utilises quantitative diary completion as a method through which to develop the required understanding of the contextual influences within which the participants make sense of their world (Larkin et al., 2006). The diaries also provided the repeated researcher/ participant contact that is considered to enhance the quality of engagement (Wagstaff & Williams, 2014) and prompted the deeper reflective appraisal of the phenomenon under investigation, suggested to be crucial to IPA research (Smith et al., 2009).

Several strategies have been employed within IPA research to evidence that interpretation of participant narratives are not simply imposition of the pre-existing views of the researcher, and through this enhance the robustness of the findings. Flowers, Davis, Larkin, Church and Marriot (2011) employed a team approach to data analysis, and Wagstaff and Williams (2014) included service users in analysing data within a study of other service users. The current study utilised an approach termed member checking, which Richards (2015) suggests is commonly used within qualitative research. This approach saw the summarised diary, the transcript of the interview and identification of the themes identified by the researcher all presented back to the participant for review. Smith et al. (2009) advocate that the interpretative process should be clearly defined and validated within IPA studies, however, they make no mention of member checking within that process. This study, therefore, adds to the current understanding of the application of IPA research.

An advantage of IPA methodology is its ability to uncover perspectives held by individual participants as well as identify commonalities and differences between the group investigated (Pringle et al., 2011). This study incorporated an additional tier of participants through inclusion of three defined staff groups. This enabled identification of cross group comparison and enhances understanding of the possibilities available within the design of IPA studies.

The methodology section contained consideration of my own position in regards my beliefs and expectations at the commencement of the study and this exercise was repeated in this chapter to review my involvement in the process. This was done through the use of reflexivity. Sanders and Wilkins (2010) suggest that reflexivity is a method through which researchers can account for their own beliefs, and how they may influence the research process. King and Horrocks (2010) separate this in to epistemological reflexivity, concerning the process through which the study was completed, and personal reflexivity which reviews how our own beliefs, experiences and values shape our involvement and interpretation within the study. This study brought together data collection methods from differing ontological paradigms and investigated a previously unexplored issue. The incorporation of a reflective process therefore uncovered both the researcher's preconceived understanding of the topic and identified key learning around the application of IPA research.

6.7.3 Practical conclusions

Implications for the NA role

Anecdotal evidence would suggest that RNs commonly accept that NAs contribute significantly to their development during the duration of their pre-registration training. Authors such as Hasson et al. (2012) have confirmed an NA role in modelling and teaching students a wide range of skills within adult care settings, while Grealish and Henderson (2016) identify that this group are contributing to the socialisation of students within practice placements. The current study adds to this, identifying that within mental health settings NAs form a key component of the student's educational support network created by clinical teams. In this study NAs modelled accomplished interpersonal and therapeutic

skills and took responsibility for the bulk of patient contact within clinical environments. They also undertook the role of overseer for significant periods of student learning.

To date NAs have offered voluntary involvement in supporting student nurse education during student placement experiences. NAs within this study related their involvement to their sense of duty towards their clinical team. This sense of belongingness however requires fostered in areas such as training (Vinales, 2015), recognition (Mohamed et al., 2013) and managerial support (Goosen, 2015), especially if it is to flourish against a background of extensive role reconfiguration for NAs (Rheaume et al., 2015). There is a need therefore to consider targeted preparation for NAs, creating awareness for them of their role in student learning and supporting this through formal recognition of their involvement in that process. As NAs are frequently expected to take on new roles without recognition or reward (UNISON, 2016) fostering their belongingness to clinical teams appears pivotal in maintaining their involvement. The current reconfiguration of nursing roles however has created conditions where role uncertainty detracts from team cohesion. This is evident from historical research (Wakefield, 2000) and in the current study. Organisations providing nursing care and nurse training must therefore incorporate strategies that support the development of this sense of belongingness across all staff groups involved.

The contribution of NAs to student learning in itself is far from problematic, what is problematic though is the lack of formal recognition of this relationship, and the consequential lack of governance resulting from that. The participants within this study, NAs, mentors and student nurses, unanimously identified benefits to be gained from formalising and supporting a relationship that already exists. The imminent publication of updated standards for pre-registration student nurse education must include accommodation of the expanding NA role and the developing relationship this group has with RNs. The repeated delays in releasing this document may reflect recognition of the rapid growth in opportunities available to NAs, and the subsequent need to formalise the position of the emerging NA grades within student nurse education.

Implications for the RN role

Mental health nursing is a diverse profession, encompassing the care of client groups varied in age, gender, background, presenting problem and care needs. The care delivered is also diverse, and the locations and settings this takes place in ranges from locked hospital wards to the clients own home. Defining the specific role of mental health nursing is therefore difficult. The Scottish Executive review of mental health nursing (2006) recognised this diversity whilst identifying the underpinning that human relationships provide across the profession. Changes to the delivery of nursing however sees consensus that in many clinical settings RNs are losing much of that direct contact with clients, moving into a coordination and managerial role (Stokes & Warden, 2004: Oeseburg et al., 2015).

It is interesting to note that some more senior nurses are able to maintain frequent client contact through undertaking clinical specialist positions (RCN, 2010). The availability of such advanced practitioner posts has grown rapidly over the past year (Scottish Government, 2016). While these positions facilitate contact between the nurse and client, that contact often incorporates interactions previously associated with medical staff including assessment, triage and prescribing. This development therefore signifies another recent, rapid advancement in the role of nursing.

Any change to the responsibilities and activities associated with one occupational group will impact on the other occupations they interact with. In nursing the growth of NA and RN expectations has created a role blurring that sits at odds with the preconceived image of nursing many neophyte nursing students have developed (Gillespie, 2013). This means that work is required on role clarification and accommodation of role crossover, and in projecting a more realistic public image of nursing. Such changes also need to be considered in relation to pre-registration nurse education.

There are suggestions that nurse education has not kept pace with the changing professional requirements for current healthcare practice (Crigger & Godfrey, 2013), leading to newly qualified RNs struggling to meet the demands of the role (Whitehead & Holmes, 2011). Issues such as burnout and high staff turnover are significant concerns for the profession and have been linked to this lack of appropriate preparation for registration (Last & Fulbrook, 2003). If RNs are now clinical specialists, coordinators, leaders and planners of care then this needs to be reflected within their educational preparation. It is imperative therefore that programmes developing student nurses towards registration need shaped to

deliver what will be required for practitioners at the time the students complete, not what was required before they started. The inclusion of a constant review process and the flexibility for updating programme content is something the regulators of such programmes must consequently consider.

RNs remain the coordinators of student nurse education within the placement setting and as such there is a requirement for them to incorporate what is known about NA involvement within this process. NAs contribute to this at present, though studies suggest that focused development of their involvement enhances the experience for all involved (Annear et al., 2014). RNs therefore need to recognise the NA role and how it unfolds in relation to student learning, considering the domains within which their educational input is incorporated and the reducing influence of NAs as the students embed themselves. They also need to be supported by the students programme provider in doing that.

Implications for the student role

Professionalism in nursing is described as the values of caring and advocacy, and their enactment by members of the profession (Blevins & Millen, 2016), the development of professionalism being a key objective for programmes leading to nurse registration (Anselmi, Glasgow & Gamboscia, 2014). Brennan and McSherry (2007) indeed identify the socialisation of student nurses into this professional role as the ultimate aim of such courses. Authors such as Shepard (2013) however describe a weakening of professionalism in nursing and Harmer (2010) advocates that reconfiguration of the nursing role has created a blurring of this professional identity.

This process of inculcation of professionalism is termed professional identity formation (Crigger & Godfrey, 2014) and the nurse mentor is understood to hold a key role in facilitating the development of this professional identity in student nurses (Jokelainen et al., 2011). The students in this study though voiced concerns that clinical behaviour was frequently being modelled for them by NAs and Grealish and Henderson (2016) highlight the difficulty student nurses identify in developing as RNs, when their role models are NAs. Shepard (2013) however counters that the professional nurse required to work within modern multi- agency care delivery requires contact with role models from a variety of backgrounds during their programme of qualification.

The CoP concept envisages a cohesive and motivated social learning environment within which there is a clear route of progression for the novice practitioner. In reality the blurring of clinical roles means student nurses are negotiating a shifting, uncertain and at times conflicted route between hands-on care and care-coordination. Steering a successful pathway through this requires an awareness of the process, and acceptance of its relevance to their learning. This was present to varying degrees in the student nurses involved in this study.

It is apparent that student nurses are not being sufficiently prepared for the influences on their role development that comes from sources out-with the preconceptions they enter their training with. This is additionally concerning as these early clinical experiences are strongly linked to student attrition (Hamshire et al., 2012). Authors such as Crigger and Godfrey (2014) therefore advocate that nurse registration programmes incorporate a focus on professional development that supports the students' personal, ethical and social development towards a professional identity. Consequentially potential students need to be aware of the reality of the role prior to commencing. An understanding of the contribution of NAs to the delivery of nursing care would be advantageous in this, as would acceptance of NA involvement in student learning.

This study confirmed a sustained shift in the responsibilities of the RN role identified within earlier literature (Griggs, 2011: Harmer, 2010). Moving towards a more managerial or clinical specialist role has implications for students training for this position. More emphasis is required in regards developing leadership and organisational skills, as well as on the ability to coordinate and delegate care. As fewer of these coordination or specialist roles are generally required, so fewer RN posts are likely to become available and shifting nursing posts into the realm of NAs may help alleviate projected RN workforce shortages (Cowan, Frame, Brunero, Lamont & Joyce, 2015). This is likely to lead to the availability of fewer RN vacancies available to students on completion and increased competition for posts.

6.7.4 Further research

This study offers an initial investigation into a subject that had previously been afforded little direct consideration within nursing research. The use of IPA as the guiding

methodology provided access to deeply held beliefs, individual to, and common across participants from the groups closest to the area of investigation. Smith et al. (2009) confirm that this uncovering of unexplored topics, and access to difficult to reach groups as strengths of this approach. They also recognise the inability of the approach to deliver predictive findings applicable across all such similar situations. Adding to this, recognition of Elias's perception of ongoing change (van Krieken, 1998) suggests that wider research is required to investigate other healthcare environments and ongoing study needed to accommodate continuing developments expected within each of the roles.

The confirmatory nature of the findings within this study, around developing nursing roles and the involvement of NAs in student learning, support transferability in relation to wider healthcare settings. Smith et al. (2009) advocate that relatedness of findings will emerge through presentation of informed contextual interpretation and it is believed that this study meets those criteria. In addition to confirming previous findings, this study also identified the impact of recent developments in nursing roles that have implications for nurse education nationally and internationally. Recognition of the NA influence on student learning within mental health settings is also of significance however, organisations such as SIGN would suggest that the methodology used would not be strongly influential in generating change (SIGN, 2015).

That the study took place within the clinical environs of only one Scottish Health Board mean that confirmation of a wider geographical relevance will likely emerge should the research be replicated elsewhere and similar findings arise. Similar exploration taking place within different clinical environments will also indicate any diversity developing via local variance within the roles or around interpretation of the roles. The use of IPA as the guiding methodology would provide uniformity in the framework of the investigation and analysis process, however utilisation of methodologies from a wider range of ontological standpoints are likely to provide a more comprehensive understanding of the subject. In the case of quantitative studies this would also mean the generation of data more likely to be of interest to policy makers (Smith et al., 2009).

The drive to combine training and clinical experience between NAs and student nurses continues apace and calls have already emerged from elsewhere to investigate this relationship in more depth, particularly around the impact on the individual student's

emotional intelligence, a key attribute for mental health nurses (Snowden et al., 2015). It would also be useful to measure the impact of exposure to student mental health nurses on the emotional intelligence of the NA grade staff to see if the direction of any consequential change matches.

With this study confirming the lead role taken by NAs in the application of a wide variety of clinical skills, especially those involving the essential care tasks that are key foundations of human dignity, the recognition that this also incorporates teaching those skills to student nurses warrants investigation within a number of areas. The educational preparation of mentors is a rigorous and robust process clearly defined by the NMC and subject to ongoing updates to ensure mentor quality. This study however suggests that akin to the coordination role RNs are said to be moving towards with patients, mentors appear to be abdicating much of the direct support of students to NAs and fulfilling more of a coordination role themselves. There is a need therefore to explore the opportunities available for enhancing the NA teaching role and to investigate means through which to further develop the mentor's direct involvement with the student.

Student nurses enter their training with preconceived perceptions of the profession they are entering, and evidence suggests that the jarring of that ideal with the reality of modern healthcare is a contributor to student attrition (Spouse, 2000). As a consequence of this authors such as Grealish and Henderson (2016) identify an ongoing reluctance to engage in what are perceived as menial care tasks that students associate with the NA role. As these tasks constitute the delivery of essential patient care there is a need to investigate the image of nursing that is projected to the public and the preconceptions of applicants during the recruitment process for pre-registration programmes. The RCN has already initiated a campaign to educate the public to the realities of nursing (UK Government, 2012), and the efficacy of this initiative should be measured in relation to student nurse recruitment and attrition.

The findings of this study identify further areas that appear to have previously been overlooked, or which have emerged so recently that related research is yet to be published. The increasing responsibilities being attached to the NA role are yet to be fully realised and the expansion of this role will further alter the dynamic between NAs, student mental health nurses and mentors. Similarly, the drift of RNs away from significant components of direct

patient care needs to be accommodated within the content of pre-registration nurse education and both of these developments generate substantial research need, both in shaping the change and in monitoring its impact.

The use of IPA to frame this research proved effective in that it facilitated deep engagement with the lived experiences of participants from across a range of clinical areas. This enabled the identification of individual and shared themes relating to the focus of the investigation. The combining of data collection methods potentiated a more accurate interpretation of participant perspectives through directing their attention to the subject and identifying for the researcher the context within which such sense was made. With both IPA and mixed methods data collection relatively recent developments in the application of research so additional use and modification is likely to further develop the effectiveness of each.

6.7.5 Wider relevance

As identified in Chapter 3, the upskilling of workers to meet productivity requirements when resources are limited is a common occurrence across a range of professions. It is also a globally accepted mechanism through which to deliver services to those who need them (WHO, 2007). This study has confirmed advancement in the roles and responsibilities associated with the group considered as professionals in the delivery of mental health nursing care, and in those considered to contribute a support role in this process. Such developments have a relevance to the education of those training for such positions, and for those planning and delivering such training. This study, therefore, has implications for professions such as teaching, social work, psychology and allied health professions including occupational therapy and physiotherapy, as well as across the range of nursing fields and specialisms.

6.7.6 Empirical conclusions

This study has produced findings that further develop the understanding of the relationship between NAs and student nurses uncovered within earlier research. Prior studies have identified a significant role for NAs in the acceptance of students during practice placements

and a considerable reliance on NAs to contribute to student learning, especially, though not exclusively, in relation to the delivery of essential care skills. None of the previous research explored this relationship within a mental health specialism, and no UK based studies have as yet incorporated the developments emerging as a consequence of the Cavendish report (2013). The findings are detailed in table 16 below

Table 16 Empirical contribution

No	Contribution- this study;
1	Confirms and adds to previous research findings suggesting that NAs frequently contribute to student nurse learning during their clinical placements.
2	Identifies that this educational relationship occurs across a range of mental health care settings.
3	Provides evidence of the form of working relationship existing between NAs and SMHNs, including the amount of time they spend together, the tasks they jointly engage in and the level of RN supervision provided.
4	Confirms the embedding of new roles for NAs and RNs and adds to the understanding of how student nurses perceive and negotiate the complex interaction between each as they progress on their programme.
5	Provides evidence of the relational aspects of the motivation for NA involvement in student learning and the negative consequences for this when the developing NA role is not recognised.
6	Delivers a comprehensive review of this subject through inclusion of representatives from all of the main groups involved in delivering on-site clinical education to student nurses

6.8 Revisiting the research intentions and questions

Q1. How long do student mental health nurses spend with registered and unregulated nursing staff in a typical day, and what is the focus of these interactions?

The diaries employed within the study provided near immediate recording of the activities students engaged in over a working week in a wide variety of placement specialisms. Having representatives from the student body, mentors fulfilling various roles and NAs allowed appraisal of what students actually did, and who they were working with as they completed their daily tasks. This uncovered a strong association between NAs and students which incorporated the application of complex interpersonal skills as well as the delivery of essential care tasks including meeting the clients dietary, recreational and hygiene needs. The profile of activities wherein students worked with mentors and other RNs differed in that these groups more frequently spent time planning, organising and coordinating care.

Q2. How do NAs perceive their role in the clinical development of student mental health nurses, including the preparation and recognition they receive for any such involvement?

Each of the NAs involved in the study clearly expressed acceptance of their contribution towards student nurse development during practice placements, all recognising an expectation amongst RN colleagues and fellow NAs around their involvement in this process. Fulfilling this role was considered a team goal and therefore something worthy of engaging in as part of their daily work, the benefits for the wider team being the maintenance of team cohesion and the easing of concerns around student welfare, particularly in the early stages of their placement experience. The NAs questioned identified a wide range of tasks and skills they led student learning in, some of which involved complex and specialist abilities while also incorporating much of the essential care required by their patients. These attributes were not considered fully recognised by colleagues or beyond, and the NAs felt largely excluded from the formal process of student learning. All of the NAs believed that more formal inclusion within student nurse learning would be beneficial for the student.

Q3. How do student mental health nurses view the role of NAs in developing their essential care skills whilst on clinical placement?

The involvement of NAs was accepted by the student nurses questioned as a frequent and expected component of their programme. Students routinely anticipated they would be working alongside NAs within practice placements, suggesting that the dominance NAs had in the responsibility for delivering face to face care mean much of their time practising essential care skills was done while working directly with them. The student perspectives emerging within the study identified, though, that their engagement with NAs was developed much further than solely around the delivery of essential care skills, and hence there was a need to expand the consideration of the relationship. This relationship was seen to alter as the student progressed within their programme, wherein learning was seen to shift to a more managerial role associated with RNs. This variance in the focus of learning was problematic for at least one of the students, as they perceived it as a choice between remaining involved in what they saw as a very client focused NA role, or moving towards the managerial RN role they saw as distanced from their patients. Accommodation of the contribution NAs made was something the students recognised, with acceptance of learning from observing poor practice, a factor one student associated with their involvement.

Each of the students suggested a recognised separation between the roles of NAs and RNs. This separation delineating the tasks each group was responsible for and determining the locations the group would be most likely to spend their time in. The extent of this split was also problematic for students as they understood their role as a delicate balancing act between the two. Despite this emphasis on fitting in with NAs the students were clear that their professional development lay very firmly in the domain of the registered nurse.

Q4. How do clinical mentors understand the role of NAs in the clinical preparation of student mental health nurses?

Like the other groups, the process of focusing attention on the actual role NAs fulfilled within the students' clinical development, saw the mentors questioned recognise that

reality differed from their previously assumed perception. This prior, taken-for-granted understanding presented as a general underestimation of both the duration over which NAs led student learning and around the extent of complexity of the tasks NAs shared with students, this new found awareness creating understanding of the missed opportunity to maximise the NA contribution that resulted. The mentors confirmed a shared expectation that NAs would routinely contribute to student nurse learning during the students' placements, such involvement rarely attracting discussion or including more than cursory planning with the NAs involved. The mentors also confirmed an expectation of a tapering off of NA influence on student development as students progressed on their programme. By stage 3 of the programme it was considered that NAs would have little involvement and students would be working alongside mentors or independently.

6.9 The strengths and limitations of the study

Rebar and Gersch (2015) advocate that the identification of the strengths and limitations of a health related research study are crucial in allowing identification of the usefulness and applicability of that study towards practice development, it is important therefore to identify the worth and limitations of this study.

Within healthcare in the UK the positivist paradigm dominates the worth attributed to research and research findings. This is clearly articulated by practice standards organisations such as SIGN, who present quantitative data as more robust and more relevant for healthcare delivery (SIGN, 2015). Arguments are however forwarded around the inability of such research designs to fully capture the complexity of human experience, with qualitative methodologies considered more attuned to exploring such perspectives (Sanders & Wilkins, 2010). Decisions around aspects of this study such as participant numbers, methods of data collection and analysis, and the extent of the claims made around the research can therefore be seen as both strengths and weaknesses depending on the ontological and epistemological perspective of the reader. These issues are now explored.

Exploration of the available literature identified that while there has been limited research around the influence of the NA on the clinical development of student nurses working within physical and older adult care settings, there has been none investigating this phenomenon within the mental health setting. This study is therefore ground breaking in fore fronting this issue and in determining how it currently presents, the topic and setting proving to be both current and relevant to the clinical development of student mental health nurses, and indeed to nursing in general.

IPA structured research is suggested to require engagement with a small number of individuals whose perspective provides illumination around a topic likely to identify and explain important aspects of an issue (Smith et al., 2009). The inclusion of NAs, mentors and student nurses provided a scope of perspectives from each of the main groups involved in student nurse development within clinical settings, and the methods of collecting their stories and data provided access to their individual and group viewpoints. That the individuals worked across a scope of clinical settings and represented different aspects of their role (students from each of the 3 years of the programme, mentors with different levels of responsibility over the duration of the study and NAs with markedly different roles and relationships with their employers), provided a wide variety of opinions from a broad scope of standpoints. It could be suggested that this diversity is a strength of this research.

That only nine individuals took part in the study, all working within one Health Board area in Scotland, exposes the project to criticism around the wider relevance of the findings and their applicability across wider healthcare settings. Smith et al. (2009) counter that the small sample sizes associated with IPA research leads to the uncovering of deeper understandings in as yet un-researched groups. They suggest that while this cannot claim to be representative of all such similar cultures it is likely to uncover meanings recognisable and useful to practitioners within comparable settings. They describe this as Theoretical Transferability. With previous studies investigating the educational relationship between NAs and student nurses generally focusing on one clinical area at a time, engagement here with individuals from across a range of settings seems likely to provide access to experiences more representative of the entire field of mental health nursing. The inclusion of NAs, mentors and students exposed to recent role developments also suggests a representativeness and currency within the interpretations emerging. These factors can be

said to strengthen the theoretical transferability of findings, and will have relevance for other nursing fields, and other comparable professions.

Having sent email invitations to all nursing staff working within one Health Board and all student mental health nurses within one campus of a university training provider it could be argued that engagement with as few as nine of the twelve respondents meant only individuals with exceptional reason to participate were included. Rebar and Gersch (2015) explain that accessing individuals likely to provide rich and detailed perspectives on a subject is key to the success of qualitative research.

The relationship between the researcher and the participants is recognised as a likely influence on the confidence of the participant to fully engage within the study (Sanders & Wilkins, 2010). In this study the NHS practitioners were previously unknown to the researcher, and steps were taken throughout the study to create an informal environment during the researcher's interactions with the student nurses to avoid inhibition of their responses arising as a result of their previous interactions. The double hermeneutic associated with interpretative phenomenological research indeed suggests that the pre-existing rapport between the researcher and the students may in fact be beneficial in facilitating a more accurate appraisal of the students' experiences.

6.10 Conclusions and summary

This research project was triggered through recognition of momentous change in the role of nursing assistant grade staff working within the NHS, arising as a consequence of several UK government sponsored enquiries and subsequent policy amendments. Core to the recommendations arising from some of these documents was the association drawn between this staff group and the student nurses who work alongside them in clinical practice, an association that in reality was significantly under-explored.

As official guidance on student education excluded any recognition of an influence of NAs in pre-registration student nurse learning, and no prior investigation had been published

within the field of mental health, the purpose of this study was to illuminate the extent and nature of any such relationship from those groups most closely involved: student mental health nurses; mentors and nursing assistants.

To explore the nuances of a human relationship requires the application of research methodology sensitive to such phenomena, and Interpretative Phenomenological Analysis provided this through the combination of diary and individual interview as methods through which to collect information.

Analysis of the information that emerged identified three key themes arising from the participants, set against the background of data from the diaries that provided the context to the relationship as it exists for the participants within the reality of their everyday practice.

Diary recordings confirmed an extensive contribution from NAs to the clinical development of student mental health nurses during their practice placement experiences. NAs recorded themselves as involved in a wide range of tasks including essential care skills, organising group work and social activities and engagement with therapeutic activities such as managing aggressive clients, carrying out graded exposure and embedding visual communication skills.

Themes emerging from the participant interviews provided explanation for issues arising from the diary analysis and illuminated perceptions that were shared across groups, as well as group specific opinions. This information indicated that it was clear that NAs were routinely expected to contribute to student nurse learning during practice placements, an expectation almost completely ignored by related policy guidance or in job descriptions. The NAs engaged with this willingly because it fulfilled a need for a sense of contribution related to pursuit of belongingness with the wider nursing team. The NA contribution was seen to incorporate the majority of client facing tasks, however varied in influence depending on the student's ability to shape their own learning.

Review of the study indicated that while limitations were evident, particularly around the representativeness of the sample group and consequential ability to consider the findings predictive in other settings, the methods used were of value in investigating the specific issue. The use of IPA assisted in uncovering deeply personal perspectives on what had

previously been an unexplored topic and provided safe and accurate detail on clinical practice without negative consequences for patient care.

The study findings have considerable significance for student nurse education and indeed for nursing practice in general. The developing NA role requires recognition and accommodation alongside or within the nursing profession. There is also a need to accommodate this ongoing change through incorporating the expanding NA role more effectively within pre-registration student learning, particularly during the students practice placements. To this end the RCN revealed, possibly unwittingly, earlier recognition of the opportunity of an educational role for NAs within nurse education within their publication Defining Nursing (2014). Within page 4 of that document they state "Not all nursing is undertaken by qualified nurses, any more than all teaching is undertaken by qualified teachers". It seems likely however that they missed an opportunity to provide the first formal recognition of this phenomenon through the combining of both concepts.

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Appendices

Appendix 1

Literature search record examples

Source	**Search terms**	**Dates to search and hits**	**Dates/ time spent**	**Notes**	
British Journal of Healthcare Assistants All content searched from 2008	All articles	2008-12 2012-2016	7/11/12 3 hours 9/12/15 5 hours	Titles reviewed and likely articles included	
year	**Hit number**	**Author**	**Get copy**	**accessible**	**Notes**
2015		Hand. Promises and pledges are the order of the day. 9 (4). 179		Yes	
		John. A search for learning transfer: does non mandatory training make a difference? 9 (1). 41-47		Yes	
		Hayes et al. Housing a modernisation agenda: ensuring academic learning environments for healthcare assistants. 9 (2). 84-92.		Yes	
2014		Stonehouse. Who's responsible and who's accountable? You are.		✓	
2014		O'Carroll. Towards a fully research-literate nursing staff and a robust nursing evidence base. 8 (9). 442-445		Yes	
		Sealey. From HCA to student nurse: my personal journey. 8 (10).		✓	
		Matthews. Foundation degree, a pathway to practice, ½: mentors are magic. 8 (10). 506-510		✓	

		Hyatt and Firth. Moving on up. 8 (12). 583-585.		✓	
		Hayes. Looking to the future of HCA education in the UK. 8 (11). 559-565.		✓	
		Hayes. IPE: interprofessional education for HCS's 8 912). 606-611		✓	
2013		none			
2012		Hasson and McKenna. Greater Clarity in Roles Needed. 5(8) 1753-1786		Yes	
2011		Callister, G. Working with students: a CPD opportunity for AP's? 5(1) 38-41		Yes	
2010		Gasper, A. Widening participation in Pre-reg nursing. 4(8). 391-393		Yes	
2010		Eaton, A. Apprenticeships: pathways of opportunity. 4(6). 289		Yes	
2010		Rout, A. Longbottom, A and Titley, J. Higher Education learning and development in care homes.4(6). 290-293		Yes	

Source	Search terms	Dates to search		Notes	
Social sciences citation index (The largest social sciences database= UWS)	Search terms=Classroom Assistants Limiters= Education, educational research. Article	17/4/13 3 hours 18/6/16 3 hours		Titles reviewed and likely articles included	
year	**Author**	**Article/ journal**	**Get copy**	**accessible**	**Notes**
2016	none				
2015	Michalik et al	Assistant teachers for pupils with special educational needs in the Czech Republic; presentation of particular research results	Got		
2014	Villa and Baptiste	Creating equitable classroom environment. Multicultural education. 21 (2): 25-32	Got it		
2013	Edmond and Hayler	On either side of the teacher: perspectives on professionalism in education. Journal of Education for Teaching. 39 (2). 209-221	Got it		
2012	Cajkler and Hall	Mulitlingual primary classrooms: an investigation of first year teachers learning and responsive teaching. European Journal of Teacher Education. 35 (2). Pp. 213-228	Got it		
2012	Butt and Lowe	Teaching assistants and class teachers: differing perceptions, role confusion and the benefits of skills based training. International Journal of Inclusive Education. 16 (2). Pp. 207-219.	Got it		

2010	Rubie-Davies, Blatchford, Webster, Koutsoubou and Basset	Enhancing learning? A comparison of teacher and teaching assistant interractions with pupils. School effectiveness and School Improvement: an International Journal of Research, Policy and Practice. 21 (4). Pp. 429-449	Got it		
2009	Blatchford, Basset, brown and Webster.	Suitable work for women? Roles, relationships and changing identities of "other adults" in the early years classroom. British Educational research Journal. 34 (6). 839-853	Got it		
2005	Russell, Blatchford, Basset, Brown and Martin	The views of teaching assistants in English key stage 2 classes on their role, training and job satisfaction. Educational Research. 47 (2). Pp. 175-189.			

Source	Search terms	Dates to search and hits	Dates/ time spent	Notes	
Social sciences citation index (The largest social sciences database= UWS)	Search terms=Classroom Assistants Limiters= Education, educational research. Article	Open Initial= 211 Education, educational research= 117 Article= 115	17/4/13 3 hours 9/7/16 2 hours	Titles reviewed and likely articles included	
year	**Author**	**Article/ journal**	**Get copy**	**accessible**	**Notes**
2016	Glasper	Can a nursing associate role fill the void left by enrolled nurse training?	Got it		
	Manchester	Bringing efficiencies to general practice	Got it		
	Clements et al	Exploring commitment, professional identity, and support for student nurses	Got it		
	Struksnes	Nursing students' conception of clinical skills training before and after their first clinical placement: A quantitative, evaluative study	Got		
	Olsen	Reimagining health professional socialisation: an interactionist study of interprofessional education	Got		
	Grealish and Henderson	Investing in organisational culture			
2015	Lait	Collaborative Clinical Placements: Interactions Among Students From Different Programs	Got it		
	Goosen	The importance of teamwork in nursing	Got		
	Oeseberg et al	Essential competencies for education of nursing assistants and care helpers in elderly care	Got		

	Ellis and Rawson	Nurses and personal care assistants role in improving the relocation of older people into nursing homes	Got		
	Rheaume et al	The changing boundaries of nursing.	got		
	Levett Jones et al	What are the primary concerns of nursing students as they prepare for and contemplate their first clinical placement experience?	Got it		
	Black	DEVELOPING AN ENHANCED PERSPECTIVE OF TURNOVER AND RETENTION OF NURSES AND HEALTH CARE AIDES IN LONG-TERM CARE HOMES	Got it		
	Watson	Does feeling part of the team affect other characteristics of nursing teamwork?	Got		
2014	Smith et al	Does time matter? An investigation of knowledge and attitudes following blood transfusion training	Got		
	Crigger and Godfey	From the inside out: a new approach to teaching professional identity formation for professional ethics.	Got		
	Annear et al	Are care workers appropriate mentors for nursing students in residential aged care?	Got		
	Grealish et al	The significane of facilitator as a change agent- organisational learning culture in aged care home settings.	Got		
2013	Edmond and Hayler	On either side of the teacher: perspectives on professionalism in education. Journal of Education for Teaching. 39 (2). 209-221	Got it		
	Grealish et al	Promoting student learning and increasing	Got		

		organizational capacity to host students in residential aged care			
2012	Cajkler and Hall	Mulitlingual primary classrooms: an investigation of first year teachers learning and responsive teaching. European Journal of Teacher Education. 35 (2). Pp. 213-228	Got it		
2012	Butt and Lowe	Teaching assistants and class teachers: differing perceptions, role confusion and the benefits of skills based training. International Journal of Inclusive Education. 16 (2). Pp. 207-219.	Got it		
2010	Rubie-Davies, Blatchford, Webster, Koutsoubou and Basset	Enhancing learning? A comparison of teacher and teaching assistant interractions with pupils. School effectiveness and School Improvement: an International Journal of Research, Policy and Practice. 21 (4). Pp. 429-449	Got it		
2009	Blatchford, Basset, brown and Webster.	Suitable work for women? Roles, relationships and changing identities of "other adults" in the early years classroom. British Educational research Journal. 34 (6). 839-853	Got it		
2005	Russell, Blatchford, Basset, Brown and Martin	The views of teaching assistants in English key stage 2 classes on their role, training and job satisfaction. Educational Research. 47 (2). Pp. 175-189.			

Detailed literature search

Year	Authors/ Journal	Title	Methodology	Sample setting	Comments	Findings
2016 1	Grealish and Henderson/ Contemporary nurse	Investing in organisational culture; nursing students experiences of organisational learning culture in aged care settings following a programme of cultural development	Quant survey.	50 yr 1 and 2 students who responded to a questionnaire- some had usual placements while others had supported placements	NAs not confident in sharing information with students and resulting tensions impede student learning Students don't feel part of the organisation due to their transitional programme	Pre and post placement questionnaires showed enhanced sense of placement worth and recognition of learning opportunities. Part of student nurse led learning project- supported by an on placement educator.
2014 2	Grealish, Henderson et al, JCN	The significance of facilitator as a change agent- organisational learning culture in aged care	Mixed- survey and journal entries		The presence of students generates interest in learning in staff	Facilitators mainly effective in generating a social learning environment within aged care settings.

		home settings.				
2013 3	Greaish et al/ NET	Promoting student learning and increasing organizational capacity to host students in residential aged care; a mixed methods research study	Mixed-surveys, questionnaires and focus groups.	35 students from across years and 15 care staff of various unspecified grades	Routine care was felt by students useful for year 1 and some year 2 students, not so beyond that Being asked to provide such care felt they were being used as cheap labour SNs were concerned routine care tasks would mean they would fall behind their peers	Carers found it more difficult to identify appropriate work for senior students For SNs working with others created professional/ occupational self awareness through interacting with others
2010 4	Greaish, Bail and Ranse/ JCN	Investing in the future; residential aged care staff experience of working with nursing students in a "Community of Practice"	Qualitative thematic analysis			Care staff facilitated student learning as it brought value to the team through fresh eyes and provided investment for the future of care.
2007 5	Ranse and Greaish/ JAN	Nursing students perceptions of learning in the	Qualitative via focus groups	25 yr 2 and 3 students	SNs also believe that ward staff learn from them	Importance of acceptance and welcome highlighted, as was the uncertainty of some students

		clinical setting of the dedicated education unit.			SNs felt they were being asked to both work and learn and sometimes the two competed for priority- ward staff not recognising the emphasis on learning	around some of the work being learning. Recognition of competence from ward staff meant SNs were more confident around their practice
2016 6	Annear et al/ BMC geriatrics	Encountering aged care; a mixed methods investigation of medical students clinical placement experiences.	Mixed methods			Pre placement views showed disinterest in the client group, understanding of lack of challenge and inferiority to hospital placements. Post experience saw improvements in all areas.
2016 6a	Annear et al/ Journal of Interprofessional care	Interprofessional education in aged care facilities; Tensions and opportunities among undergraduate health student cohorts	Focus group and thematic analysis	61 medical students, 40 nursing and 20 paramedic in 2 RACFs		Professional hierarchy present from commencement and impeded learning. Intervention is required to alleviate this
2015 6b	Robinson, See,	Wicking teaching aged care	Action learning/action	2 residential aged care facilities and around 30	Developed to counter stigma around working in	Reviewing efficacy of a programme of preparation and support for a

	Lea et al/ Dementia; the international journal of social research and practice	facilities programme: innovative practice	research	nursing, medical and paramedic students	these areas. Found supports required differ by area.	clinicians and b students involved in OA care settings- validates their model of support for students in this area- flaw= outline only given of data and of how it fit with analysis
2015 6c	Stratton et al/ Australasian journal of paramedicine	Residential aged care facility clinical placements for undergraduate paramedic students; an evaluation of the Australian experience.	Mixed methods	21 final year paramedic students		Students identified increased understanding of dementia and of the communication skills needed for this group and the palliative approach to care.
2015 6d	Lea et al/ JCN	Aspects of student nurses placements associated with perceived likelihood of	Questionnaire and correlational stats	71 yr 2 nursing students at 2 residential aged care facilities	Supportiveness of care workers influenced whether student would return to work in the area and contributed to the educational	Students more likely to want to work in aged care is good mentor relationship/good support from HCA/ clear learning opportunities There is a need for a whole workforce approach to develop student learning

		working in residential aged care			worth students attributed to the placement	
2014 7	Elliot, Annear, Bell et al/ Health expectations	Residents with mild cognitive decline and family members report students enhance capacity of care and bring a new breath of life in two aged care facilities in Tasmania	Mixed methods inc grounded theory qualitative and quality of life questionnaire	21 subjects (13 residents and 8 carers) in two nursing homes	Students enhanced social activity Helping students was seen by carers as a way of giving something back Residents felt vulnerable and considered that students needed to develop their sensitivity Residents felt students generated better care standards	4 themes emerged from participants emphasising benefits brought by students. Residents' quality of life was also good when students were placed there.
2015 8	Lea et al/ International nursing review	Improving student nurses' aged care understandings through a supported placement	Mixed methods	40 second year nursing students and a control of 39 similar in RACFs	Preparation enhanced the students placement, interest and knowledge. Little is known around care workers undertaking a mentor role	Same
2014 9	Annear Lea and Robinson	Are care workers appropriate mentors for	Action research	10 year 2 student nurses and 17 Nurse and carer mentors	Students started with a low sense of worth in essential care tasks and saw	Introduction of a care guide framing hygiene tasks as assessment build students interest in what was a subject

	/ BMC Nursing	nursing students in residential aged care?			little relevance in learning them so were reluctant for carers to supervise them. Carers felt disrespected by students Care workers only recognised the value of their work when directed to consider it- as did mentors	of disinterest and overall care workers are appropriate mentors- especially in the development of hands on care- support is needed for this though
2014 10	Lea et al/ Journal of Nursing Education	Learning opportunities in an aged care environment: the role of supported placements for first year nursing students	Mixed methods	30 year 1 students	Pace of the environment more conducive to learning than acute areas Welcoming environment and effective orientation needed to facilitate good learning experience	Students see benefits in placement experience
2007 11	Robinson et al/ Australian Health Review	Living on the edge; issues that determine the capacity of residential aged care providers to support student	Action research mixed methods. Thematic analysis and questionnaires			Care home environments have limited resources to support student learning and need to have sufficient resources to accommodate staff absences. Good experiences encouraged students to consider aged care for career.

		nurses on clinical placement				
2013 12	Hasson et al/ NET	Delegating and supervising unregistered professionals; The student nurse experience.	Sequential mixed methods			Student nurses had little preparation for undertaking delegation and supervision of HCAs- they picked this up as training went on and was complicated by fears of conflict.
2013 13	Hasson et al/ NET	A qualitative study exploring the impact of student nurses working part time as a health care assistant.	A qualitative stage of a larger study			Experience as a HCA was seen as causing confusion by some but overall provided advantages in work experience
2012 14	Hasson et al/ JAN	Perceptions of the unregistered healthcare workers role in pre-registration student nurses clinical training.	Final stage of study used qualitative thematic analysis			HCAs undertaking tasks beyond their qualifications and were teaching this to students with and without mentor approval. Their involvement was based on availability, closeness to patients and to students.

2012 15	McKenna and Hasson/ Journal of Research in Nursing	Health care assistants and mental attendants daily work tasks in acute hospital care	A review of a Swedish study.			HCAs undertaking various tasks- no uniformity or recognition of this. Recognition HCAs there contribute to student learning and point raised about unrecognised involvement here.
2011	Hasson and McKenna / BJHCA	Greater clarity in roles needed	A position paper			Calls for clarification of the roles
2005 16	Keeney et al/ JAN	Nurses, midwives and patients perceptions of trained health care assistants.	Mixed methods though with a quantitative slant (Survey inc open questions)			Practitioners content with quality of NA care though some were reluctant to take responsibility for delegated tasks. Patients felt NAs mainly involved in personal care.
2005 17	Keeney et al/ Learning in Health and social care	Healthcare assistants experiences and perceptions of participating in a training course	3 stage mixed methods			HCA's felt their knowledge and practice improved as a result of the training.
1994	McKenna	Nursing skills	Lit search			3 main assumptions- rich skills mix is

18	/ JAN	mix substitutions and quality of care; an exploration of assumptions from the research literature.				ineffective. Mostly unqualified is ineffective. High numbers of qualitative staff are good.
2012 19	Clements / unpublished thesis	Commitments in students training for caring professions; a focus on student nurses' experiences of support	Mixed methods		Found students were reluctant to be treated as NAs by being asked to complete tasks they associate with NAs	
1981 20	Melia/ unpublished thesis	Student nurses' accounts of their work and training; a qualitative analysis	40 students from 2 colleges of nursing		Students walked a tightrope between acceptance from NAs to see them join the team and managing to meet their own specific learning needs They felt in older adult care there was no difference in the student or NA role Melia describes the	Common expectation that all staff and students will pull their weight Acceptance of a dominance of NAs and a need to fit in with them NAs useful on site teachers who can keep the student in line with local expectations Settling down in role meant moving away from patients, at least one student did not want to do this Students saw a differentiation

					NAs as having developed knowledge to the commonsense level- not reflective of current trends Nursing was acute care, older adult care was not nursing More senior students move away from auxiliary work NAs taught students common proceedures	between nursing and dirty work Early guidance in placement NA driven
2010 21	Lascelles, M., A/ unpublished thesis	Students' and mentors' experiences of mentoring and learning in practice during the first year of an accelerated programme leading to nurse registration		http://etheses.whiterose.ac.uk/2094/1/uk_bl_ethos_535672.pdf	Mentors believe that NAs can contribute useful info for students around basic care	Students believe that NAs can teach them outdated and flawed practice
2006 22	Wright/ Nursing and residentia	The role of Healthcare-assistants in supporti	Mixed using a questionnaire	25 NAs attending a workshop on student nurse training	Education sessions helped NAs situate the students learning in relation to	The session helped NAs understand the importance of their contribution to student learning. The day also helped NAs understand the

	l care	ng student nurses			their programme and the immediate learning need	responsibilities and requirements of the student role
2012 23	Hasson/ unpublished thesis				Yr 1 and 2 students felt RNs were uncaring and unprofessional due to their distancing from clients NAs recognised changing educational needs of students equated with managerial experience in year 3 RNs delegate SNs to work with NAs to experience particular tasks SN's would informally work with NAs at times NAs participated in student learning as they felt it accommodated RNs being too busy NAs took their involvement for granted and did not consider how it would develop Yr 1 students should be taught by NAs-	NAs felt students developed this uncaring attitude as they progressed- due to programme and role demands and RN role models NAs saw students at the bottom of a ward hierarchy based on competence- if the student had been an NA this changed their status SNs believed that NAs facilitated the socialisation process into the team and often did this through being welcoming and friendly Formal assessment and learning was seen as RN controlled SNs felt working with NAs offered access to key tasks and skills from a group who they could feel more relaxed about approaching

					both SNs and NAs felt this NAs involvement emphasised they could only teach the skill, not the theory	

Appendix 2

Dissemination of this research project

Completed article, poster and conference presentations related to this project

Article

Gillespie, M. & Rivers, I. (In press). How much time do student nurses spend with assistant grade nurses and what do they do; a diary study. *Mental Health Practice*. Accepted 22/6/2-17.

Conference presentations;

Gillespie, M. (2016).The influence of unregulated staff on the clinical development of pre-registration student mental health nurses. ENTER conference. Napier University, Edinburgh. 18/11/2016.

Gillespie, M. (2016). The elephant in the treatment room; the influence of nursing assistants on the clinical development of student mental health nurses. NET2016. Churchill College Cambridge. 7/9/2016

Gillespie, M. (2015). Using social constructivist epistemology to explore the influence of nursing assistants on the clinical development of student mental health nurses. NET2015. Churchill College Cambridge. 9/9/2015.

Gillespie, M. (2014). The influence of unregulated staff on the clinical development of pre-registration student mental health nurses. Scottish Mental Health Nursing Research Conference. Napier University. Edinburgh. 19/8/14

Gillespie, M. (2013). The influence of unregulated staff on Pre-registration mental health nurse education; a review of the literature. RCN Education Forum International Conference. Glasgow. 5/6/13

Poster presentations;

Gillespie, M. (2014). Time diaries as a method of investigating student nurse practice placements. University of Strathclyde research Day. 19/6/14

Gillespie, M. (2014). Time diaries as a method of investigating student nurse practice placements. University of Strathclyde. Health and Social Science research day 30/4/14

Gillespie, M. (2014). Time diary use in researching student nurses. RCN Education Forum Conference Harrogate 26-27 Feb 2014.

Gillespie, M. (2013). Nursing Assistants- do they help student nurses achieve their goals? Engage with Strathclyde. Faculty of Humanities and Social Sciences Postgraduate Research Day. University of Strathclyde. 30/4/13

Appendix 3

Diary examples

Practice Research Diary

Mentor copy

Diary Instructions and explanation of terms

1. Contact Mark.Gillespie@uws.ac.uk if you have any concerns or questions

2. Please complete the diary as close in time to the event as possible and include both when you work directly with the student and when you know they are working with someone else.

3. **Location** means the main area you were working in at that time

4. **Main activity** means the main task/ activity that you completed over that time- e.g. talking to a client

5. **Your own student** means you are their recognised mentor

6. **Direct supervision** means you were there watching/ assisting the student

7. **Indirect mentor supervision** means you had allocated someone else to monitoring and feed back to you

8. **Other staff present** means where the student is working alongside someone else- if so give their job title

9. **Comments** should include your understanding of what you/ others were teaching/ practising with the student and what you felt about the role of the person you had allocated to do this when you were not present.

Date Time	Main Location (e.g. office/ clients room)	Main activity (e.g. feeding/ personal hygiene/ student admin)	Working with own mentored student Y / N	Giving Direct supervision Y / N	Indirect supervision Y / N Via whom?	Other staff present (identify who)	Comment on what you are working on with the student, are you teaching/ assisting others or have you allocated another member of staff to work with the student, and your thoughts around that. Please use the additional sheet if required
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Please include additional sheets as required

Practice Research Diary

HCSW copy (Condensed)

Diary Instructions and explanation of terms

1. Contact Mark.Gillespie@uws.ac.uk if you have any concerns or questions

2. Please complete the diary as close in time to the event as possible and for times that you are working alongside students.

3. **Location** means the main area you were working in at that time

4. **Main activity** means the main task/ activity that you completed over that time- e.g. talking to a client

5. Was the students mentor present

6. **Indirect mentor supervision** means they had someone else monitoring the student and feeding back to them

7. **Were you the main student guide** means were you the main person working with the student

8. **Other staff present** means was there another HCSW/ a qualified nurse/ an OT/ or any other staff there

9. **Comments** should include your understanding of what you were practising / guiding the student with, and what you felt about the role of assisting

Date Time	Main Location (e.g. office/ clients room)	Main activity (e.g. feeding/ personal hygiene/	Was the students mentor supervising them directly	students mentor providing indirect supervision Y / N	Were you the students main guide Y / N	Other staff present (identify who)	Comment on what you are working on with the student, are you teaching or assisting them? Have you been allocated by another member of staff to work with the student, and your thoughts around

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Date Time	Main Location (e.g. office/ clients room)	Main activity (e.g. feeding/ personal hygiene/ student admin))	Was the students mentor supervising them directly Y / N	students mentor providing indirect supervision Y / N	Were you the students main guide Y / N	Other staff present (identify who)	Comment on what you are working on with the student, are you teaching or assisting them? Have you been allocated by another member of staff to work with the student, and your thoughts around that. Please use the additional sheet if required
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Date Time	Main Location (e.g. office/ clients room)	Main activity (e.g. feeding/ personal hygiene/ student admin))	Was the students mentor supervising them directly Y / N	students mentor providing indirect supervision Y / N	Were you the students main guide Y / N	Other staff present (identify who)	Comment on what you are working on with the student, are you teaching or assisting them? Have you been allocated by another member of staff to work with the student, and your thoughts around that. Please use the additional sheet if required
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Please include additional pages as required

Practice Research Diary

Student copy (condensed)

Diary Instructions and explanation of terms

1. Contact Mark.Gillespie@uws.ac.uk if you have any concerns or questions

2. Please complete the diary as close in time to the event as possible.

3. **Location** means the main area you were working in at that time

4. **Main activity** means the main task/ activity that you completed over that time- e.g. talking to a client

5. **Working with** is the main person/ people you were working with in completing the task- e.g. a trained nurse, not my mentor

6. **Direct mentor supervision** means your mentor was there watching/ assisting you

7. **Indirect mentor supervision** means they had someone else monitoring you and feeding back to them

8. **Supervised by someone else** means another member of staff supervised you without being asked to by your mentor

9. **Comments** should include your understanding of what you were learning/ practising and what you felt about the role of the person assisting you (if there was one).

Date Same shift as mentor Y / N Time	Main Location (e.g. office/ clients room)	Main activity (e.g. feeding/ personal hygiene/meds)	Working with (e.g. trained nurse/ NA)	Direct mentor supervision Y / N	Indirect mentor supervision Y / N	Supervised by other (identify who)	Comment on who you are working at the time, what you are learning from them/teaching them, and your thoughts around that. Please use the additional sheet if required
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Date Same shift as mentor Y / N Time	Main Location (e.g. office/ clients room)	Main activity (e.g. feeding/ personal hygiene/meds)	Working with (e.g. trained nurse/ NA)	Direct mentor supervision Y / N	Indirect mentor supervision Y / N	Supervised by other (identify who)	Comment on who you are working at the time, what you are learning from them/teaching them, and your thoughts around that. Please use the additional sheet if required
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Please use additional sheets as required

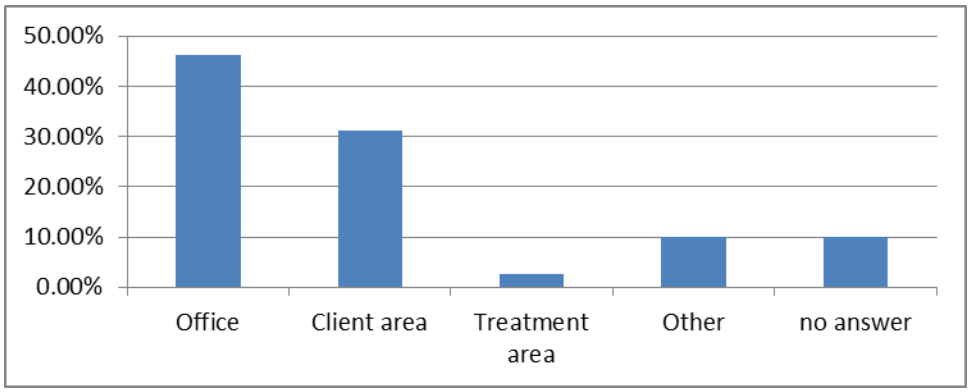
Appendix 4

Diary feedback form example

Mentor Diary Feedback Form

The findings are presented in graph form and there is space underneath each for any comments you may want to make on the findings.

1. Where you spent your time



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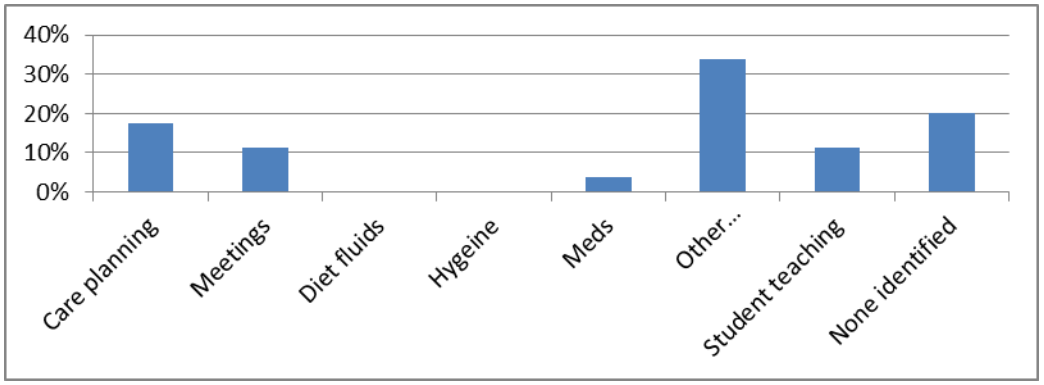
2. Activities you were involved in



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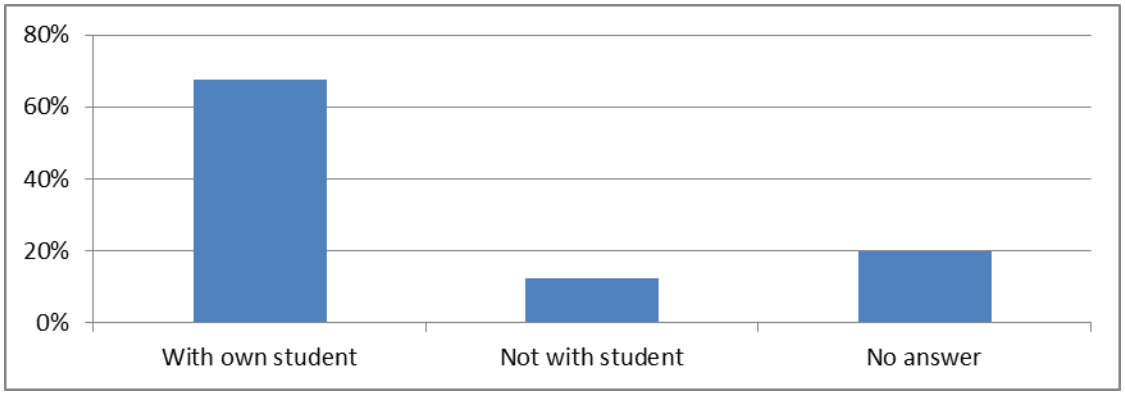
3. Time spent with your own student



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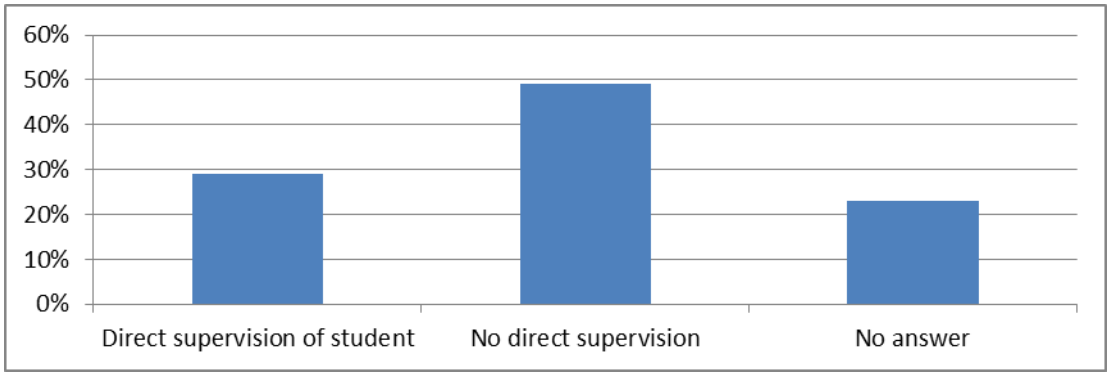
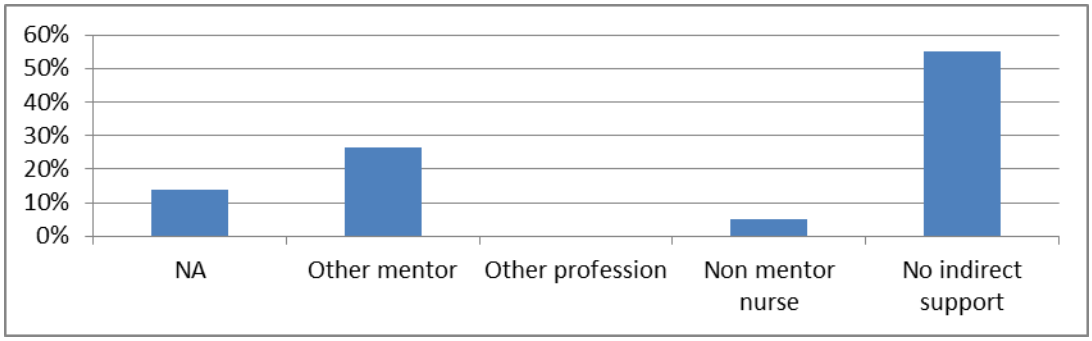
4. Time spent in direct supervision of student



Comment

5. Student supervision when not direct from mentor



Comment-

Do you have any general comments to make?-

Appendix 5

Interview questions template

Interview Question Outline

Explore all questions further where able

Student nurses

Commence by reviewing their diary and explore the time spent working with NA's and the tasks they were engaged in at the time

Ask how representative the diary was of their usual experience, the similarities and differences

Ask about how they perceive the NA role and influence within their current clinical environment

Ask about how decisions are made around the tasks suitable for them to undertake alongside NA's

Ask if they feel they are learning anything from the NA's, and if so what

Ask about how such learning could be enhanced

Ask how any such learning is formally recognised and supported

Ask how any such learning would be enhanced by recognition and support.

Ask if and how they will utilise NA's in supporting students when they are mentors.

Ask about any other ways NA's have influenced this placement

Ask what the main influence of NA's on their training has been

Ask if they are unhappy in any way with the NA role in their training

Ask if they have any further comments

Nursing Assistants

Commence by reviewing their diary and explore the time spent working with students and the tasks they were engaged in at the time

Ask how representative the diary was of their usual experience, the similarities and differences

Ask if there are tasks/ skills that they often complete alongside student nurses.

Ask how decisions are made around tasks they can undertake alongside student nurses.

Ask if they feel they are teaching anything to the student nurses, and if so what and how

Ask if and how they feel that any such teaching is formally recognised and supported

Ask if and how any such teaching would be enhanced by recognition and support and explore this

Ask about their perception of their role in student nurse education

Ask if they are unhappy in any way with their role in student nurse education

Ask about how they perceive the student nurse role within their clinical placement

Ask if they have any further comments

Mentors

Commence by reviewing their diary and explore the time spent working with students, the tasks they were engaged in at the time and the tasks they allocated NA's to work alongside student nurses.

Ask how representative the diary was of their usual experience, the similarities and differences

Ask about how they perceive the NA role and influence in relation to student nurse training within their clinical area

Ask if there are tasks they allocate NA's to complete alongside student nurses

Ask how they determine which tasks NA's are able to undertake alongside student nurses, what they are/ how frequently

Ask if they feel the NA's are teaching anything to the student nurses, and if so what and how

Ask if and how they feel that any such teaching is formally recognised and supported

Ask if and how any such teaching would be enhanced by recognition and support and explore this

Ask if they are unhappy in any way with the current NA role in student nurse training

Ask if they feel able to fully utilise NA's within student nurse education

Ask if they have any further comments

Appendix 6

Diary results

Quantitative results

Student mental health nurse diary content (by 30 minute segments over 1 working week)

Activity involved in

Activity involved in	Student sessions/ (%) S1- total= 80	S2- total= 81 sessions	S3- total= 100 sessions
Care planning	9 (11%)	19 (23%)	11 (11%)
Meetings with other professionals	2 (3%)	2 (2%)	1 (1%)
Diet and fluids	7 (9%)	12 (15%)	27 (27%)
Hygiene	2 (3%)	5 (6%)	18 (18%)
Medicines	1 (1%)	11 (14%)	8 (8%)
Other interventions*	29 (36%)	23 (28%)	27 (27%)
Student administration	7 (9%)	0 (0%)	2 (2%)
Other	5 (6%)	1 (1%)	2 (2%)
General administration	18 (23%)	8 (10%)	4 (4%)
*Other interventions include; S1- Memory assessments, memory based interventions and patient escort. S2- Calming patients, admission assessments, talking to patients S3- Talking to patients, art groups and helping patients relax.			

Who the student was working with

Who the student was working with	Student sessions/ (%) S1- total= 80	S2- total= 72 sessions	S3- total= 100 sessions
No answer	9 (11%)	3 (4%)	2 (2%)
Registered nurse	20 (25%)	14 (19%)	25 (25%)
NA	18 (23%)	15 (21%)	67 (67%)
Other professional	5 (6%)	17 (24%)	4 (4%)
No one	23 (29%)	7 (10%)	2 (2%
other	5 (6%)	16 (22%)	0 (0%)

Who supervised the student

Who the student was supervised by	Student sessions/ (%) S1- total= 80	S2- total= 73 sessions	S3- total= 98 sessions
None identified	9 (11%)	5 (7%)	2 (2%)
Nurse direct	20 (25%)	32 (44%)	22 (22%)
Nurse indirect	20 (25%)	12 (16%)	3 (3%)
No one	5 (6%)	5 (7%)	0 (0%)
NA	20 (25%)	18 (25%)	66 (66%)
Other professionals	3 (4%)	2 (3%)	6 (6%)
Activities when NA was main supervisor (in descending order); **S1**= Diet and fluids, Patient escort, Patient activity (Quiz/ dominos), Personal Hygiene. **S2**= Patient activity (talking to and calming patients), Diet and fluids, Personal hygiene. **S3**=Diet and fluids, personal hygiene, Patient activities (Quiz, painting, relaxing with patients, General tidying			

where the student spent their time

Location time spent in	Student sessions/ (%) S1- total= 80	S2- total= 71 sessions	S3- total= 100 sessions
No location identified	0 (0%)	0 (0%)	2 (2%)
Office	31 (39%)	21 (30%)	15 (15%)
Client area	1 (1%)	38 (54%)	82 (82%)
Other	7 (9%)	10 (14%)	1 (1%)
Treatment area	16 (20%)	2 (3%)	0 (0%)

The time students spent under direct mentor supervision

Time spent with direct mentor supervision	Student sessions/ (%) S1- total= 80	S2- total= 71 sessions	S3- total= 100 sessions
Direct supervision	18 (22%)	13 (18%)	19 (19%)
No direct supervision	53 (66%)	58 (82%)	60 (60%)
No answer	9 (11%)	0 (0%)	21 (21%)

NA diary content (by 30 minute segments over 1 working week)

Activity the NA was involved in

Activity involved in	NA sessions/ (%) N1- total= 73	N2- total= 8 sessions	N3- total= 15 sessions
Care planning	7 (10%)	3 (38%)	3 (20%)
Meetings with other professionals	0 (0%)	0 (0%)	0 (0%)
Diet and fluids	13 (18%)	0 (0%)	0 (0%)
Hygiene	7 (10%)	0 (0%)	0 (0%)
Medicines	0 (0%)	0 (0%)	0 (0%)
Other interventions*	29 (40%)	4 (50%)	8 (53%)
Student administration	0 (0%)	1 (13%)	4 (27%)
Other	0 (0%)	0 (0%)	0 (0%)
Other activities	16 (22%)	0 (0%)	0 (0%)
*Other interventions include; N1- Crosswords, word searches, bingo, art groups and talking with patients. N2- use of counselling/ CBT, School assessment. N3- Use of communication activities, IT development, school assessment, using visual aids.			

The time mentors felt the student spent with direct mentor supervision

Time student spent with direct mentor supervision	NA sessions/ (%) N1- total= 73	N2- total= 8 sessions	N3- total= 17 sessions
Direct supervision	4 (5%)	0 (0%)	2 (12%)
No direct supervision	15 (21%)	8 (100%)	4 (24%)
No answer	54 (74%)	0 (0%)	11 (65%)

Where NA's spent their time

Location time spent in	NA sessions/ (%) N1- total= 73	N2- total= 7 sessions	N3- total= 17 sessions
No location identified	6 (8%)	0 (0%)	2 (12%)
Office	4 (5%)	0 (0%)	5 (29%)
Client area	59 (81%)	0 (0%)	4 (24%)
Other	4 (5%)	1 (14%)	4 (24%)
Treatment area	0 (0%)	6 (86%)	2 (12%)

Mentors diary content (by 30 minute segments over 1 working week)

The activity the mentor was involved in

Activity mentor was involved in	Mentor sessions/ (%) M2- total= 80	M3- total= 76 sessions	M4- total= 78 sessions
Care planning	14 (18%)	26 (34%)	13 (17%)
Meetings with other professionals	9 (11%)	2 (3%)	15 (19%)
Diet and fluids	0 (0%)	7 (9%)	1 (1%)
Hygiene	0 (0%)	4 (5%)	0 (0%)
Medicines	3 (4%)	8 (11%)	13 (17%)
Other interventions*	27 (34%)	13 (17%)	12 (15%)
Student administration	7 (11%)	0 (0%)	0 (0%)
No answer/ other admin	16 (20%)	16 (21%)	13 (17%)

*Other interventions include;
M1- Various therapeutic interventions- e.g. counselling, CBT approaches. Also client assessment.
M4- Security checks and financial checks
M3- Assessment and client interaction.

The location the mentor spent their time in

Location time spent in	Mentor sessions/ (%) M2- total= 80	M3- total= 76 sessions	M4- total= 78 sessions
No location identified	8 (10%)	16 (21%)	11 (14%)
Office	36 (46%)	21 (28%)	24 (31%)
Client area	25 (31%)	37 (49%)	10 (13%)
Other	8 (10%)	0 (0%)	17 (22%)
Treatment area	2 (3%)	2 (3%)	16 (21%)

The time mentors spent with students

Time spent with own student	Mentor sessions/ (%) M2- total= 80	M3- total= 76 sessions	M4- total= 78 sessions
With own student	54 (68%)	0 (0%)	0 (0%)
Not with own student	10 (13%)	76 (100%)	78 (100%)
No answer	16 (20%)	0 (0%)	0 (0%)

The time mentors provided direct support to students

Time spent providing direct support to the student	Mentor sessions/ (%) M2- total= 80	M3- total= 76 sessions	M4- total= 78 sessions
Providing direct support	23 (29%)	41 (54%)	51 (65%)
Not providing direct support	39 (49%)	19 (25%)	16 (21%)
No Answer	18 (23%)	16 (21%)	11 (14%)

The time mentors spent in indirect support to students

Indirect supervision of the student carried out by	Mentor sessions/ (%) M2- total= 80	M3- total= 76 sessions	M4- total= 78 sessions
No indirect	44 (55%)	33 (43%)	63 (81%)
NA supervising	11 (14%)	7 (9%)	14 (18%)
Other mentor supervising	21 (26%)	36 (47%)	0 (0%)
Non mentor supervising	4 (5%)	0 (0%)	0 (0%)
Other professional supervising	0 (0%)	0 (0%)	1 (1%)
Activities when NA was supervisor (in descending order); M2- Socialisation, relaxation/ desensitisation. M3- Personal hygiene. M4- Ward security checks, infection control measures, patient interaction/ socialisation.			

Appendix 7

Participant information leaflet

Participant Information Sheet for student nurses, healthcare support workers and mentors

Name of department: School of Education
Title of the study: The influence of unregulated staff on the clinical development of pre-registration mental health nurses

Introduction

Thank you for your time in reading this, and hopefully in participating within this study. My name is Mark Gillespie and I'm a post graduate student at the University of Strathclyde. My contact details are; Phone 0141 849 4293. Email Mark.Gillespie@uws.ac.uk

What is the purpose of this investigation?

This study investigates how student mental health nurses, healthcare support workers and mentors understand the role healthcare support workers have in supporting student nurses on clinical placement.

Do you have to take part?

Participation in this study is entirely voluntary and your involvement or refusal would have no impact at all on your progress as a student nurse, your role as a healthcare support worker or as a mentor. In fact participation is entirely confidential and you will be asked only to disclose broad biographical information, none of which would identify you. If you decide to take part and then later change your mind, you are free to do this at any time.

What will you do in the project?

You are asked to complete this consent form and then a week long diary whilst at work, outlining the work you are involved in and the staff groups you are working alongside. This diary will be explained beforehand in a meeting with the main researcher (me). Following the diary you would be asked to spend up to an hour in an audio recorded interview with me, discussing your diary contents and exploring your views on this subject. This interview would take place at your workplace, close by or elsewhere should you request that.

Why have you been invited to take part?

You have been approached for this study because of your unique position in being in one of the groups most strongly related to the subject. The first three respondents from each group will be accepted into the study.

What are the potential risks to you in taking part?

There are no known risks arising from your participation

What happens to the information in the project?

All information will be collected, analysed and stored in a manner that ensures confidentiality, security and anonymity. Data arising from the study will be stored securely and destroyed following analysis and presentation of final conclusions. This will be around September 2016

The University of Strathclyde is registered with the Information Commissioner's Office who implements the Data Protection Act 1998. All personal data on participants will be processed in accordance with the provisions of the Data Protection Act 1998.

Thank you for reading this information – please ask any questions if you are unsure about what is written here.

What happens next?
For those who are not interested in taking part in the study- thank you for your time in reading this.

For those who are interested in taking part please contact me at the email address given in the section immediately below this one. I will then send you a consent form, asking you to read and sign to confirm that you are willing to take part in the study.

I will provide full instruction on completing the diaries before we commence and will be available to answer any questions during the period of the research and after it. I will provide you with my summary of the diary content before the interviews are completed and will provide you with an account of my summary of our interview for you to check and comment on before drawing up my final study. I will also provide you with access to any published materials emerging from the study as I plan to share my findings through professional journals.

If you do not wish to get involved then thank you for your attention

Researcher contact details:
Mark Gillespie, Post graduate student, School of Education, University of Strathclyde, Lord Hope Building, 141 St James Road, Glasgow, G4 0LT. Phone – 0141 849 4293, email – mark.gillespie@strath.ac.uk.

Chief Investigator details:
Dr Aileen Kennedy, Senior Lecturer, School of Education, University of Strathclyde, Lord Hope

Building, 141 St James Road, Glasgow, G4 0LT. Phone- 0141 444 8061, email- aileen.kennedy@strath.ac.uk

This investigation was granted ethical approval by the University of Strathclyde Ethics Committee.

If you have any questions/concerns, during or after the investigation, or wish to contact an independent person to whom any questions may be directed or further information may be sought from, please contact:

Secretary to the University Ethics Committee
Research & Knowledge Exchange Services
University of Strathclyde
Graham Hills Building
50 George Street
Glasgow
G1 1QE

Telephone: 0141 548 3707
Email: ethics@strath.ac.uk

Consent Form for student nurses, healthcare support workers and mentors

Name of department: School of Education
Title of the study: The influence of unregulated staff on the clinical development of pre-registration mental health nurses

- I confirm that I have read and understood the information sheet for the above project and the researcher has answered any queries to my satisfaction.
- I understand that my participation is voluntary and that I am free to withdraw from the project at any time, without having to give a reason and without any consequences.
- I understand that I can withdraw my data from the study at any time.
- I understand that any information recorded in the investigation will remain confidential and no information that identifies me will be made publicly available.
- I consent to being a participant in the project
- I consent to being audio recorded as part of the project Yes/ No

(PRINT NAME)	
Signature of Participant:	Date:

Appendix 8

Email inviting participation

Invitation for mentors/ HCSW's

Are you a mentor or healthcare support worker with a view on the role of healthcare support workers in the education of student nurses? If so I would appreciate a couple of minutes of your time to think about helping with a research study into this subject.

I am currently researching the role that healthcare support workers have in the clinical education of student mental health nurses, and to explore this properly I need to speak to the experts in that- and if you are a mentor or healthcare support worker, that means you. I would really appreciate your help with this, and your help would take the form of completion of a week- long diary and then taking part in a short interview with me. Further details are given in the attachment and I would encourage you to take a short time away from your busy schedule in order to help identify what really goes on around this subject. Please contact me on the email address given below if you are interested or are looking for further information before committing yourself.

Thank you for your time

Mark Gillespie

Mark.Gillespie@uws.ac.uk

Invitation for student nurses

Interested in discussing the influence of healthcare support workers on your clinical practice?

If so then I would like you to participate in a short research study investigating this topic. I am currently researching the role that healthcare support workers have in the clinical education of student mental health nurses, and to explore this properly I need to speak to the experts in that- and if you are a student nurse, that means you. I would really appreciate your help with this, and your help would take the form of completion of a week- long diary and then taking part in a short interview with me. Further details are given in the attachment and I would encourage you to take a short time away from your busy schedule in order to help identify what really goes on around this subject. Please contact me on the email address given below if you are interested or are looking for further information before committing yourself.

Thank you for your time

Mark Gillespie

Mark.Gillespie@uws.ac.uk

Appendix 9

Feedback from feasibility trial

Learning from pilot diary- student 1

Time column worked well

Main location worked well

Main activity worked well (see below for examples)

Working with- too vague and saw a yes/ no as opposed to the actual profession worked with

Direct mentor supervision and indirect mentor supervision columns seem ok

Supervised by other seems ok

Comment was mainly on the task undertaken

Wider comment page not utilised

Feedback on format- No issues raised and format praised

Interventions include- bingo, shopping, movement to music and life story work

Student 2

Time column worked well

Main location worked well

Main activity worked well

Working with- worked well

Direct mentor supervision worked OK

Indirect seems OK

Supervised by other- rarely completed though data from previous 2 boxes helped guide analysis of this

Comment was mainly on the task undertaken

Feedback on diary format- felt the format clear, didn't take long to complete though no time in shift so done at home after shift. Felt launch was clear though requirements for comments section could have been repeated. Some learning identified around the scope of activities undertaken and the breadth of people the student learns from.

HCSW feedback

Each column worked well and was comprehensively completed

Feedback advised that the format was appropriate though expectations maybe not clear as concerns were raised about not being able to work over the 5 days with one student. Importantly little time within a shift to complete the diary so this was done at the end of each day.

The NA reported increased awareness of their role in the education of students- something they hadn't previously been aware of

Mentor feedback

The columns were appropriately completed apart from the other staff present part which was blank throughout- possibly not clear enough on requirements here

Overall comments- format clear and with sufficient space. Insufficient time to complete at the time of the event- done 1-2 days later in a block and often based on ward routine. Launch appropriate.

Appendix 10

Example of data

S2 data within analysis process

					1= CARE PLANNING			LOCATION			WORKING WITH		SUPERVISION BY		DIRECT MENTOR SUP								
					meeting with other hc staff			1= OFFICE			1= NURSE		1= NURSE DIRECT		1= YES								
					3= DIET FLUIDS			2= CLIENT AREA			2= na		2= INDIRECT		2= NO								
					4= HYGEINE			3= OTHER			3= OTHER TRAINED		3= NONE										
					5= MEDS			4= TREATMENT AREA			4= OTHER		4= NA										
					6= OTHER INTERVENTIONS						5= NO ONE		5= OTHER TRAINED										
					7= STUDENT ADMIN						6= other student												
					8= general admin																		
day 3								Day 4							day 5								
TIME	ACTION	LOCATION	WITH	DIRECT SU	BY MENTOR			TIME	ACTION	LOCATION	WITH	DIRECT SU	BY MENTOR		TIME	ACTION	LOCATION	WITH	DIRECT SU	BY MENTOR			
1	6	1	5	2	2			1	8	1	5	2	1		1	6	3	1	2	2			
2	1	4	5	2	1			2	6	4	5	2	1		2	6	3	1	2	2			
3	1	4	5	2	1			3	6	4	5	2	1		3	6	3	1	2	2			
4	6	4	1	2	2			4	6	4	5	2	1		4	6	3	1	2	2			
5	6	4	1	2	2			5	6	4	6	2	2		5	6	3	1	2	2			
6	6	4	1	2	2			6	6	4	6	2	2		6	6	3	1	2	2			
7	1	1	5	2	1			7	6	1	5	2	1		7	6	3	1	2	2			
8	6	4	5	2	2			8	6	1	5	2	1		8	6	3	1	2	2			
9	3	3	6	2	2			9	1	1	5	2	1		9	6	3	1	2	2			
10	0	0	0	0	0			10	0	0	0	0	0		10	0	0	0	0	0			
11	5	4	1	2	2			11	5	4	1	1	2		11	1	1	5	2	1			
12	8	1	6	2	2			12	6	4	5	2	1		12	4	4	5	2	1			
13	1	4	1	1	2			13	6	4	5	2	1		13	8	1	1	2	2			
14	1	4	3	1	2			14	6	1	1	1	2		14	8	1	1	2	2			
15	1	4	3	1	2			15	6	1	1	1	2		15	8	1	6	2	2			
16	8	1	1	2	1			16	6	1	1	1	2		16	8	1	6	2	2			
17	8	1	1	2	1			17															

Appendix 11

Example of transcribed interview

R	If you are OK to start can I just get you to confirm your name for me please.	
S2	Its S2	
R	Thanks S2, I thought that what we would do is start off by looking back at the diary that you completed and I just wondered was there anything with regards the actual diary completion that sort of surprised you, with regards the findings that you realised you had.	
S	Not so much surprised me but just in general the week I completed the diary was a very different week to the rest of my placement, so I felt the results for that week didn't surprise me because I knew that's what I'd done in comparison to the other 6 weeks that I was there. If I had done it any other of those 6 weeks I think the results would have been very different.	
R	What would have been different?	
S	Emm…time spent in the office doing admissions and care plans. In the first 5 weeks of my placement I think we had 3 new admissions, it was a really quiet block during Summer and then the week that I did my diary we had about 7 new admissions that one week, so it was a much busier week in terms of paperwork than the rest of my placement had been.	
R	So I noticed that there were days where it was almost, one day when it was almost entirely admissions	
S	Yeah, because it was a case of on that week, maybe the Monday we has 2 new admissions and we had some over the weekend that we had to complete and then the Tuesday we had 2 new admissions, Wednesday we had 3 new admissions, so there was days that was just doing admissions.	
R	So maybe slightly less- representative although we will get the chance to look at how things would normally be. Can I start with who you were working with, what I saw was a sort of relatively even split between trained nurses, healthcare support workers and other professions, mainly OT, Physio. Would that be representative of what you would normally do then?	
S	Emm…yes, again.. I would…it was very much a sort of placement where you are left to do what…not what you want but you are kind of left to do your own day, its not as much as your mentor saying come along with me or go with them, so I just…whoever was about I would tend to follow so if the physios were in I would take that on myself to go to them and ask if I could see what they were doing and the same with the OTs, so when they were in I did spend a long time with them, and then I spent a lot of time with the nursing assistants, just when there wasn't much else going on like when the physios weren't in, or there was no specific thing that the nurses had asked me to do then it was naturally then with the nursing assistants that I was working alongside.	
R	I suppose then moving on from that what I saw was that supervision fell mainly as fare as you could see to trained staff, probably about 50% of your time, or trained nursing staff. Healthcare support workers seemed the second largest bulk of who was supervising you	

	and then other professions seemed to make the third largest of the groups.	
S	Again it was very I suppose indirect supervision in a way that in general it would be a case that I would, they would just leave me to get on with things but sometimes I have maybe said that they would supervise me just because I happened to be with them but they had never been asked directly to supervise me but just some of the times when I was filling it in I was thinking more of when I was doing this job who is it I would have went to if I had a problem to ask and a lot of the times then it was the nursing assistants. Like I said because that week I was in the office a lot then it was the nursing staff, the trained staff that were the ones I was working with on that stuff	
R	So would that have changed the dynamic then from the other weeks, the fact that you were in the office more	
S	Yeah the other weeks I was out on the floor more than the office.	
R	And would that mean that you would be spending more time with other groups during those other weeks?	
S	Yeah	
R	Which groups	
S	Nursing assistants	
R	Nursing assistants, Ok. Where you spent your time, most, probably about half the time was spent within client areas, by client areas dining rooms, bedrooms and corridors. Roughly 40% of it was spent in the office but again that seemed to be very heavily weighted towards the one day, em and about 10% treatment areas generally associated with medications. Was that sort of reflective of your normal experience?	
S	Em, I'd say normally it would be more time spent with client, in client areas.	
	Approximate, what would you say, I know its difficult but…an approximate figure.	
	Going by the rest of the weeks, office time I would say 25% of the week if even, again just because there wasn't any new admissions going on during those other weeks, it was only, there would only be one day of the week I'd spend a large time in the office and that's when we were doing the Kardex, so , yeah, maybe 20-25% and the rest in client areas.	
R	Considerably different then	
S	Uh huh	
R	What you were doing over those times; and again there is a relatively even split that week between administration, which again seemed to be weighted heavily towards that particular one day, food and fluids, hygiene, and then probably slightly less, other treatments. Would that again be skewed because of the nature of that one week?	
S	Yes, admin wouldnt have been as high, it was more personal care and hygiene and I did quite a few medication rounds, and all those stuff I would say were quite high up on what I was mainly doing, admin it was just that week (says something too low to make out)	
	Time spent then (S laughs) with direct mentor supervision, in reviewing it it seemed, round about 20% of the time.	

S	Yeah, em its again, its very much, like my placement before this one partly because it was a clinic you had to be with someone all of the time because it was very strict. Everyone had their specific jobs and appointment times to keep to and this being in a ward setting it was just more laid back and I was very much left to do things, so I was always, most of my shifts I was on with my mentor but it wasn't a case of I was by her side for the whole shift, she was happy for me just to go and do whatever, and if I had any questions or whatever I could go back to her and the same with the paperwork, it was very much a case of she told me what she wanted me to do and then left me to it, it wasn't she was sitting beside me going through it with me. It was just she had given me some old ones to look through so I could work out myself what to do and then at the end go back to her, she'd check over but it was never really sit down with me to go over things	
R	You mentioned then that the diary itself was not particularly representative of a normal week, what would you say had been the main similarities with the other weeks, and the main differences.	
S	Similarities is when I was on an early shift the mornings was always pretty much the same, get patients up, personal care, breakfast, so that I think maybe one morning I was in the office doing paperwork that had been left from the day before but most mornings I was on an early shift was that, it was the same routine. Differences then, just as I'm saying in the office more …	
R	Dealing with admissions?	
S	Yeah	
R	How do you perceive the nursing assistant role and their influence within that clinical environment	
S	(Pause), their role as in just day to day?	
R	Yeah, I suppose both day to day and in relation to your learning	
S	Well, I suppose LIKE a lot of the hands on stuff it was them that were doing it, in terms of personal care and feeding a lot of the times the nurses weren't around with those sort of aspects, it was the nursing assistants who were taking the lead, and they always sort of manage themselves, although there will be a nurse that's in charge, they are kind of left, they are trusted to within themselves work out who is doing what and when. Even at times working out when whose going and what break. There will be a nurse that's sort of, is in charge of making sure it happens, but they are happy for them to sort it themselves, and occasionally the trained staff will come out and help with some stuff but their priority is more I suppose the bigger picture. Doing office work and medication rounds and stuff, so a lot of my time, especially as a first year, where I am just learning a lot of the basics was then spent with the nursing assistants, and they, what I found difficult sometimes was though was if they were managing themselves, they would sometimes, for example like with personal care in the mornings they would pair up and they would go to this patient, and me wanting to learn would want to go with some of them and well say can I come and do this with you, and they are like, "we are fine with just the two of us" and it wasn't so much that I didn't think they could do it with just 2 of them, it was just, it was just that I needed to be with someone to learn how to do it, but quite	

	often it would be a case of "no we don't need you here", "we don't need you here" so I'd spend the morning just trying to find someone that would say "yeah, come with me and I will show you", they did quite I suppose, like just from different perspectives they weren't thinking of it as a, a learning opportunity, they were just trying to get on with their job and they didn't need a third person to do it, or even a second person if it was just someone who just needed one person to help them. But from my perspective it was just I needed, you know I wanted someone to work with and just see how they did things, and speaking to other students that were there, they found had the same thing that they, some of the students actually avoided doing morning shifts cos they hated that, sort of, they felt it was very, I don't know, as if they were very protective of their job and they didn't want the student in doing stuff, I think it was more they just didn't, they just had a different perspective, they just wanted to get on with it, so I think I spent a lot of time with them and I did learn a lot working with the nursing assistants and just general, em, not just in the mornings personal care but just throughout the day, but I think because they've got a different outlook maybe then there was opportunities that I could have had but, I kind of missed out on because they weren't as willing to have me on board I suppose.	
R	How could we enhance the ability to take those opportunities?	
S	I don't know cos, its like, as a student its difficult going in and em, like you don't want to upset, rock the boat and tread on people's toes so I didn't want to impose myself on any of them if they were like "don't come" , but when, actually in my last week when I was there and a new student started and one of the nurses that was on duty at that time specifically said to her "Oh these are the nursing assistants on today, why don't you buddy up with Carol" and specifically appointed a nursing assistant for her to be her sort of buddy that day, and did that for her first week, every day she was like "can you pair up". In that way it was coming, it was a kind of order from a nurse that to do it, so they couldn't just, the nursing assistants couldn't just go off and do stuff and leave the student behind because then the student could say "Oh I've been told I've to stay with you" so if the even assistant did say " no we don't need you she could at least have that to fall back on, to say I've been told I'm to stay with you. And I think that would have helped even in the first couple of weeks of settling in, I suppose there is some authority behind it so they can't get rid of me (laughs).	
R	You mentioned being a first year that you felt you were in that position. Do you perceive then that that will change as you go back in second and third year	
S	Em I don't think their attitude, that the sorts of attitude from them will change, I just, in terms of experience I will be more confident in doing stuff so that I wont feel that I need that support as much I suppose. So if there's patients that I know that just need one person to get them up, once I'm settled in the placement and know the patient then I'd be happy to go do it myself, which I was by the end of the placement, I was but for the first few weeks when you don't know the patients, you don't know who needs more than one person or	

	whatnot to help them and you don't have as much experience then it would be useful to have more support	
	What I'm picking up then is that the nursing assistants have a certain amount of influence on what they do and how you, what they do with you?	
	Yeah, uh huh, yeah em, Yeah. Cos the trained staff can stay out of it, and their very much…they're happy for me to go and work with the nursing assistants, but once I'm with them there wasn't…I was working a lot with them but there wasn't any . I suppose I didn't have a manager, a mentor within that setting.	
	Who makes decisions on the tasks that are suitable for you to work with nursing assistants on?	
	Emm…I suppose the nursing assistants. Em…like there was some stuff that I knew from the trained staff, like it was stuff like I knew not to do…like going on one to one observations that was, that was the nursing assistants that mainly did that because within themselves they had a rota of what patients they were with, but I knew that I definitely wasn't allowed to go on with them, but in terms of …yeah again cos the nursing assistants managed their own days and managed who was doing what, I suppose they had a big influence on that in terms of if it was a quite violent patient or a difficult patient and someone and I would come and they'd quite often say "Oh no, we'll get someone else" or erm...mostly they did.	
	How did they define the criteria for the kind of things you could work on. Is there a…how were the rules made?	
	I suppose just on their personal opinions as much as anything. It was just. I suppose if it was too difficult, like if it was a patient that we know we were going to have some difficulties with, they'd maybe be like "Oh no, I'll wait till someone else comes" rather than me. Which I think, fair enough I suppose if I don't have as much experience as other nursing assistants or whatnot…but it would just really be down, to the personal opinion of whose there, and if they are short staffed then yeah they would take me, so it wasn't a hard and fast rule (laughs).	
Me	Are you learning anything from the nursing assistants, and if so what?	
S	Yeah, just a lot of the basic care and the emm, even things like I'd never before, coming in I'd never worked in a care setting or anything so things like washing and dressing patients and dealing with toileting , which all you know you do yourself, but doing for someone else is very different. So just, it has been good working alongside them and learning I suppose basic care needs, and things like that and just general. Like the first time I went on that placement, cos its my base placement, so my very first four week block then it was the nursing assistants that really in the end showed me about and where everything was. There had been a problem that I didn't have a mentor so it was then down to the nursing assistants to say its ridiculous that you've been here for two, three weeks now and you don't even know where something quite simple is kept, so one of the nursing assistants then said come with me, I'm going to show you everything, so I definitely learned a lot	

R	What about with regards interpersonal skills, is there anything you picked up from them on that?	
S	Working with patients?	
R	Yeah	
S	Yes, I think I've seen a lot of what to do and what not to do, and sometimes what they are doing is not how I would have handled some situations. But a lot of positives as well.	
R	OK, so the things that you are learning, you are not always learning from…	
S	How they are doing it yeah. How they are doing it but in a negative way I suppose.	
R	OK, how could the learning from the nursing assistants, how could we enhance that? How could we develop that?	
S	I think what I was saying…that…maybe…you mentor or somebody specifically saying and them going to the nursing assistants and saying would you mind if Amy pairs up with you today whilst on the shift and just take her with you on everything that you're going to be doing. Like so I suppose like a co-mentor type thing as a nursing assistant. Think that would be helpful because , like I say there was a lot I learned, but I had to push through a lot to get to it, but if there was someone on each shift. If that was going to be a day that I was working with the nursing assistants, if there was someone specifically named to be part…like to be my partner for that day then that would…	
R	That would make a difference?	
S	Yeah that would help a lot	
R	Would you feel comfortable working with nursing assistants as a formal part of your training?	
S	Yeah	
R	Do you have any difficulties with that?	
S	I wouldn't, no.	
R	You wouldn't?	
S	(laughs) Again I think depending on the nursing assistant, cos they were all very different, and most of them were lovely and I got on well with, but for some of them I think there is a bit of a tension, they don't know how to treat students, because we are not a nursing assistant and not a qualified nurse , you're in the middle, and I think for some of them, some of them took it on board. They see you're a student and they just want to help you. Others maybe had the attitude of "Oh you don't know as much as me but after two years, two more years of training you're going to be in a better job than me and you're gonna be like above me. But I've been in this job for twenty years so, like that sort of attitude, there was a bit of a nursing assistant, qualified nurse divide I suppose in my ward. Not greatly, but just in little things you picked up on. So I think as a student they didn't really know like, where you stood in it all, so I think from my point of view I wouldn't have any issue with it, but I know, perhaps some of them would, and some of them have the attitude its not our job to train students, so then they'd be like I don't mind showing you this bit, I don't know why she'd asked me, its not my job to do it, and…it puts the student I suppose in a difficult position.	

R	That leads me nicely on to the next question, which is how is their role formally recognised and supported?	
S	How is?	
R	The nursing assistants role in supporting students, formally recognised and supported?	
S	I think its recognised but maybe not supported, that sort of thing. The nursing staff, like my mentor knew that I was working alone with them, but I don't know how well that they, I mean they were fine in supporting me but I don't know if they were given any direction in terms of what to do with me or anything…emm…yeah I suppose…and some days when the nurses or whatever were busy . I was essentially another nursing assistant…emm…but so yeah I think it is recognised students do spend a lot of time with nursing assistants but there's nothing formally I suppose put in place for that to be as good as it could be.	
R	OK, if support and recognition was in place how would learning be improved?	
S	I think you would just learn more, faster. I think what I learned from the nursing assistants in my placement, I think if I was like I said paired up with one and it was a more formal system that they were, they had a responsibility for me as well, then I think that what learned, what I learned just naturally over time as when things turned up, then I worked out how to do it, I think if I was with someone who was showing me the roes more formally then I think you'd learn more, faster, rather than just when things happen to turn up, it might have been something that had already been covered	
R	When you're a mentor how will you utilise nursing assistants to support student education?	
S	I think like I said in terms of , just learning a lot of the, the basic nursing skills they are the good ones to show the students. Definitely would want, especially a new student, to spend a lot of time with the nursing assistants, but like I'd said I'd probably take it as my duty as a mentor to arrange that, rather than just leaving my student to go, get on with it, and for the first couple of weeks anyway, try and find someone every shift that, and say to them "can you keep an eye on the student and show her whatever you're going to do, let her go along, and even if its just observe, if it's a difficult patient or whatever, just let her see but emm, what it is you do". Cos like with a lot of the other like I was saying I've worked a lot in the diary with the physios and the OT, or the speech therapists or whoever, whenever they came in I would go and a lot of the time I was just sitting in and observing what they did, so the same with nursing assistants, that even if it's not directly involved, its observing some of the things they are doing, and getting a more, better understanding of their role, then its just as important, I think as like the physios and OT.	
R	Are there any other ways that nursing assistants have influenced you in this placement?	
S	I think just what I was saying (pause) I think, yes but I suppose in a more negative way, just I think some of their handling of situations, I could see the difference between the trained staff and I suppose their understanding of dementia and the patient and client group,	

	compared to some of the nursing assistants, that there might be situations I was working with them and a situation arose from it that to them they were like, risk, the patient is really violent and difficult, but from my perspective I could see that actually it was more their interaction with the patient that started it. I think, yeah I learned in a sort of negative way, I did learn a lot more.	
R	Do they have any influence on your acceptance in the ward team?	
S	Yeah, I think so	
R	How powerful an influence?	
S	Well very, because a lot of my time in the lounge was spent with them, if they had kind of cut me out then it would have been very difficult, very difficult	
R	And do you purposely adapt to be accommodated?	
S	Yes, yeah (laughs) I suppose so, well it depends what you mean by adapt, like I would, like a lot of the time, like 'm happy to just go with the flow and things. I don't think, I don't think I adapt in terms of practice or anything. A lot of the times maybe in the sitting room, patients were just in, and the TV was on or whatnot , they would often be sitting chatting in a group, like nursing assistants but I'd be talking to the patients rather than be going and, as much as I wanted to get on with them I knew it wasn't my, kind of main point (laughs). It wasn't just to get into the group, it was more patients so I don't think I adapted in that terms but I was happy just to, like you knowsit with tme and I got on fine.	
R	On your training or in your training until now what has the main influence of nursing assistants been on you?	
S	Main influence?	
R	If any?	
S	I think just what I've been saying is just the kind of building blocks of all of the kind of basic skills of nursing acre and …certainly in that ward, yeah…on other placements…emm again its been mixed depending on what nursing assistant you have been working with, but on the last placement there was one nursing assistant who was really good at teaching and he really, emm, was keen to, if he had me then he would step by step teach me everything that he was doing, so I learned a lot working with him, whereas there was another nursing assistant, that even if the sister had said I was paired up with her, she would do stuff but not even tell me what she was doing, whereas the other one, he would let me do, he would show me and then let me do it step by step, so a big influence on teaching in the placements, yeah	
R	Good. Are you unhappy in any way with the role of the nursing assistant in your training?	
S	I wouldn't say I was unhappy with it, no. I think it could be better like I was saying but I'm happy that it is what it is and yeah (laughs).	
R	Are there any issues related to nursing assistants and their influence on their student nurse training that you feel you want to discuss, that we haven't spoken about?	
S	Don't think so, I think just the , like I was saying there is a different I suppose perspective in the nursing assistants outlook and the role of the trained staff, their outlook, and I think sometimes in the ward I was in there could be a clash of that in the nursing assistants felt the	

	trained staff didn't do much because a lot of the time they are maybe in the office or doing the medication rounds or whatnot and so the nursing assistants see it as the trained staff aren't working as hard as we are , they don't understand as they're not out doing this, and that was, like they were saying a lot of this to me as a student but oh you know, so I suppose perceptions of other staff could be influenced and who they thought were the best nurses were the ones that came out and sat in the patient areas for most of the shift, but then on the flip when I was working with the nurses and there was loads of paperwork to do, like in that week when we had loads of admissions, and some of the nurses were just sitting through in the lounge , you were just like why aren't they here helping do the paperwork, so there is just that, there is different viewpoints, but I suppose then either way your opinion can be influenced, either towards the nursing assistants or from the nursing assistants towards the trained staff. Emm where I found quite interesting I suppose	
R	Were you in a third group?	
S	Yeah (laughs) I was just yeah in the middle but emm, but I was very much I suppose , especially when I started, I suppose then they felt they could take their grievances out on me because I'm not one of the trained staff, but I suppose I will be and so they were moaning at me that "Oh the nurses they don't do much and they're in there, and they should be out here helping us" Emm, so I just, I found that quite interesting that they were having that sort of putting their opinions on me about the trained staff	
R	That is interesting. Is there anything else that you want to discuss?	
S	I don't think so laughs)	
R	Thank you for your time	

Appendix 12

Example of transcription with analytical comments added

R	If you are OK to start can I just get you to confirm your name for me please.	
1	Its S2	
R	Thanks S2, I thought that what we would do is start off by looking back at the diary that you completed and I just wondered was there anything with regards the actual diary completion that sort of surprised you, with regards the findings that you realised you had.	
2	Not so much surprised me but just in general the week I completed the diary was a very different week to the rest of my placement, so I felt the results for that week didn't surprise me because I knew that's what I'd done in comparison to the other 6 weeks that I was there. If I had done it any other of those 6 weeks I think the results would have been very different.	
R	What would have been different?	
3	Emm…time spent in the office doing admissions and care plans. In the first 5 weeks of my placement I think we had 3 new admissions, it was a really quiet block during Summer and then the week that I did my diary we had about 7 new admissions that one week, so it was a much busier week in terms of paperwork than the rest of my placement had been.	Placement workload variable
R	So I noticed that there were days where it was almost, one day when it was almost entirely admissions	
4	Yeah, because it was a case of on that week, maybe the Monday we has 2 new admissions and we had some over the weekend that we had to complete and then the Tuesday we had 2 new admissions, Wednesday we had 3 new admissions, so there was days that was just doing admissions.	Workload driven by ward requirements
R	So maybe slightly less- representative although we will get the chance to look at how things would normally be. Can I start with who you were working with, what I saw was a sort of relatively even split between trained nurses, healthcare support workers and other professions, mainly OT, Physio. Would that be representative of what you would normally do then?	
5	Emm…yes, again.. I would…it was very much a sort of placement where you are left to do what…not what you want but you are kind of left to do your own day, its not as much as your mentor saying come along with me or go with them, so I just…whoever was about I would tend to follow so if the physios were in I would take that on myself to go to them and ask if I could see what they were doing and the same with the OTs, so when they were in I did spend a long time with them, and then I spent a lot of time with the nursing assistants, just when there wasn't much else going on like when the physios weren't in, or there was no specific thing that the nurses had asked me to do then it was naturally then with the nursing assistants that I was working alongside.	Responsibility for shaping learning given to students Opportunistic learning NAs seen as least attractive option
R	I suppose then moving on from that what I saw was that supervision fell mainly as fare as you could see to trained staff, probably about 50% of your time, or trained nursing staff. Healthcare support workers seemed the second largest bulk of who was supervising you	

	and then other professions seemed to make the third largest of the groups.	
6	Again it was very I suppose indirect supervision in a way that in general it would be a case that I would, they would just leave me to get on with things but sometimes I have maybe said that they would supervise me just because I happened to be with them but they had never been asked directly to supervise me but just some of the times when I was filling it in I was thinking more of when I was doing this job who is it I would have went to if I had a problem to ask and a lot of the times then it was the nursing assistants. Like I said because that week I was in the office a lot then it was the nursing staff, the trained staff that were the ones I was working with on that stuff	Student left to shape learning Opportunistic unplanned learning Learning influenced by awareness of specific staff skills Office work equates with nursing staff
R	So would that have changed the dynamic then from the other weeks, the fact that you were in the office more	
7	Yeah the other weeks I was out on the floor more than the office.	*Out on the floor*
R	And would that mean that you would be spending more time with other groups during those other weeks?	
8	Yeah	
R	Which groups	
9	Nursing assistants	NAs associated with out of office work
R	Nursing assistants, Ok. Where you spent your time, most, probably about half the time was spent within client areas, by client areas dining rooms, bedrooms and corridors. Roughly 40% of it was spent in the office but again that seemed to be very heavily weighted towards the one day, em and about 10% treatment areas generally associated with medications. Was that sort of reflective of your normal experience?	
10	Em, I'd say normally it would be more time spent with client, in client areas.	
	Approximate, what would you say, I know its difficult but…an approximate figure.	
	Going by the rest of the weeks, office time I would say 25% of the week if even, again just because there wasn't any new admissions going on during those other weeks, it was only, there would only be one day of the week I'd spend a large time in the office and that's when we were doing the Kardex, so , yeah, maybe 20-25% and the rest in client areas.	Most student time in client areas
R	Considerably different then	
11	Uh huh	
R	What you were doing over those times; and again there is a relatively even split that week between administration, which again seemed to be weighted heavily towards that particular one day, food and fluids,	

	hygiene, and then probably slightly less, other treatments. Would that again be skewed because of the nature of that one week?	
12	Yes, admin wouldnt have been as high, it was more personal care and hygiene and I did quite a few medication rounds, and all those stuff I would say were quite high up on what I was mainly doing, admin it was just that week (says something too low to make out)	
	Time spent then (S laughs) with direct mentor supervision, in reviewing it it seemed, round about 20% of the time.	
13	Yeah, em its again, its very much, like my placement before this one partly because it was a clinic you had to be with someone all of the time because it was very strict. Everyone had their specific jobs and appointment times to keep to and this being in a ward setting it was just more laid back and I was very much left to do things, so I was always, most of my shifts I was on with my mentor but it wasn't a case of I was by her side for the whole shift, she was happy for me just to go and do whatever, and if I had any questions or whatever I could go back to her and the same with the paperwork, it was very much a case of she told me what she wanted me to do and then left me to it, it wasn't she was sitting beside me going through it with me. It was just she had given me some old ones to look through so I could work out myself what to do and then at the end go back to her, she'd check over but it was never really sit down with me to go over things	Student left to shape own learning Autonomy from mentor who provided a resource Maybe mentor could have offered more
R	You mentioned then that the diary itself was not particularly representative of a normal week, what would you say had been the main similarities with the other weeks, and the main differences.	
14	Similarities is when I was on an early shift the mornings was always pretty much the same, get patients up, personal care, breakfast, so that I think maybe one morning I was in the office doing paperwork that had been left from the day before but most mornings I was on an early shift was that, it was the same routine. Differences then, just as I'm saying in the office more …	A sense of predictable routine care
R	Dealing with admissions?	
15	Yeah	
R	How do you perceive the nursing assistant role and their influence within that clinical environment	
16	(Pause), their role as in just day to day?	
R	Yeah, I suppose both day to day and in relation to your learning	
17	Well, I suppose LIKE a lot of the hands on stuff it was them that were doing it, in terms of personal care and feeding a lot of the times the nurses weren't around with those sort of aspects, it was the nursing assistants who were taking the lead, and they always sort of manage themselves, although there will be a nurse that's in charge, they are kind of left, they are trusted to within themselves work out who is doing what and when. Even at times working out when whose going and what break. There will be a nurse that's sort of, is in charge of making sure it happens, but they are happy for them to sort it themselves, and occasionally the trained staff will come out and help with some stuff but their priority is more I suppose the bigger picture. Doing office work and medication rounds and stuff, so a lot of my time, especially as a first year, where I am just learning a lot of the basics was then spent with the nursing assistants, and they, what I	NAs responsible for essential care NAs autonomous Nurses happy to abdicate responsibility Nurses focus on different tasks Early learning has emphasis

	found difficult sometimes was though was if they were managing themselves, they would sometimes, for example like with personal care in the mornings they would pair up and they would go to this patient, and me wanting to learn would want to go with some of them and well say can I come and do this with you, and they are like, "we are fine with just the two of us" and it wasn't so much that I didn't think they could do it with just 2 of them, it was just, it was just that I needed to be with someone to learn how to do it, but quite often it would be a case of "no we don't need you here", "we don't need you here" so I'd spend the morning just trying to find someone that would say "yeah, come with me and I will show you", they did quite I suppose, like just from different perspectives they weren't thinking of it as a, a learning opportunity, they were just trying to get on with their job and they didn't need a third person to do it, or even a second person if it was just someone who just needed one person to help them. But from my perspective it was just I needed, you know I wanted someone to work with and just see how they did things, and speaking to other students that were there, they found had the same thing that they, some of the students actually avoided doing morning shifts cos they hated that, sort of, they felt it was very, I don't know, as if they were very protective of their job and they didn't want the student in doing stuff, I think it was more they just didn't, they just had a different perspective, they just wanted to get on with it, so I think I spent a lot of time with them and I did learn a lot working with the nursing assistants and just general, em, not just in the mornings personal care but just throughout the day, but I think because they've got a different outlook maybe then there was opportunities that I could have had but, I kind of missed out on because they weren't as willing to have me on board I suppose.	on essential care skills Called *basics* NAs have the power to refuse student assistance I want to learn from someone NAs unaware of learning needs hence prevent learning opportunities Students avoid early shift as NAs excluded them Students seen as a hinderance Conflicting NA priorities prevent learning opportunities
R	How could we enhance the ability to take those opportunities?	
18	I don't know cos, its like, as a student its difficult going in and em, like you don't want to upset, rock the boat and tread on people's toes so I didn't want to impose myself on any of them if they were like "don't come" , but when, actually in my last week when I was there and a new student started and one of the nurses that was on duty at that time specifically said to her "Oh these are the nursing assistants on today, why don't you buddy up with Carol" and specifically appointed a nursing assistant for her to be her sort of buddy that day, and did that for her first week, every day she was like "can you pair up". In that way it was coming, it was a kind of order from a nurse that to do it, so they couldn't just, the nursing assistants couldn't just go off and do stuff and leave the student behind because then the student could say "Oh I've been told I've to stay with you" so if the even assistant did say " no we don't need you she could at least have that to fall back on, to say I've been told I'm to stay with you. And I think that would have helped even in the first couple of weeks of settling in, I suppose there is some authority behind it so they can't get rid of me (laughs).	Being a newcomer is precarious Nurses giving direction to NAs facilitates learning opportunities Their orders to NAs gave students permission to approach them

R	You mentioned being a first year that you felt you were in that position. Do you perceive then that that will change as you go back in second and third year	
19	Em I don't think their attitude, that the sorts of attitude from them will change, I just, in terms of experience I will be more confident in doing stuff so that I wont feel that I need that support as much I suppose. So if there's patients that I know that just need one person to get them up, once I'm settled in the placement and know the patient then I'd be happy to go do it myself, which I was by the end of the placement, I was but for the first few weeks when you don't know the patients, you don't know who needs more than one person or whatnot to help them and you don't have as much experience then it would be useful to have more support	NAs wont change, I will. New students need more support
	What I'm picking up then is that the nursing assistants have a certain amount of influence on what they do and how you, what they do with you?	
20	Yeah, uh huh, yeah em, Yeah. Cos the trained staff can stay out of it, and their very much…they're happy for me to go and work with the nursing assistants, but once I'm with them there wasn't…I was working a lot with them but there wasn't any . I suppose I didn't have a manager, a mentor within that setting.	Nurses avoid NA/ student relationship Students feel unconnected
	Who makes decisions on the tasks that are suitable for you to work with nursing assistants on?	
21	Emm…I suppose the nursing assistants. Em…like there was some stuff that I knew from the trained staff, like it was stuff like I knew not to do…like going on one to one observations that was, that was the nursing assistants that mainly did that because within themselves they had a rota of what patients they were with, but I knew that I definitely wasn't allowed to go on with them, but in terms of …yeah again cos the nursing assistants managed their own days and managed who was doing what, I suppose they had a big influence on that in terms of if it was a quite violent patient or a difficult patient and someone and I would come and they'd quite often say "Oh no, we'll get someone else" or erm...mostly they did.	Rules guide allocation to NA Some tasks outwith student remit NAs self managing NAs excluded students from difficult tasks
	How did they define the criteria for the kind of things you could work on. Is there a…how were the rules made?	
22	I suppose just on their personal opinions as much as anything. It was just. I suppose if it was too difficult, like if it was a patient that we know we were going to have some difficulties with, they'd maybe be like "Oh no, I'll wait till someone else comes" rather than me. Which I think, fair enough I suppose if I don't have as much experience as other nursing assistants or whatnot…but it would just really be down, to the personal opinion of whose there, and if they are short staffed then yeah they would take me, so it wasn't a hard and fast rule (laughs).	Tasks determined through personal opinion Student contributed to decisions around suitable tasks to work with NAs on Resource shortage influenced

		overriding rules
Me	Are you learning anything from the nursing assistants, and if so what?	
23	Yeah, just a lot of the basic care and the emm, even things like I'd never before, coming in I'd never worked in a care setting or anything so things like washing and dressing patients and dealing with toileting , which all you know you do yourself, but doing for someone else is very different. So just, it has been good working alongside them and learning I suppose basic care needs, and things like that and just general. Like the first time I went on that placement, cos its my base placement, so my very first four week block then it was the nursing assistants that really in the end showed me about and where everything was. There had been a problem that I didn't have a mentor so it was then down to the nursing assistants to say its ridiculous that you've been here for two, three weeks now and you don't even know where something quite simple is kept, so one of the nursing assistants then said come with me, I'm going to show you everything, so I definitely learned a lot	*Basic care* NAs linked with basic care needs NAs significantly involved at the start of the placement NAs fill in for mentors
R	What about with regards interpersonal skills, is there anything you picked up from them on that?	
24	Working with patients?	
R	Yeah	
25	Yes, I think I've seen a lot of what to do and what not to do, and sometimes what they are doing is not how I would have handled some situations. But a lot of positives as well.	Able to discern examples of good and poor practice modelled by NAs
R	OK, so the things that you are learning, you are not always learning from…	
26	How they are doing it yeah. How they are doing it but in a negative way I suppose.	
R	OK, how could the learning from the nursing assistants, how could we enhance that? How could we develop that?	
27	I think what I was saying…that…maybe…you mentor or somebody specifically saying and them going to the nursing assistants and saying would you mind if Amy pairs up with you today whilst on the shift and just take her with you on everything that you're going to be doing. Like so I suppose like a co-mentor type thing as a nursing assistant. Think that would be helpful because , like I say there was a lot I learned, but I had to push through a lot to get to it, but if there was someone on each shift. If that was going to be a day that I was working with the nursing assistants, if there was someone specifically named to be part…like to be my partner for that day then that would…	More organised support would be a benefit (means support not organised) Had to chase learning
R	That would make a difference?	
28	Yeah that would help a lot	
R	Would you feel comfortable working with nursing assistants as a formal part of your training?	
29	Yeah	

R	Do you have any difficulties with that?	
S	I wouldn't, no.	
R	You wouldn't?	
30	(laughs) Again I think depending on the nursing assistant, cos they were all very different, and most of them were lovely and I got on well with, but for some of them I think there is a bit of a tension, they don't know how to treat students, because we are not a nursing assistant and not a qualified nurse , you're in the middle, and I think for some of them, some of them took it on board. They see you're a student and they just want to help you. Others maybe had the attitude of "Oh you don't know as much as me but after two years, two more years of training you're going to be in a better job than me and you're gonna be like above me. But I've been in this job for twenty years so, like that sort of attitude, there was a bit of a nursing assistant, qualified nurse divide I suppose in my ward. Not greatly, but just in little things you picked up on. So I think as a student they didn't really know like, where you stood in it all, so I think from my point of view I wouldn't have any issue with it, but I know, perhaps some of them would, and some of them have the attitude its not our job to train students, so then they'd be like I don't mind showing you this bit, I don't know why she'd asked me, its not my job to do it, and…it puts the student I suppose in a difficult position.	Animosity from some NAs A split between NAs and nurses Students add a third group to the dynamic Some NAs feel compelled to help students
R	That leads me nicely on to the next question, which is how is their role formally recognised and supported?	
31	How is?	
R	The nursing assistants role in supporting students, formally recognised and supported?	
32	I think its recognised but maybe not supported, that sort of thing. The nursing staff, like my mentor knew that I was working alone with them, but I don't know how well that they, I mean they were fine in supporting me but I don't know if they were given any direction in terms of what to do with me or anything…emm…yeah I suppose…and some days when the nurses or whatever were busy . I was essentially another nursing assistant…emm…but so yeah I think it is recognised students do spend a lot of time with nursing assistants but there's nothing formally I suppose put in place for that to be as good as it could be.	NA role is unstructured and unsupported At times students do the same as NAs
R	OK, if support and recognition was in place how would learning be improved?	
33	I think you would just learn more, faster. I think what I learned from the nursing assistants in my placement, I think if I was like I said paired up with one and it was a more formal system that they were, they had a responsibility for me as well, then I think that what learned, what I learned just naturally over time as when things turned up, then I worked out how to do it, I think if I was with someone who was showing me the ropes more formally then I think you'd learn more, faster, rather than just when things happen to turn up, it might have been something that had already been covered	Structuring support better would enhance learning Learning at times opportunistic
R	When you're a mentor how will you utilise nursing assistants to support student education?	

34	I think like I said in terms of , just learning a lot of the, the basic nursing skills they are the good ones to show the students. Definitely would want, especially a new student, to spend a lot of time with the nursing assistants, but like I'd said I'd probably take it as my duty as a mentor to arrange that, rather than just leaving my student to go, get on with it, and for the first couple of weeks anyway, try and find someone every shift that, and say to them "can you keep an eye on the student and show her whatever you're going to do, let her go along, and even if its just observe, if it's a difficult patient or whatever, just let her see but emm, what it is you do". Cos like with a lot of the other like I was saying I've worked a lot in the diary with the physios and the OT, or the speech therapists or whoever, whenever they came in I would go and a lot of the time I was just sitting in and observing what they did, so the same with nursing assistants, that even if it's not directly involved, its observing some of the things they are doing, and getting a more, better understanding of their role, then its just as important, I think as like the physios and OT.	NAs associated with introduction- to ward and to essential skills My duty as a mentor= a responsibility to organise learning Rather than just leaving my student= feeling abandoned Student chasing their own learning
R	Are there any other ways that nursing assistants have influenced you in this placement?	
35	I think just what I was saying (pause) I think, yes but I suppose in a more negative way, just I think some of their handling of situations, I could see the difference between the trained staff and I suppose their understanding of dementia and the patient and client group, compared to some of the nursing assistants, that there might be situations I was working with them and a situation arose from it that to them they were like, risk, the patient is really violent and difficult, but from my perspective I could see that actually it was more their interaction with the patient that started it. I think, yeah I learned in a sort of negative way, I did learn a lot more.	NAs can role model negative behaviours
R	Do they have any influence on your acceptance in the ward team?	
36	Yeah, I think so	
R	How powerful an influence?	
37	Well very, because a lot of my time in the lounge was spent with them, if they had kind of cut me out then it would have been very difficult, very difficult	Repeats twice= emphasis of the power of NAs to shape acceptance
R	And do you purposely adapt to be accommodated?	
38	Yes, yeah (laughs) I suppose so, well it depends what you mean by adapt, like I would, like a lot of the time, like 'm happy to just go with the flow and things. I don't think, I don't think I adapt in terms of practice or anything. A lot of the times maybe in the sitting room, patients were just in, and the TV was on or whatnot , they would often be sitting chatting in a group, like nursing assistants but I'd be talking to the patients rather than be going and, as much as I wanted to get on with them I knew it wasn't my, kind of main point (laughs). It wasn't just to get into the group, it was more patients so I don't	Practice wont be compromised to fit in with the team Combined bonding with patient work

	think I adapted in that terms but I was happy just to, like you know sit with them and I got on fine.	
R	On your training or in your training until now what has the main influence of nursing assistants been on you?	
39	Main influence?	
R	If any?	
40	I think just what I've been saying is just the kind of building blocks of all of the kind of basic skills of nursing care and …certainly in that ward, yeah…on other placements…emm again its been mixed depending on what nursing assistant you have been working with, but on the last placement there was one nursing assistant who was really good at teaching and he really, emm, was keen to, if he had me then he would step by step teach me everything that he was doing, so I learned a lot working with him, whereas there was another nursing assistant, that even if the sister had said I was paired up with her, she would do stuff but not even tell me what she was doing, whereas the other one, he would let me do, he would show me and then let me do it step by step, so a big influence on teaching in the placements, yeah	NA skills underpin care NAs can be good teachers NAs teach NAs influential
R	Good. Are you unhappy in any way with the role of the nursing assistant in your training?	
41	I wouldn't say I was unhappy with it, no. I think it could be better like I was saying but I'm happy that it is what it is and yeah (laughs).	Accepting of the NA role, not happy with it.
R	Are there any issues related to nursing assistants and their influence on their student nurse training that you feel you want to discuss, that we haven't spoken about?	
42	Don't think so, I think just the , like I was saying there is a different I suppose perspective in the nursing assistants outlook and the role of the trained staff, their outlook, and I think sometimes in the ward I was in there could be a clash of that in the nursing assistants felt the trained staff didn't do much because a lot of the time they are maybe in the office or doing the medication rounds or whatnot and so the nursing assistants see it as the trained staff aren't working as hard as we are , they don't understand as they're not out doing this, and that was, like they were saying a lot of this to me as a student but oh you know, so I suppose perceptions of other staff could be influenced and who they thought were the best nurses were the ones that came out and sat in the patient areas for most of the shift, but then on the flip when I was working with the nurses and there was loads of paperwork to do, like in that week when we had loads of admissions, and some of the nurses were just sitting through in the lounge , you were just like why aren't they here helping do the paperwork, so there is just that, there is different viewpoints, but I suppose then either way your opinion can be influenced, either towards the nursing assistants or from the nursing assistants towards the trained staff. Emm where I found quite interesting I suppose	NAs and nurses differ Hard work associated with NAs and their goals Students seen as different from both groups Nurses involved in direct care tasks valued by NAs Nurses can resent nurses who spend time with NAs Students caught in the middle.
R	Were you in a third group?	

43	Yeah (laughs) I was just yeah in the middle but emm, but I was very much I suppose , especially when I started, I suppose then they felt they could take their grievances out on me because I'm not one of the trained staff, but I suppose I will be and so they were moaning at me that "Oh the nurses they don't do much and they're in there, and they should be out here helping us" Emm, so I just, I found that quite interesting that they were having that sort of putting their opinions on me about the trained staff	Students a third group but offer NAs a safe opportunity to gripe safely
R	That is interesting. Is there anything else that you want to discuss?	
44	I don't think so laughs)	
R	Thank you for your time	

Appendix 13

Theme composition example (S2)

A Themes- workload allocation has several influences
Placement workload variable/ Workload driven by ward requirements/ Rules guide allocation to NA/ Learning influenced by awareness of specific staff skills/ Tasks determined through personal opinion/ Student contributed to decisions around suitable tasks to work with NAs on/ Resource shortage influenced overriding rules
Left to create own learning- abandonment and a need for structure
Responsibility for shaping learning given to students/ Student left to shape learning/ Student left to shape own learning/ My duty as a mentor= a responsibility to organise learning/ Rather than just leaving my student= feeling abandoned/ Student chasing their own learning/ Learning at times opportunistic/ Had to chase learning/ Opportunistic learning/ Opportunistic unplanned learning/ I want to learn from someone/ Autonomy from mentor who provided a resource Maybe mentor could have offered more/ Nurses giving direction to NAs facilitates learning opportunities/ Their orders to NAs gave students permission to approach them
NAs are influential though not always in a positive way
NAs responsible for essential care/ NAs autonomous/ NAs self managing / Nurses happy to abdicate responsibility/ NA skills underpin care/ NAs can be good teachers/ NAs teach/ NAs influential/ NAs can role model negative behaviours/ NAs fill in for mentors/ NAs seen as least attractive option/ Hard work associated with NAs and their goals/ Nurses involved in direct care tasks valued by NAs/ Office work equates with nursing staff/ NAs associated with out of office work/ *Out on the floor /* Most student time in client areas Nurses focus on different tasks/ Early learning has emphasis on essential care skills/ *Basic care /* NAs linked with basic care needs/ NAs associated with introduction- to ward and to essential skills/ Called *basics* /A sense of predictable routine care NAs unaware of learning needs hence prevent learning opportunities/ NAs have the power to refuse student assistance/ Students avoid early shift as NAs excluded them/ Students seen as a hinderance/ Conflicting NA priorities prevent learning opportunities/ NAs excluded students from difficult tasks/ Animosity from some NAs/ Some NAs feel compelled to help students
Powerless and adrift,
Being a newcomer is precarious/ New students need more support/ NAs significantly involved at the start of the placement/ Students feel unconnected/ Students caught in the middle/ Students a third group but offer NAs a safe opportunity to gripe safely/ Students seen as different from both groups/ Repeats twice= emphasis of the power of NAs to shape acceptance/ Nurses avoid NA/ student relationship/
Able to discern examples of good and poor practice modelled by NAs
A split between NAs and nurses/ Students add a third group to the dynamic/ NAs and nurses differ/ Nurses can resent nurses who spend time with NAs/ At times students do the same as NAs
Practice wont be compromised to fit in with the team/ Combined bonding with patient work/ Some tasks outwith student remit/ NAs wont change, I will./

Appendix 14

Development of themes

Overall themes

Theme	S1	S2	S3
1 Autonomy in learning comes with experience	X		
1 Ignoring the value of the NA role development	X		
1 Basic care tasks are important, but not a nursing skill	X		
1 It is important to be one of the team	X		
1 NA involvement with students could improve, if they wanted it.	x		
2 workload allocation has multiple drivers		X	
2 Left to create own learning- abandonment and a need for structure		X	
2 NAs are influential, though not always in a positive way		X	
2 Powerless and adrift,		X	
2 Controlling entry in to a professional identity		x	
3 NAs proximity to clients has significant advantages for care delivery			X
3 The Nurses role is different and pushes them away from clients (the complexity of it is anxiety producing)			X
3 The NA work ethic facilitates a sense of safety and acceptance for some students			X
3 Students shape their own learning (and NAs are valuable resources)			X
3 More recognition of the NA role would help student learning			x
Students need to drive their own learning, and this gets easier with experience 1 Autonomy in learning comes with experience 2 workload allocation has multiple drivers 2 Left to create own learning- abandonment and a need for structure 3 Students shape their own learning (and NAs are valuable resources)			
Becoming a nurse is anxiety provoking and confusing 1 It is important to be one of the team 1 Basic care tasks are important, but not a nursing skill 2 Controlling entry in to a professional identity 2 Powerless and adrift, 3 The Nurses role is different and pushes them away from clients (the complexity of it is anxiety producing) 3 The NA work ethic facilitates a sense of safety and acceptance for some students			
NAs are influential to students, but recognition could enhance this 1 NA involvement with students could improve, if they wanted it. 1 Ignoring the value of the NA role development 2 NAs are influential, though not always in a positive way 3 More recognition of the NA role would help student learning			

3 NAs proximity to clients has significant advantages for care delivery			

Theme	M2	M3	M4
1 Feeling pressure to retain the status quo	X		
1 There is a difference between the roles	X	x	
1 Feeling powerless in updating recognition	X		
1 The NA role is undervalued	x		
2 The roles differ though crossover is important		x	
2 student seniority shapes learning need		x	
2 Student learning is complex and controlled by nurses		x	
2 NA influence is variable though worthwhile		x	
3 Reflection uncovers acceptance			X
3 The importance of the NA role			X
3 NAs contribute to student nurse development			X
3 Students can impede learning			X
3 Working together for student development			x
Working together, as a team 1 There is a difference between the roles 2 The roles differ though crossover is important 3 Working together for student development			
The NA role with students is valuable though not always recognised as such 1 The NA role is undervalued 1 Feeling pressure to retain the status quo 1 Feeling powerless in updating recognition 2 NA influence is variable though worthwhile 3 The importance of the NA role 3 NAs contribute to student nurse development 3 Reflection uncovers acceptance			
There are varied factors contributing to student nurse learning 2 student seniority shapes learning need 2 Student learning is complex and controlled by nurses 3 Students can impede learning			

Theme	N1	N2	N3
1. Feeling NAs have a role in embedding student within the team (awareness of both roles)	X	x	x
1. After nurses allocate NAs are left to shape student learning (though informally)	X		
1. NAs have an orientation role with all students	X		
1. NA role is expanding and skilled	X		
2. NAs skills are recognised only within the clinical team		X	
2Expanding NA role involves teaching students		X	
2. Team membership is why NAs help students	x	X	x
2.There is a need to show support and value for the NA role		x	
3. Some people recognise my skills and some don't			X
3. NAs teach students complex interventions and professional and interpersonal skills			X
3. I have a role as part of a team (and my role in teaching students is controlled by others)	x	x	X
3. NAs keep students in touch with clients and their families			x
Being part of a team drives NA input within student education 1. Feeling NAs have a role in embedding student within the team (awareness of both roles) 2. Team membership is why NAs help students 3. I have a role as part of a team (and my role in teaching students is controlled by others) 1. NAs have an orientation role with all students	x	x	X
There is limited recognition of NA skills 1. NA role is expanding and skilled 2. NAs skills are recognised only within the clinical team 3.Some people recognise my skills and some don't			
NAs have informal responsibility for much of the clinical development of student MH nurses 1. After nurses allocate NAs are left to shape student learning (though informally) 2Expanding NA role involves teaching students 3. NAs teach students complex interventions and professional and interpersonal skills 3. NAs keep students in touch with clients and their families			

Appendix 15

Ethics approvals

University of Strathclyde approval

From: Laura Clark
Sent: 11 February 2015 09:26
To: Aileen Kennedy; Mark.Gillespie@uws.ac.uk
Cc: Eleni Karagiannidou
Subject: Type 1 Ethics Application - Approval
Importance: High

Type 1 Ethics Application - Approval

Our ref: 543 10-Feb-15

Dear All

The influence of unregulated staff on the clinical development of pre registration mental health nurses

CI Aileen Kennedy Other Investigator Mark Gillespie

I can now confirm full ethical and sponsorship approval for the above study.

Regards

Laura

University of the West of Scotland approval
School of Health Nursing & Midwifery
Request SEC Access to Participant Gatekeeper Form

For Projects External to the University of the West of Scotland/ Project External to the School of Health Nursing & Midwifery (HNM)

Applicant:

1. Complete Section A and B;
2. Submit completed form (and supporting evidence) by email to Professor Austyn Snowden, Chair of School Ethics Committee, School of Health Nursing & Midwifery, UWS (austyn.snowden@uws.ac.uk).

SECTION A: Project Details (and supporting documentation)		
Name of Applicant	Mark Gillespie	
External Institution (if the project is external to UWS)	University of Strathclyde	
External School/Department (if the project is internal to UWS, but external to the School HNM)	NA	
Title of project	The influence of unregulated staff on the clinical development of pre- registration mental health nurses	
Have you included the evidence of ethical approval for the project? *The required evidence is:*	*Delete as appropriate*	
A copy of the local application for ethical approval	YES	
A copy of the letter(s) confirming all local approval has been granted	YES	
A copy of all data collection tools	YES	
A copy of all participant information/ consent forms	YES	
Note: If the answer to any of the above is no, please be aware that your request for access permission will be declined.		

SECTION B: Proposed Access		
Who are the proposed participants from within the School of HNM that you are requesting to access as part of your study? *Please give detail*	Mental Health Students on the Paisley Campus, stages 1-3. In total I am looking to recruit 3 students.	
When would you require access to the proposed participants? *Please state the dates/ times/ duration of access*	Between May 2015 and July 2015 I would be looking to emails student cohorts, meet with those interested in participating, explain the requirements at this meeting and supply a 5 day diary for them to keep whilst on placement (N.B. there are strict instructions to focus on work practices and to avoid breeching client confidentiality). I would then meet the students for an individual interview.	
What type of data collection will the proposed participants be involved in?	Questionnaire	
	Interview	✓

Please tick as appropriate. *Include copies of supporting documentation (refer to Section A).*	Focus Group	
	Other (please provide detail)	Diary of work practices
How will the proposed participants be informed of the study? *Please tick as appropriate.* *Include copies of supporting documentation (refer to Section A).*	Participant information sheet	✓
	Written consent form	✓
	Other (detail) Introductory email and within the initial meeting with the investigator.	✓

SIGNATURE OF APPLICANT…Mark Gillespie…….. DATE 31/3/15
(If submitted by email, this will constitute a signature. Please ensure the date is accurately noted)

School HNM, School Ethics Committee (Chair):

1. Complete Sections C and D;
2. Submit completed form by email to Elaine Biggam, Administrator to School Ethics Committee, School of Health Nursing & Midwifery, UWS (elaine.biggam@uws.ac.uk);
3. Copy the email to the named gatekeeper.

SECTION C: Review of Request for Access Permission	
Has the request for access been accompanied by:	*Delete as appropriate*
1. Evidence of local ethical approval?	YES
2. All necessary supporting documentation?	YES

Note: If the answer to either of the above is no, the request for access permission should NOT be granted.

SECTION D: Outcome of Review	
I have reviewed the above request and supporting information. All relevant information has been included. The request decision is noted as:	*Delete as appropriate* GRANTED
The appropriate gatekeeper to the proposed participants in this study is/are:	**Mr Allan Donnell**

SIGNATURE OF SEC REVIEWER (CHAIR)…… …… DATE 31st March 2015
(If submitted by email, this will constitute a signature. Please ensure the date is accurately noted)

Gatekeeper:

1. Complete Section E;
2. Submit completed form by email to Elaine Biggam, Administrator to School Ethics Committee, School of Health Nursing & Midwifery, UWS (elaine.biggam@uws.ac.uk).

SECTION E: Gatekeeper Decision	
I have reviewed the above request and supporting information.	*Delete as appropriate*

All relevant information has been included. The request decision is noted as:	GRANTED / NOT GRANTED
Comments/ Conditions of Access *Please make any comment and/or list conditions of access*	

SIGNATURE OF GATEKEEPER…….. DATE……..
(If submitted by email, this will constitute a signature. Please ensure the date is accurately noted)

NHS Greater Glasgow and Clyde approval

Dear Mark
Happy to support – good luck, look forward to final piece.
Rhona please note for information.
Regards, Linda

Linda Hall
Lead Professional Nurse Advisor Mental Health Services
Administration Building, Dykebar Hospital
Grahamston Road, Paisley, PA2 7DE
☏: 0141 314 4124
☏: 07818001634

From: Pratt, Margo
Sent: 03 March 2015 14:49
To: Hall, Linda
Cc: 'Mark Gillespie'
Subject: FW: approval for study

Hi Linda,

Please find attached information relating to a study proposed by Mark Gillespie at the University of the West of Scotland.

Mark has completed an ethics application form and related paperwork for his study - attached. I have also included his original email below.

It is customary that we would recommend that researchers get authorisation from an appropriate source within the organisation. In the past, I'd have sent this to Mari for inclusion in Mental Health Services Clinical Governance Workplan, to make sure that the outcome of the project is fed back into the organisation as well as any other identified sources of publication.

Could you let Mark know whether you are happy for this study to proceed, or indeed to return any issues to him for consideration. I've cc'd him into this email.

Best wishes,

Margo.

Margo Pratt
Interim Lead Clinical Improvement Co-ordinator
Clinical Governance Support Unit
Ward 15, Dykebar Hospital, PA2 7DE
Tel 0141 314 4020/ ext 44020
Fax: 0141 314 4015

SPSP MH teamsite
http://teams.staffnet.ggc.scot.nhs.uk/teams/Partnerships/MHP/SPSPMentalHealth/default.aspx

From: Mark Gillespie [mailto:Mark.Gillespie@uws.ac.uk]
Sent: 06 January 2015 13:24
To: Pratt, Margo
Subject: approval for study

Hi Margo, hope you are well. I am in the process of trying to arrange a study of how people view the influence of nursing assistants in the clinical development of student mental health nurses. This is almost through the ethics approval process for the sponsoring organisation, The University of Strathclyde, and I had contacted NHS ethics sources for their approval as well, though having recently deemed the study as clinical development I was given your name by your colleague Jennifer Doherty. I am keen to try to push this through by the end of this month and wondered if there was any further information you required from me?

Regards

Mark

Mark Gillespie
RMN. BA (CPN), Pg Cert (TLHE) LPE. Pg Dip (PSI). MEd.
HEA (Fellow)

Nurse Lecturer/ Programme lead for MSc in Psychosocial Interventions.
Room A612
School of Nursing
University of the West of Scotland
High St Paisley
PA1 2BE
Tel 0141 849 4293

Recent publications

McFadden, G and Gillespie, M (2014) Application of reminiscence therapy for dementia in practice. British Journal of Mental Health Nursing. Vol 3 (6). PP. 272-276.

Gillespie, M and Toner, A (2013) The safe administration of long-acting depot antipsychotics. British Journal of Nursing. 22 (8). Pp. 16-20.

Visit www.uws.ac.uk for more details
University of the West of Scotland is a registered Scottish charity. Charity number SC002520.

****
****

GG&C R&D opinion

Thank you for your email and the additional information you sent previously. Please accept my apologies for the delay in coming back to you about this, which has been a consequence of recent changes in our department and staff absence.

I can now confirm that I have reviewed this information on behalf of NHS GG&C Research & Development and consider this study to come under the remit of service evaluation/ service improvement. Therefore this study does **not require NHS R&D management approval** and as there will be no patient involvement there is no requirement for review by NHS Ethics

You should, however, inform Clinical Effectiveness that you are contributing to this review (Contacts) Jen Doherty tel: 201 0728 email: jennifer.doherty@ggc.scot.nhs.uk or Hazel Moss 201 0728
If you require any further information, please do not hesitate in contacting me.

Kindest Regards
Joanne

Joanne McGarry
Academic Research Coordinator
Research and Development Directorate
NHS Greater Glasgow and Clyde
Research and Development Central Office
Tennent Institute, 1st Floor
Western Infirmary
38 Church Street
Glasgow, G11 6NT
Scotland, UK

Email: joanne.mcgarry@ggc.scot.nhs.uk
Tel: +44 (0)141 211 2142
Web: www.nhsggc.org.uk/r&d

Please note that R&D operates a paperlite electronic record system. Please submit study documents via e-mail.
Live in Scotland? Join SHARE and help us improve Scottish Health:
http://www.registerforshare.org/

From: Mark Gillespie [mailto:Mark.Gillespie@uws.ac.uk]
Sent: 11 December 2014 09:22
To: Mackenzie, Lorn
Subject: RE: advice re ethical approcal

Please note that R&D operates a paperlite electronic record system. Please submit study documents via email.

Appendix 16 Ethics application

University of Strathclyde

Ethics Application Form

Please answer all questions

1. Title of the investigation

The influence of unregulated staff on the clinical development of pre-registration mental health nurses

Please state the title on the PIS and Consent Form, if different:

2. Chief Investigator (must be at least a Grade 7 member of staff or equivalent)

Name: Aileen Kennedy
☐ Professor
☐ Reader
x☐ Senior Lecturer
☐ Lecturer
☐ Senior Teaching Fellow
☐ Teaching Fellow
Department: School of Education
Telephone: 0141 444 8061
E-mail: aileen.kennedy@strath.ac.uk

3. Other Strathclyde investigator(s)

Name: Mark Gillespie
Status (e.g. lecturer, post-/undergraduate): Post graduate student EdD
Department: School of Education
Telephone: 0141 849 4293
E-mail: Mark.Gillespie@uws.ac.uk

4. Non-Strathclyde collaborating investigator(s) (where applicable)

Name:
Status (e.g. lecturer, post-/undergraduate):
Department/Institution:
If student(s), name of supervisor:
Telephone:
E-mail:
Please provide details for all investigators involved in the study:

5. Overseas Supervisor(s) (where applicable)

Name(s):
Status:
Department/Institution:
Telephone:
Email:
I can confirm that the local supervisor has obtained a copy of the Code of Practice: Yes ☐ No ☐
Please provide details for all supervisors involved in the study:

6. Location of the investigation

At what place(s) will the investigation be conducted
At various NHS Greater Glasgow and Clyde premises, to allow interviews to

take place close to the participant's workplaces. These settings are likely to be private office spaces attached to clinical areas, as the participants will work in clinical areas. As an alternative I will offer use of private offices within the local campus of the university that is responsible for student nurse placement with that health authority. Contact with NHS patients will be avoided through making appointments to see the participants within the office areas, though my job requires me to visit a wide variety of NHS premises on a regular basis.

If this is not on University of Strathclyde premises, how have you satisfied yourself that adequate Health and Safety arrangements are in place to prevent injury or harm?

The NHS has a responsibility for ensuring their premises are safe and fit for purpose.

7. Duration of the investigation

Duration(years/months) : 3 months

Start date (expected): **1 / 4 / 15** Completion date (expected): **1 / 7 / 15**

8. Sponsor

Please note that this is not the funder; refer to Section C and Annexes 1 and 3 of the Code of Practice for a definition and the key responsibilities of the sponsor.

Will the sponsor be the University of Strathclyde: Yes x☐ No ☐

If not, please specify who is the sponsor:

9. Funding body or proposed funding body (if applicable)

Name of funding body: **NA**

Status of proposal – if seeking funding (please click appropriate box):

☐ In preparation
☐ Submitted
☐ Accepted

Date of submission of proposal: / / Date of start of funding: / /

10. Ethical issues

Describe the main ethical issues and how you propose to address them:

While the study will adhere to the ethical guidance of the sponsoring institution, Strathclyde University, the NHS and the students host institution, UWS, it is the ethical regulation of Strathclyde that will provide the lead on this. Information on the nature of the study, the data collection and storage methods involved and of the confidentiality and voluntary nature of participation will all be made clear to participants, to enable them to make an informed choice in respect of their involvement. To promote confidentiality the participant's identity will be disguised through the use of

pseudonyms when findings are published. This will be detailed in writing within the participants' information sheet and reinforced verbally during each meeting with the researcher. It is impractical to hide the participants involvement in the study from their work colleagues as some time at work needs to be spent on diary completion. This will be pointed out within the participants' information sheet.

The main ethical challenge appears to be the possible disclosure of some form of unprofessional practice by one or more of the participants. This would necessitate further investigation and raising the matter officially should there be evidence of potential harm. Such an issue occurring is rare and unlikely to arise within the confines of this research, however the need to report unsafe practice will be raised with participants before they commence the study. This information will be included within the participants information sheet and again in each meeting with the researcher. The face to face discussion will allow clarification of any uncertainties the participants may have over this, and expectations will be defined in relation to Nursing and Midwifery Council standards for practice. That the study takes place on NHS premises requires an application through their ethical approval process, however as there is no patient interaction planned, either direct or indirect, so there are no specific ethical concerns foreseen that are particular to that organisation. A reminder of the boundaries of confidentiality, especially around the identification of patients will be included within the participants' information sheet and on the diary sheets supplied to participants. It will also be stated at the start of each meeting between the researcher and the participants. Any patient issues included within diary content or interview discussion will be screened by me to prevent inappropriate disclosure. This role is familiar to me in my role as a nurse educator.

There is also a possibility that participants employed by the NHS may feel inhibited in what they say by the scope of what their job description allows. Student nurses might also feel compelled to report only what they feel fits with university expectations. The anonymity of

responses will be emphasised with participants throughout the study in order to minimise this risk.

11. Objectives of investigation (including the academic rationale and justification for the investigation) Please use plain English.

The quality of healthcare delivery in the UK has been strongly challenged through the publication of several recent reports (Healthcare Commission, 2009; Mencap, 2012; Mental Welfare Commission for Scotland, 2011). While each was critical of a variety of aspects of care, all commented negatively on the standard of nursing provided, a factor that has been highlighted by both the media and the UK government. A focus on nursing, nurse education and the role of unregulated nursing assistants (NA's) intensified with the publication of the largest of these inquiries (Francis, 2013). This report reviewed the circumstances surrounding over 400 deaths more than would be expected at one NHS trust, and culminated in the development of no fewer than three governmental publications (Department of Health, (DH) 2013a, 2013b, 2014), with subsequent responses from both the Nursing and Midwifery Council (NMC), the organisation that regulates the nursing profession within the UK (NMC, 2013), and the Royal College of Nursing (RCN), the professional body that represents nurses and nursing assistants (RCN, 2013). The term Nursing Assistant (NA) is one of many job titles employed across the UK to describe this role, and is used here as it is the one advocated by the recently commissioned government sponsored inquiry into this staff group (Cavendish, 2013). As local health boards use the term Healthcare Support Worker to describe the same staff group, so both titles will be used interchangeably.

Emerging as a response to concerns arising within these inquiries, the conjoining of both practical and educational experience between NA's and student nurses is considered an approach through which improvements can be made for both groups in areas such as recruitment, in selection of suitable applicants, and in assisting in the provision of compassionate care, while also offering NA's the opportunity for occupational advancement (DH, 2014). The evidence surrounding the impact of NA's on student nurses within the practice setting is however sparse (Hasson et al, 2013),

suggesting a need to explore this relationship further. The intention is for the proposed research to investigate this relationship and how it is understood by those most closely involved; the student nurse, the mentor and the nursing assistant. This will be done through investigation of the following research questions.

Q1. How long do student mental health nurses spend with registered and unregulated nursing staff in a typical day, and what is the focus of these interactions?

Q2. How do NA's perceive their role in the clinical development of student mental health nurses, including the preparation and recognition they receive for any such involvement?

Q3. How do student mental health nurses view the role of NA's in developing their essential care skills whilst on clinical placement?

Q4. How do clinical mentors understand the role of NA's in the clinical preparation of student mental health nurses?

References

Cavendish, C.(2013). The Cavendish Review: An Independent Review Into Healthcare Assistants and Support Workers in the NHS and Social Care Settings. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/236212/Cavendish_Review.pdf

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Department of Health. (2013b). *The Government Response to the House of Commons Health Committee Third Report of Session 2013-14: After Francis: making a difference*. London. HMSO

Department of Health. (2014). *Hard Truths, The Journey to Putting Patients First; Volume one of the Government Response to the Mid- Staffordshire NHS trust Public Inquiry.* Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/270368/34658_Cm_8777_Vol_1_accessible.pdf

Hasson, F. McKenna, H.P. Keeney, S. (2013). Perceptions of the unregistered healthcare worker's role in pre-registration student nurses' clinical training. *Journal of Advanced Nursing*. 69 (7). 1918-1929.

Healthcare Commission (2009) *Investigation into Mid-Staffordshire Foundation NHS Trust*. Retrieved from http://www.rcn.org.uk/__data/assets/pdf_file/0004/234976/Healthcare_Commission_report.pdf

Mencap. (2012). *Death by indifference: 74 deaths and counting. A progress report 5 years on*. Retrieved from http://www.mencap.org.uk/sites/default/files/documents/Death%20by%20Indifference%20-%2074%20Deaths%20and%20counting.pdf

Mental Welfare Commission for Scotland. (2011). *Summary investigation report into the care and treatment of Mrs V*. Edinburgh. Mental Welfare Commission for Scotland.
Nursing and Midwifery Council. (2013). *NMC Response to the Francis Report: The Response of the Nursing and Midwifery Council to the Mid Staffordshire Foundation NHS trust Public Inquiry Report*. Retrieved from http://www.nmc-uk.org/Documents/Francis%20report/NMC%20response%20to%20the%20Francis%20report%2018%20July.pdf
Royal College of Nursing. (2013). *Mid Staffordshire NHS Foundation Trust Public Inquiry Report: Response of the Royal College of Nursing*. London. RCN.

12. Participants

Please detail the nature of the participants:

The participants will be UWS mental health nursing students, nurse mentors (qualified nurses who have undertaken additional educational preparation sufficient for registration as a mentor for pre-registration nursing students) and nursing assistants working within NHS GG&C student placement areas.

Summarise the number and age (range) of each group of participants:

Number: **9** Age (range) **17-65**

Please detail any inclusion/exclusion criteria and any further screening procedures to be used:

There are no exclusion criteria and the only screening will be to ensure participants are included from the three main groups involved, student nurses, mentors and nursing assistants. Three participants will be included from each of these groups. If more than one person volunteers for the study from the one clinical area this will be accepted.

13. Nature of the participants

Please note that investigations governed by the Code of Practice that involve any of the types of participants listed in B1(b) must be submitted to the University Ethics Committee (UEC) rather than DEC/SEC for approval.

Do any of the participants fall into a category listed in Section B1(b) (participant considerations) applicable in this investigation?: Yes ☐ No **x**☐

If yes, please detail which category (and submit this application to the UEC):

14. Method of recruitment

Describe the method of recruitment (see section B4 of the Code of Practice), providing information on any payments, expenses or other incentives.

Email invitations (appendix 1) will be the primary route of advertising for the study as access can be arranged to the NHS group email facility in Greater Glasgow and Clyde Health Board. This is enabled through the close working relationship between NHS staff employed to support mentors and HEI's involved in student nurse education. The use of the internet in research design is suggested to increase access to users of digital media and health boards now recognise email as a formal route through which to communicate with their staff. The students will similarly be approached via the university email system, with an invitation emailed out to all staff and relevant students within both organisations. Interest from a large number of participants will allow purposive selection. This selection will be completed solely through acceptance of the first 3 respondents showing an interest from each of the defined groups. Rapid responses would suggest the individuals are interested in the subject and are therefore likely to provide strong views around it. Insufficient response would trigger the use of snowball sampling. This incorporates using existing participants to identify and help recruit further relevant subjects. As stated in box 6 above interviews will take place within NHS premises close to the participants workplaces to minimise distruption to their work. Interviews are planned to last no longer than one hour each and participants will each be asked to meet with the interviewer on two occasions (the introduction to the study requirements and for the interview itself). A third meeting will be offered to allow participants to review the researchers summary of their transcribed interview. Diary completion is expected to take between 10 and 20 minutes on each of the 5 days the participant records. The expected time commitment for participants will be detailed within the participant recruitment documentation.

15. Participant consent

Please state the groups from whom consent/assent will be sought (please refer to the Guidance Document). The PIS and Consent Form(s) to be used should be attached to this application form.

Consent will be sought from all participants, who will receive outline details of the purpose and structure of the study as an attachment to the email inviting participation (appendix 2). Individuals expressing an interest in

taking part will further be offered more comprehensive information, being asked to meet with the researcher to discuss any concerns or to have any specific questions answered. Consent forms will be signed during this interview with instructions that the participant can withdraw from the study at any time up until analysis is complete, though recognising that any contributions made up to that point would likely influence the researchers understanding and therefore influence the reports findings to some degree.

16. Methodology

Investigations governed by the Code of Practice which involve any of the types of projects listed in B1(a) must be submitted to the University Ethics Committee rather than DEC/SEC for approval.

Are any of the categories mentioned in the Code of Practice Section B1(a) (project considerations) applicable in this investigation? ☐ Yes ☒ No

If 'yes' please detail:

Describe the research methodology and procedure, providing a timeline of activities where possible. Please use plain English.

Interpretative Phenomenological Analysis (IPA) will be used as the guiding methodology

The study will initially incorporate participants completing a week long diary recording the activities they are engaged in while on duty, detailing the staff they are working alongside and their views on this. For NA's this will encourage consideration of time spent with student nurses. For student nurses this will encourage consideration of time spent with nursing assistants. For mentors this will encourage consideration of the time they allocate for nursing assistants to spend with student nurses.

The diary will then be appraised using initial descriptive analysis for consideration of the text components and descriptive statistics will be employed to allow a visual representation (in graph form) of the time spent doing what and with whom. This information will be used to guide the questions for the planned semi structured interview with each participant and would be referred to at the start of that interview.

Following diary completion each participant would be interviewed individually, with audio recordings allowing transcription and analysis of content. Analysis would follow IPA recommendations as defined by Smith,

Flowers and Larkin (2009). Analysis would be checked with participants before final write up.

The findings of the study would then be disseminated through peer review professional journals and via conference presentations.

What specific techniques will be employed and what exactly is asked of the participants? Please identify any non-validated scale or measure and include any scale and measures charts as an Appendix to this application. Please include questionnaires, interview schedules or any other non-standardised method of data collection as appendices to this application.

In order to answer the research questions defined above requires a methodology that allows investigation of the relationship between nursing assistants and student mental health nurses during the students practice placements, as well as facilitating exploration of how the main groups involved (nursing assistants, student nurses and mentors) perceive this relationship. Interpretative Phenomenological Analysis is a methodology that accommodates this and will therefore guide the study.

Initial data will be collected through participants completion of a week- long diary (appendix 3, 4 and 5). The participants will be identified through a defined code in their diary to promote confidentiality and they will be offered the choice of postal return or collection by me. The diaries will record their work activities and identify any significant links between nursing assistants and student nurses, including reporting the forms of work they share. This diary, which will be piloted prior to use within the study, will also encourage all participants to record initial thoughts on the role of NA's in student nurse education in the form of qualitative comments on the activities they are undertaking. Information arising from this diary will contribute to the development of questions for the semi structured interviews that follow, with each participants diary responses being referred to within their own subsequent interview discussion. This information will be summarised in numerical form to provide visual feedback, and in a written review of the qualitative content of diary. This qualitative content will be appraised through initial descriptive analysis in line with the guiding methodology.

Individual interviews with each participant will then allow them to further share their perspective on the relationship between NA's and student nurses, with the semi structured questions used for the interviews formed from a review of the existing literature around the topic (appendix 6) as well as from the data emerging from the diaries. The interviews will be audio recorded and the discussion transcribed for subsequent analysis guided by IPA.

IPA encourages close consideration of the experiences of a small number of relevant individuals, thereby providing a deep exploration of the phenomenon in question. Analysis of data involves descriptive and then interpretative analysis of the transcribed interviews, providing understanding of the viewpoints of the individual participants, as well as enabling comparison of similarities and differences between them.

Where an independent reviewer is not used, then the UEC, DEC or SEC reserves the right to scrutinise the methodology. Has this methodology been subject to independent scrutiny? Yes ☐ No x☐
If yes, please provide the name and contact details of the independent reviewer:

17. Previous experience of the investigator(s) with the procedures involved. Experience should demonstrate an ability to carry out the proposed research in accordance with the written methodology.

I have no prior experience in the use of IPA, however I have completed a qualitative study of similar design as part of an MEd. This exposed me to the demands of qualitative research and to the use of methods that are not dissimilar to the ones planned here. My two supervisors are both experienced researchers and research supervisors: Dr Kennedy has extensive experience of a range of qualitative methods, including interviews and surveys, and has experience of working in the field of professional education.

18. Data collection, storage and security

How and where are data handled? Please specify whether it will be fully anonymous (i.e. the identity unknown even to the researchers) or pseudo-anonymised (i.e. the raw data is anonymised and given a code name, with the key for code names being stored in a separate location from the raw data) - if neither please justify.

Participants will be known only to the primary researcher and their

involvement will be pseudo-anonymised through the use of code names e.g. M1 for the first mentor, S1 for the first student and N1 for the first nursing assistant. This will be explained to all who register an interest in participating.

Explain how and where it will be stored, who has access to it, how long it will be stored and whether it will be securely destroyed after use:

Raw data will be stored in a password protected file format on a password protected laptop stored securely by the primary researcher. Participants will be allocated a code identifier by the researcher at the commencement of their involvement and this will be used from then on to protect the participants confidentiality. The Information identifying the participants will be stored within a password protected PC and together with the completed diaries will be stored within a locked room within a locked and guarded building. Diary sheets will be anonymised through use of the pre-defined code known only to the participants and researchers. Audio recordings of the interviews will be stored digitally on the same PC. All data will be destroyed 5 years after completion of the study (expected around Sept 2021).

Will anyone other than the named investigators have access to the data? YesX ☐ No ☐
If 'yes' please explain:
Both research supervisors will have access to all data.

19. Potential risks or hazards

Describe the potential risks and hazards associated with the investigation:

There are no known risks or hazards related to the research with no predicted harm to participants' health, wellbeing or safety. The environments used within the study already fall under the health and safety remit of the NHS further safeguarding the participants' wellbeing.

Participants may complete the questionnaires as part of a group of peers or friends, with a danger that they give a consensus view, rather than their own.

Has a specific Risk Assessment been completed for the research in accordance with the University's Risk Management Framework (http://www.strath.ac.uk/safetyservices/aboutus/riskmanagement/)? Yes ☐ No ☒
If yes, please attach risk form (S20) to your ethics application. If 'no', please explain why not:
The entire process is expected gto take place within NHS Greater Glasgow and Clyde premises. This organisation has a requirement to ensure the health and safety of those using such environments.

20. What method will you use to communicate the outcomes and any additional relevant details of the study to the participants?

Prior to commencing the study

Prospective participants will receive an outline of the study in an email. Interested parties will then receive a full written account of the study and will be asked to meet with the primary researcher in order to answer their questions and to ensure they are fully aware of the study structure, process and purpose. The diary sheets will be introduced by the primary researcher with instructions for completion given both verbally and in writing, and the primary researcher will also provide further verbal explanation of the interview process prior to this commencing. Participants will also be informed of the primary researchers contact details and encouraged to raise any uncertainties they may have at any time within the study.

During the study

Participants will have access to documentation relating to them on request at any time within the study and review of the diary content will form an integral part of the individual interview. Analysis of their data will be discussed with individual participants prior to final write up and their comments on this will be included within the overall analysis.

After the study

All participants will be offered a copy of the final paper and of any subsequent publications arising from it. These will be emailed with an offer to meet and discuss the findings.

21. How will the outcomes of the study be disseminated (e.g. will you seek to publish the results and, if relevant, how will you protect the identities of your participants in said dissemination)?

The study finding will contribute to the development of a thesis which will be submitted as part of an EdD. The thesis will be stored at Strathclyde university where academic staff and enrolled students will have access. The study is likely to be the subject of several articles submitted to peer reviewed professional journals as well as being offered for presentation at relevant professional conferences. A purpose of professional doctorates is to progress practice and dissemination of findings in this way seems likely to achieve this aim. To protect the anonymity of those involved the participants will not be identified by name or location of employment and will be referred to only by their occupation and allocated pseudonym.

Checklist	Enclosed	N/A
Participant Information Sheet(s)	☒	☐
Consent Form(s)	☒	☐
Sample questionnaire(s)	☐	☒
Sample interview format(s)	☒	☐
Sample advertisement(s)	☒	☐
Any other documents (please specify below)		
Diary mentor	☒	☐
Diary HCSW	☒	☐
Diary student nurse	☒	☐
	☐	☐
	☐	☐

22. Chief Investigator and Head of Department Declaration
Please note that unsigned applications will not be accepted and both signatures are required

I have read the University's Code of Practice on Investigations involving Human Beings and have completed this application accordingly. By signing below, I acknowledge that I am aware of and accept my responsibilities as Chief Investigator under Clauses 3.11 – 3.13 of the Research Governance Framework and that this investigation cannot proceed before all approvals required have been obtained.

Signature of Chief Investigator 

Please also type name here: Aileen Kennedy

I confirm I have read this application, I am happy that the study is consistent with departmental strategy, that the staff and/or students involved have the appropriate expertise to undertake the study and that adequate arrangements are in place to supervise any students that might be acting as investigators, that the study has access to the resources needed to conduct the proposed research successfully, and that there are no other departmental-specific issues relating to the study of which I am aware.

Signature of Head of Department

Please also type name here

Date: / /

23. Only for University sponsored projects under the remit of the DEC/SEC, with no external funding and no NHS involvement

Head of Department statement on Sponsorship
This application requires the University to sponsor the investigation. This is done by the Head of Department for all DEC applications with exception of those that are externally funded and those which are connected to the NHS (those exceptions should be submitted to R&KES). I am aware of the implications of University sponsorship of the investigation and have assessed this investigation with respect to sponsorship and management risk. As this particular investigation is within the remit of the DEC and has no external funding and no NHS involvement, I agree on behalf of the University that the University is the appropriate sponsor of the investigation and there are no management risks posed by the investigation.

If not applicable, tick here ☒

Signature of Head of Department

Please also type name here

Date: / /

For applications to the University Ethics Committee, the completed form should be sent to ethics@strath.ac.uk with the relevant electronic signatures.

24. Insurance
The questionnaire below must be completed and included in your submission to the UEC/DEC/SEC:

Is the proposed research an investigation or series of investigations conducted on any person for a Medicinal Purpose? Medicinal Purpose means: ▪ treating or preventing disease or diagnosing disease or ▪ ascertaining the existence degree of or extent of a physiological condition or ▪ assisting with or altering in any way the process of conception or ▪ investigating or participating in methods of contraception or ▪ inducing anaesthesia or ▪ otherwise preventing or interfering with the normal operation of a physiological function or ▪ altering the administration of prescribed medication.	No

If "**Yes**" please go to **Section A (Clinical Trials)** – all questions must be completed
If "**No**" please go to **Section B (Public Liability)** – all questions must be completed

Section A (Clinical Trials)

Does the proposed research involve subjects who are either: i. under the age of 5 years at the time of the trial; ii. known to be pregnant at the time of the trial	Yes / No

*If "**Yes**" the UEC should refer to Finance*

Is the proposed research limited to: iii. Questionnaires, interviews, psychological activity including CBT; iv. Venepuncture (withdrawal of blood); v. Muscle biopsy; vi. Measurements or monitoring of physiological processes including scanning; vii. Collections of body secretions by non-invasive methods; viii. Intake of foods or nutrients or variation of diet (excluding administration of drugs).	Yes / No

*If "**No**" the UEC should refer to Finance*

Will the proposed research take place within the UK?	Yes / No

*If "**No**" the UEC should refer to Finance*

Title of Research	
Chief Investigator	
Sponsoring Organisation	

Does the proposed research involve:		
a)	investigating or participating in methods of contraception?	Yes / No
b)	assisting with or altering the process of conception?	Yes / No
c)	the use of drugs?	Yes / No
d)	the use of surgery (other than biopsy)?	Yes / No
e)	genetic engineering?	Yes / No
f)	participants under 5 years of age(other than activities i-vi above)?	Yes / No
g)	participants known to be pregnant (other than activities i-vi above)?	Yes / No
h)	pharmaceutical product/appliance designed or manufactured by the institution?	Yes / No
i)	work outside the United Kingdom?	Yes / No

If **"YES"** to **any** of the questions a-i please also complete the **Employee Activity Form** (attached).
If **"YES"** to **any** of the questions a-i, and this is a follow-on phase, please provide details of SUSARs on a separate sheet.
*If "**Yes**" to any of the questions a-i then the UEC/DEC/SEC should refer to Finance (aileen.stevenson@strath.ac.uk).*

Section B (Public Liability)

Does the proposed research involve :		
a)	aircraft or any aerial device	No
b)	hovercraft or any water borne craft	No
c)	ionising radiation	No
d)	asbestos	No
e)	participants under 5 years of age	No
f)	participants known to be pregnant	No
g)	pharmaceutical product/appliance designed or manufactured by the institution?	No
h)	work outside the United Kingdom?	No

*If **"YES"** to any of the questions the UEC/DEC/SEC should refer to Finance(aileen.stevenson@strath.ac.uk).*

For NHS applications only - Employee Activity Form

Has NHS Indemnity been provided?	Yes See note below
Are Medical Practitioners involved in the project?	No
If YES, will Medical Practitioners be covered by the MDU or other body?	NA

This section aims to identify the staff involved, their employment contract and the extent of their involvement in the research (in some cases it may be more appropriate to refer to a group of persons rather than individuals).

Chief Investigator		
Name	**Employer**	**NHS Honorary Contract?**
		Yes / No
Others		
Name	**Employer**	**NHS Honorary Contract?**
		Yes / No
		Yes / No
		Yes / No
		Yes / No

Please provide any further relevant information here:

Regarding NHS Indemnity- the researcher who will be undertaking the study within NHS premises already has a role in supporting student nurses in NHS placement settings. To support this role both the NHS and his employer recognise the mandated need for him to work within such settings, both expect it to occur and both regularly support it, through this NHS indemnity is assumed.