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# The Path to Nurse Registration

by

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A dissertation presented in fulfilment
of the requirements for the degree of
Doctor of Education

2005

# ACKNOWLEDGEMENTS

I would like to give particular thanks to Mr Iain Smith for all his valuable help, advice and continued support in acting as my supervisor. I would also like to give special thanks to Professor John Atkinson and Eileen Cunningham for valuable advice and continued encouragement. Particular thanks are due also to the University of Paisley for their financial help and support and to the student nurses who participated in this research and therefore made it possible.

## ABSTRACT

The aim of this study was to identify the factors promoting or impeding pre-registration degree level education at the first School of Nursing offering transfer from diploma to degree programmes.

A quantitative approach was used to collect data from student nurses using a questionnaire. This included an attitude towards obtaining a degree scale developed using psychometric tests to maximise reliability and validity. The remainder of the questionnaire consisted of checklists of the factors influencing the decision to accept transfer or not and demographic information.

In the main study the questionnaire was distributed to 113 third year adult branch student nurses. The response rate was 93%. The 105 participants were typical of student nurses, i.e. the majority were female, mature and worked part-time.

Attitudes towards obtaining a degree were generally positive. The majority of students believed obtaining a degree will help nurses develop their career and increase professional status. However, the majority disagreed that obtaining a degree is essential to be a good nurse, will make nurses better at their jobs and will improve the patient care provided by nurses. Only 25% believed obtaining a degree ought to be essential for all student nurses.

Twenty nine students did not accept transfer to the degree. Of these 79% reported this was due to the combined pressures of academic workload, family and work. None of these participants believed that obtaining a degree will make nurses better at their jobs.

A theory-practice divide seemed to exist, whereby many of the participants did not relate the increased degree knowledge with clinical practice.

Based on this study's limited evidence, achieving an all graduate profession at the point of registration appears difficult because of students' limited abilities and motivation to obtain a degree. Possible solutions include to narrow the entrance gates or to achieve an all graduate profession after registration by implementing short-term learning contracts for newly qualified nurses.

Understanding which types of students accept or decline transfer could be better understood by improved information systems.

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# INTRODUCTION

## I. Background

Formal pre-registration nurse education has changed radically since it began in the mid nineteenth century to today at the start of the twenty first. Currently pre-registration nurse education for the majority of students in the United Kingdom (U.K.) is at diploma level. However, for many years many have argued that pre-registration nurse education should be at degree level, that is, that nursing should move towards an all graduate profession. There are many arguments for and against this, which this research considers in subsequent chapters.

In 2003, a major change in Scottish pre-registration nurse education brought the prospect of an all degree profession a step closer. Universities, which until then had offered only three year diploma courses, began to offer three year degree programmes as well. As a result student nurses can now transfer from diploma to degree programmes during the final year of their studies. This means that many more nurses than ever before will have a degree as the minimum academic standard of pre-registration nursing in Scotland. However, not all nurses are able nor wish to transfer onto an undergraduate pre-registration programme. Hence, issues of ability and aspiration are important to consider for several reasons. Firstly, universities need to plan for the additional resources required to accommodate degree level education. Secondly, local and national targets set for the number of students studying at degree level need to be met. In addition, if the ultimate aim is that the degree programme becomes the only way to register as a nurse, then this will require detailed information on the possible impact on the recruitment and selection of student nurses. To fully understand these issues requires knowing which types of student nurses accept or decline transfer onto a degree programme in terms of demographics, entrance qualifications, academic achievements and motivational factors. This can only be done by having accurate, accessible and appropriate data to analyse.

Large amounts of routine data are generated during student nurse training programmes which are accurate and appropriate to use; however they are often fragmented and therefore not easily accessible for analysis. These data could be much more easily managed through the better use of information technology. This can be achieved by the development of a computerised comprehensive student nurse educational data set (SNEDS) including all of the above i.e. demographics, learner characteristics, academic achievements and reasons for accepting or declining transfer onto degree programmes.

This study uses a quantitative approach to collect anonymous data from students in the first university in Scotland to offer transfer from a diploma to degree pre-registration programme, as detailed above, using a questionnaire survey. This university prides itself on recruiting students from a wide socio-economic background, into all disciplines (Lifelong Learning Research Group, 2002).

The questionnaire data represent a sub-set of the data proposed for a SNEDS. As a by-product of this research, the variables required for a comprehensive SNEDS are proposed. This sub-set of the SNEDS are then used to demonstrate that existing data sources can be combined and used to much better use with very few additional resources e.g. for audit purposes, for examining trends, research hypothesis generation (Graves, 1998b, as cited by Stevens, 1999) and the exploration of research questions.

## II. Why this research is important

This research is important for several reasons. The first is to add the student voice to the general debate on an all degree profession, as this appears to be lacking in previous literature. This research therefore uses a student focused approach. The second is to recommend a comprehensive computerised SNEDS, which the literature again suggests does not appear to exist in many institutions. The final reason is to provide useful information for educators to develop more effective promotional campaigns for degree transfer programmes.

## III. Aim and objectives

The aim of this study was to identify the factors promoting or impeding pre-registration nursing education at degree level at a large School of Nursing offering both diploma and degree programmes.

This was met by the following objectives:

1. To carry out a questionnaire survey. This served two purposes:

   i. to collect relevant data on the movement of student nurses between diploma and degree courses based on two groups:

      a. transfer students (those who accepted transfer),

      b. declined transfer students (those who declined transfer)

Initially there was a third group: not offered transfer students (those who were not eligible and not offered transfer). Students were initially not eligible if they did not meet specific academic criteria. However, a change in school policy during the research process meant all student nurses were offered transfer. This decision was unconnected to this research.

   ii. to collect data on why students accepted or declined transfer from diploma to degree programmes.

2. To use the above data, to identify factors promoting or impeding pre-registration education at degree level.

3. To define a student nurse educational data set (SNEDS) for adult student nurses which could be used for audit purposes, to generate research hypothesis and explore research questions.

## IV. Structure of the Report

The report is divided into six main chapters. The first three chapters set the debate in context. At the end of each chapter a summary is provided.

Chapter one takes a historical look at nurse education provision. It considers how the past has led to where nurse education is now, briefly considers what lessons can or have been learnt from the past and finally considers what the future of nurse education requires to be. In doing so it focuses on some of the main policy documents driving changes in nurse education. In addition, it examines the varied attitudes towards obtaining a degree and moving to an all graduate nursing profession within the United Kingdom and within other relevant western nations.

Chapter two focuses on the differences between student nurses taking degree or diploma courses. These include demographic variables, clinical competence and career mindedness. It also explores to whom obtaining a degree benefits. Finally, this chapter considers the factors promoting or inhibiting study at degree level.

Chapter three considers general principles of motivation i.e. what motivates student nurses to obtain a degree when given the choice of a diploma or a degree. This chapter is theoretical in nature because of the lack of previous research. A number of factors including attitudes towards obtaining a degree are considered as possible motivating factors. This chapter also considers how to measure attitudes, the inherent problems in doing so and the links between attitudes and behaviours.

Chapter four describes the design of the study. This includes the instrument development, pilot and main study. These are described and justified. In addition, other methods considered and the advantages and disadvantages of these are discussed.

The findings are presented in chapter five.

The final chapter provides discussion of the key findings, the limitations of the study, lessons learned, recommendations and proposed further research.

## V. Literature Review Strategy

The aims of the literature search were to identify and locate:

- information to develop and carry out a questionnaire survey
- evidence on past and current opinion pertaining to attitudes towards obtaining a degree and moving towards an all degree profession
- possible factors promoting or inhibiting study at degree level, and
- information to define a minimum data set.

A systematic literature search using Cumulative Index to Nursing and Allied Health Literature (CINAHL), MEDLINE, British Nursing Index Plus: May 2004 Edition, Royal College of Nursing (RCN) Journals and EBSCO: Health Source Nursing/Academic Edition was carried out using the keywords: survey, questionnaire, attitude scale, valid, reliable, degree, diploma, nursing education, nursing students, minimum preparation, entry into practice, selection, recruitment, academic achievement, diplomate, graduate and minimum dataset.

These were used in a variety of combinations. Additional information was found by hand searches for the most up to date articles from nursing and educational journals. Where possible secondary references from material retrieved were sourced to extend the search further. A number of historical documents were not found.

The bulk of the literature review was from 1986 onwards. This date was chosen because this was when the United Kingdom Central Council (UKCC) published the Project 2000 report (UKCC, 1986) which recommended the overhaul of nurse

education as it was then and still remains today. Hence, the majority of student nurses at present still complete the Project 2000 diploma course. The debate about an all graduate profession commenced before this date; however it intensified following the move into higher education as a result of the Project 2000 Report.

The computerized literature search did not find any nurse education articles directly linked to the aim of the study. This was expected as the ability to transfer from a diploma to a degree programme was a recent development in nurse education. However, other relevant articles were found which helped to provide the theoretical base for this study.

Some of the articles found were American or from other European or other English speaking countries where the educational systems are quite different, but where relevant debates on a move towards an all graduate profession exist. These were also included.

# SETTING THE DEBATE IN CONTEXT: A DEGREE OF HARMONY

# CHAPTER ONE: Past, Present and Future

## 1.1. Introduction

The move to an all graduate nursing profession is a topical debate. However, a look at the past suggests this debate has been around a long time but as yet remains unresolved. Many policy changes have occurred in nurse education, which have increased the number of nurses obtaining a degree; however there is currently no decision within the U.K. to end diploma courses and move to an all graduate profession at the point of registration.

This is a somewhat cautious response to the debate compared to other Western nations some of which now only provide degree level programmes. To try to understand why the debate still remains unresolved here, a brief historical and current perspective of the development of nurse education in the U.K. has been included in this first chapter, as well as comparisons with other relevant nations.

It was hoped this historical perspective might shed light on the future requirements of nurse education. The benefits of studying history in order to help predict the future are well established. Indeed, Winston Churchill, when asked how he was able to anticipate the future, replied *'Because I study history'* (Niven, 1971, as cited by Cutcliffe, 2003, p.338).

## 1.2. A brief history of Nurse Education in the United Kingdom

Ever since nurse education began it has existed *'to provide appropriately prepared practitioners for the delivery of nursing care'* (Crotty, 1993, p.165). The preparation and the appropriateness of the preparation for the delivery of nursing care are interlinked. However, they have changed and continue to change over time. They are dependent on society's needs, public expectations, political ideologies and developments in medical technology (Crotty, 1993) at a particular point in time.

The following brief history of nurse education charts the path taken from one century to the next in order to more fully understand how and if nurse education has tried to keep a pace of such changes.

The first and most famous nursing school known as the Nightingale School commenced in 1860 within St. Thomas's Hospital in London (Maggs, 1983, p.10). The system of training introduced in this school by its founder Florence Nightingale was described as experimental at the time, and has since come under both much criticism and praise (Baly, 1987, p.35).

Maggs (1983) described how nurse duties had until then focused on cleaning the wards, keeping the patients clean and giving out medicines. It was much to the displeasure of the new probationers in the Nightingale School, who were all relatively young (aged between 21-25 years) and female, when these cleaning duties continued, if not increased. The probationers thought cleaning lavatories too menial a task for their new status. This was not a duty they expected. However, for Florence Nightingale, cleanliness or the newly discovered 'science of hygiene' was sacrosanct.

This hospital 'apprenticeship' style training had little formal educational component but instead emphasised the need to develop obedience (Maggs, 1983). Indeed, nursing aimed to attract and select women who did not question obedience (Zelek and Phillips, 2003). It was believed nurses learnt simply by doing (Fitzpatrick et al 1993, p.1489). This was in relation to doing what the doctor and senior nurses said, including the infamous 'Matron' (Maggs, 1983 and Lorentzon, 2003).

Intellect was a less desirable attribute (Lorentzon, 2003). This was because to Florence Nightingale the 'fundamental qualities' required to become a nurse, that is honesty, punctuality, obedience and sobriety, to name but a few, were far more important (Maggs, 1983, p.103). Hence, the selection of probationers was very thorough in relation to ensuring their character was suitable for nursing (Mellish, 1984) but not their academic ability. On completion of training the nurses received a

certificate. However, Lorentzon (2003, p. 326) used a quote from a letter written in 1888 by Florence Nightingale in which she stated, *'it is not the certificate which makes the nurse or midwife. It may unmake her'*.

Many nurses did not complete their training, perhaps due to the harshness of the training, but often due to illness (Baly, 1987). Baly (1987) provided lists of the reasons why some of the first probationers did not complete their training. These included: unsuitable, insobriety, inefficient, incompetent and moral character defective!

Despite its critics this hospital apprenticeship training was accepted and spread. Standards however varied. Some courses were only one year in length (Nursing and Midwifery Council ((NMC), no date). Many called for registration as a means to regulate nursing and to regulate who was able to call him or herself a nurse. State registration of doctors had begun in 1858 and midwives in 1902 (NMC, no date). Registration for nurses did not happen for several more years because of opposition. However, by 1910 most hospitals did provide a three year training programme (Maggs, 1983).

Florence Nightingale was one of the best known opponents to the registration of nurses partly because she believed the hospital provided a good training (Maggs, 1983) and partly because she believed the essential qualities of a nurse could not be taught nor regulated (NMC, no date). However, state registration for nurses did come into force in 1921 (Maggs, 1983). This was due largely to the pioneering work of Mrs Bedford-Fenwick, who was also one of the first nurses to argue for nurse education to be provided in universities (Burke and Harris, 2000, p.621). Mrs Bedford-Fenwick was only able to introduce registration via a private members bill in 1919 through the College of Nursing. The college had commenced in 1916 and later became the Royal College of Nursing (RCN) (NMC, no date) which still remains today.

In the early1930s it was still being suggested that the apprenticeship style training

might not be meeting all student nurses needs (Lancet, 1932, as cited by Fitzpatrick et al 1993). However, any proposed changes were dismissed because of fears of creating academic nurses who would lack clinical skills.

In 1947 a review carried out by the Ministry of Health on the recruitment and training of nurses suggested that the training provided still lacked consistent standards (Wood, 1947, as cited by Lusk et al, 2001). In addition, the latter also reported that attrition rates remained high. This report recommended that students be granted full student status. This 'forward thinking' recommendation was not accepted, mainly because it did not agree with the views of current more traditional nurse leaders and because it was feared it would jeopardise hospital requirements of ensuring wards were adequately staffed (Bentley, 1996). The 'apprenticeship' model of training was characterised by student nurses being employees and hence counted as part of the staffing complement of a hospital (Nursing Commission, 1998).

Instead changes to the training, focusing on increasing professional status, were made to try to improve recruitment and retention (White, 1985, cited in Lusk et al 2001).

In 1961 a further government review of nurse education was commenced. The results were published in 1964 and were known as the Platt Report. This also recommended student status but this aspect was again not implemented.

By 1962 student nurses had to complete a high school education or successfully complete an entry test before entering into nurse training (Lusk et al, 2001). Despite concerns that this might worsen recruitment, it was reported to have had quite the opposite effect.

Also during the 1960s Enrolled Nurse training was temporarily introduced to attempt to meet staffing requirements. This was not phased out completely until 1995 (Le Var, 1997b). This two year course was considered a more practical training for those who did not meet the entrance qualifications of the three year programmes.

Further reforms for better educated nurses led to the first degree course being commenced in Edinburgh in 1965 (Burke and Harris, 2000, p.621).

In 1972, a further more successful government review was published: the Briggs Report. This report recommended the creation of a new statutory framework for nursing and midwifery (Bentley, 1996). As a result the United Kingdom Central Council for Nurses, Midwives and Health Visitors (UKCC) and four National Boards for England, Scotland, Wales and Northern Ireland were established in 1979 (Le Var, 1997a, p.171). The UKCCs legal function included establishing and improving standards of training. The Boards were predominantly involved in approving institutions to provide training.

The apprenticeship model of nurse education continued and up until 1989 the majority of nurse education continued to be provided within schools of nursing which remained attached to hospitals. The qualification gained during this nurse 'training' continued to have no academic currency. Nurse 'tutors' had to cope with up to six intakes of students per year, constant teaching and very little time, if any, for research (Meerabeau, 2001). Thus, the nurse education system itself appeared to be preventing further development of the profession.

White (1985, as cited by Meerabeau 2001, p.429) argued that further reform of nurse education was also hindered by disagreements between three main interested parties: the 'rank and file' who believed nursing was a practical occupation, those arguing for the increased professionalism of nursing and thus a move into higher education and managers whose interest, as before, lay in ensuring wards were adequately staffed. However, the differences between these three main parties were not insurmountable. Other professionals, for example doctors were and remain the classic example of practical professionals who have always been highly educated.

Nevertheless, the arguments for a move into higher education did gain ground as the level and length of education was seen to be becoming increasingly important to the interpretation of what was professionalism (Glen, 1995). Other health practitioners

allied to medicine were moving into higher education. However, Cutcliffe (2003) suggested that higher education itself did not wish to welcome nursing into its ranks. Burke and Harris (2000, p.621) suggested this was because the courses were too vocational. It was also suggested that nurse academics were second rate and in need of guidance (Cadman, 1997, as cited by Burke and Harris, 2000, p.621).

On the other hand, Carlisle (1996) suggested that many institutions viewed the attraction of increasing student numbers and hence funding positively.

Eventually, after discussions between the RCN, the UKCC and National Boards it was agreed with the Government, that Project 2000: A New Preparation for Practice (UKCC, 1986) would be launched. As a result nurse education finally moved into higher education institutions. Le Var (1997b) noted that the Government only accepted the Project 2000 Report because of the convincing arguments that changes in society's health needs could not be met by the existing nurse education system and that more flexible better educated practitioners were needed to meet future health needs.

### 1.3. Current context of nurse education in the UK and beyond

The merger of nurse education and higher education (HE) was completed by 1997 (Council of Deans and Heads, 2002). Nurse education was now part of the university 'system' and nurse tutors became 'academics'. Students were now being 'educated' to become competent professionals able to think critically for themselves (Fitzpatrick et al 1993, p.1489).

The merger has been referred to by some as an 'amalgam' in that nurse education was seen to be aiming for both an extensive knowledge base and the mastering of the skills associated with a vocation (Glen, 1994). However, ensuring that the best from both systems was incorporated into nurse education has not been easy, as some of the subsequent discussion suggests.

This merger also coincided and hence benefited the Government's policy to widen access to higher education (HMSO, 2003). Student nurses have greatly boosted the Governments figures. However, this widening of access has meant that higher education is no longer an elite system but a system of mass education (Jarvis, 1997 and Longden, 2000).

The Council of Deans and Heads for Nursing (2002) support the 'widest possible access' to pre-registration nursing for many good reasons which are discussed below. However, Glen (2002, p.358) has suggested that this expansion of higher education has in fact eroded the increased professionalism that many nurse academics wanted.

Mass education has resulted not only in the growth of traditional students, that is, 18-26 year olds, but in the whole profile of age ranges, backgrounds and expectations of students (Glen, 2002). However, mass education is only the first step to better educate the masses. The government plans to commit to a universal system within the next few years, thus increasing further the number of people attending university (Longden, 2000). It is therefore feared that, in general terms, this will only result in increased non-completion rates and financial wastage and in Lees (1999, as cited by Longden, 2000) opinion a reduction in academic quality. This will also mean ever greater public spending on HE and further growing concerns about quality and value for money (Becher and Trowler, 2001).

Nevertheless, meeting the Government's agenda of widening access has brought both advantages and disadvantages to nurse education. The advantages have included access to greater study resources and a wider range of staff and teaching expertise (Fitzpatrick et al, 1993). These were all considered conducive to develop the critical thinkers, so desired. Some feel, in relation to the disadvantages that mass education, and in particular policies to widen access, have simply been a means to increase the number of nurses.

Interestingly, the entrance qualifications for the diploma option, worth 300 academic points, are a minimum of five points in some institutions. Students can then transfer

to a degree. Twenty years previously the entrance qualifications for the RGN qualification, now recognised as only being worth 200 academic points, were 5 standard grades and Higher English as the minimum.

However, increasing diversity has also occurred through necessity. This is because of the diminishing pool of young females (Robinson et al, 2003). The reason for nursing historically being predominately female is because it was seen as 'women's work' and therefore of inferior status. It may be that this perspective still remains, however as the discussion of the current and future role of nursing in subsequent sections demonstrates, is not merited.

This contrasts markedly with medicine in which historically the opposite was the case, in that males made up the majority of medical students. However, it has been reported that the majority of acceptances into UK medical schools are now female: (61%) versus (49%) males (British Medical Association, 2004). Medicine has succeeded in reversing this historical trend where nursing has not. It has been reported that nursing needs to improve its image (NHS Scotland, 2001, p.2) and perhaps this will attract more males.

However, correcting the gender balance is not simple. Although, one of the main arguments for more women in medicine was to achieve equality for men and women, some argue that female doctors predominantly work in the low status and low earning jobs within medicine (Riska, 2001). Hence, discriminatory practices continue to exist within medicine. Indeed, Riska (2001) argues that with the increase in the number of women in medicine there has been a decrease in the power of medicine within society.

It is because nursing has always been associated with women that the status of nursing is low. Hence, for more males to enter nursing, status may improve for female nurses, but tend to be seen as negative for men (Porter-O'Grady, 1998). Nevertheless, even if more men did enter nursing, female nurses may loose the power they do at least hold within nursing, as it is possible that men would ascend to

the leadership positions. However, because there are so few men in nursing, this is currently not possible. This seems to suggest a catch 22 situation for both men and women in relation to nursing (Porter-O'Grady, 1998).

Subsequently, recruits into nursing remain predominately female. This is one area where increasing diversity is not working! In 2002-2003, only 454 or (13%) of nursing recruits were male out of 3608 (NHS Education for Scotland (NES) 2003). Hence, female student nurses are progressively being drawn from an older section of society. Indeed, it is reported that nearly half of all pre-registration students are mature, that is, over 26 years old (Nursing and Midwifery Admissions System, 2003 as cited by RCN, 2004a). This in turn means many have families to support and therefore work part-time as well as fulfil their role as full time students (RCN, 2004a). In recognition of this, more family friendly policies have been introduced into pre-registration nurse education (Robinson et al, 2003). Nevertheless, this also means the entire nursing population is ageing (Hakesley-Brown, 1999). It was reported by the NMC (2004, p.3) that in 1995 over half of all nurses on the register were under 40, whereas in 2004, 'well over half' were over 40 and more than 1 in 4 were over 50.

In comparing the age of **all** students entering via the Universities and Colleges Admission Services (UCAS) (1999) a quite different picture was evident. It was reported that more than 75% of all applicants to universities and colleges were under 21 years of age and that the number of mature applicants was decreasing. [Student nurses applying to Scottish institutions for diploma or some ordinary degrees do so via the Centralised Applications to nursing and midwifery Training Clearing House (CATCH) (2004). The remaining applications, for example, Honours degrees are all done via UCAS.]

Such changes have meant that potential applicants, many of whom may be Health Care Assistants (HCAs) and therefore with relevant experience but perhaps without appropriate academic qualifications, can undertake vocational courses up to Level 3 and then meet the entrance requirements for nurse education (Taylor, 2002).

Currently in Scotland HCAs are also being fast tracked into nursing via Further Education (FE) Colleges. This means HCAs attend a one year course in FE before joining a second year cohort in HE. These students are sponsored by their NHS employers and are contracted to return to their original place of work as registered nurses. This therefore has the advantage of encouraging retention of registered nurses in areas where turnover is high. This also fills places lost to high attrition rates in the first year of university programmes.

These types of policies are crucial because the NHS still faces major shortages of nurses (Buchan, 2002). This has in part been blamed on NHS Trusts underestimating the number of training places required in the past and because many registered nurses are leaving the NHS. However, since 1994-95 the number of training places has increased annually (Auditor General, 2001, p.3). This has been no easy challenge for universities to meet, though the Auditor General (2001) reported that these demands have been met to date. However, to continue to increase student numbers will require increased investment, as institutions begin to reach 'full capacity' and the quality of education provision risks being jeopardised. Hence, increasing the number of student nurses is essential to replace the many registered nurses leaving nursing. However, it is feared that continually widening the entrance gates to increase numbers may reduce the likelihood of achieving an all degree profession and/or possibly lower standards. These debates are discussed further in subsequent sections.

The measures to address nurse shortages not only include educating more students, but to also encourage existing staff to remain in nursing by offering training and development, to encourage qualified staff back into the profession and to encourage staff to work in the UK from abroad (Buchan, 2002). Much of the attraction of staff development for registered nurses has been reported to be in 'topping up' to a degree. Ironically, moving to an all degree profession may require a further 'incentive', for example, Masters Degrees, to continue to encourage nurses either to remain in nursing or to keep up to date.

Despite the above concerns, Project 2000 has been reported by some as the '*high*

*point of professional influence on nursing education*' (Meerabeau, 2001, p 430). This may be so, but not all have commended the subsequent widening of access into nurse education to address nurse shortages. Watson (2001) in his published speech to the RCN Congress suggested that widening access is simply *'a euphemism for lowering educational standards'* and that *'in fact almost anyone can try their hand at nursing.'* If this were so, this would seem to not be conducive to increasing professional status.

On the other hand, Glen (1995) feared a different problem, in that in the quest for increased knowledge and hence increased professional status, the clinical skills required by nurses would be neglected. Miers (2002) suggested this was because an academic culture defines practical skills as inferior to intellect. To some extent this has occurred, because as a result of the merger, the theoretical content of pre-registration education has increased and the clinical placement time decreased.

In addition, the way in which nurse pre-registration clinical placement time is provided has become increasingly more flexible. The Open University recently commenced a pre-registration nursing programme for HCAs in 2003. These HCA/students require the sponsorship of their employer, so that they can continue to work in their HCA job part-time, but also study and take on the role of a student nurse on a part time basis (The Open University, 2003). Hence, their clinical experience as a HCA appears to count as part of their pre-registration clinical placement time towards their nurse registration. This would appear to be confusing for students, staff and patients alike.

Nevertheless, a further advantage of such policies has been that professionals within the National Health Service (NHS), including nurses, now come from a more diverse background and may more accurately reflect the communities they serve as was previously recommended by Taylor (2002).

Therefore, despite all of the above concerns, Project 2000 has on the whole been praised as having had a significant effect on the structure, organisation and delivery of nurse education (Winson, 1995). The diploma became and still is the minimum

requirement for nurse registration. The majority of pre-registration nurse education in the U.K. is provided at this level; however this may change in Scotland because of the recent introduction of the degree transfer scheme. Hence, on completion of pre-registration education nurses now not only receive a professional qualification but an academic qualification also. Students therefore now have student status, though not completely, and hence receive a bursary instead of a salary. Student status is partial because students are only 'almost' supernumerary to the NHS workforce, continuing to contribute to twenty per cent of staffing levels (Le Var, 1997b). However, for the first time since nurse education began **all** pre-registration education has academic currency and has divorced itself to some extent from service providers (Meerabeau, 2001).

Nevertheless, this has led to yet more criticisms of Project 2000. Wards, which previously had been staffed with first, second and third year student nurses, who until then had been employees of the NHS, were initially short staffed. Students were therefore replaced with health care assistants (NursingNetUK, no date).

Perhaps unfortunately, nurse lecturers have also reduced their contact time with clinical areas. Clinical staff, that is, mentors perform student clinical assessments. Lecturers provide a liaison/support role, predominately to the mentors. However, in 2004, Practice Education Facilitators (PEFs) were introduced in Scotland to further support students and to contribute to the development of the clinical learning environment (NHS Education for Scotland (NES), no date).

A further criticism is that Project 2000 has not, as intended, appeared to have reduced attrition rates (Glossop, 2002, p.376). The reasons why students leave pre-registration nurse education have been well documented and include academic, family and health difficulties, wrong career choice (Glossop, 2002), lack of support, financial difficulties (Glossop; 2002, RCN, 2002a and Finlay, 2000) and in relation to the clinical learning environment (Finlay, 2000). However, it is yet to be seen what impact the recent introduction of PEFs will have on attrition.

Attrition varies markedly from institution to institution. A target of 13% has been set for nursing students (Auditor General, 2001). This has been reached in some institutions, though others are reported, anecdotally, to be running as high as 30%. In Scotland the attrition for students from first year pre-registration diploma education was 23% in 2001-02 of the numbers commencing in the same year (RCN Labour Market Review, 2002, p.21).

Project 2000 was also not accepted wholeheartedly by 'traditionally' trained nurses. Project 2000 was seen as a threat (Meerabeau, 2001) because of the academic emphasis of the course.

Indeed, contrary to some of the evidence provided above, Project 2000 was blamed in the press for producing nurses that were too highly qualified (Sewell, 1999 as cited by Meerabeau, 2001) and that nursing was too academic (Phillips, 2000 and Dobson, 1999, as cited by Blenkinsop, 2003). This latter point suggests that 'academic' nurses cannot 'care' as well for their patients (Blenkinsop, 2003). A view that is disputed by many (Blenkinsop, 2003 and RCN, 2004a). Representatives of the RCN and the UKCC have defended such arguments and have supported Project 2000 as a positive move for the future of nursing (Meerabeau, 2001).

A recent and further major change to the profession occurred on the first of April 2002 when the NMC took over from the UKCC and the four National Boards. The NMC is the new professional body and all pre-registration nursing programmes must now meet the NMC requirements. The NMC in turn must also be increasingly aware of and meet appropriately, European Union requirements. Currently requirements include that pre-registration nurse education consists of a common foundation programme (CFP) and a branch programme. The branch options are child, adult, mental health and learning disability nursing (NMC, 2002). These three year programmes are now 4600 hours in length and equally divided between theory and practice (NMC, 2003). This remains a heavy workload for student nurses compared to other three year university programmes. However, the NMC do not specify whether this theory be at degree or diploma level.

## 1.4. The debate on a move to an all degree profession

Following the move into higher education interest in an all degree profession, although not a new debate, emerged more strongly as the next logical step. The RCN have been the key organisation in favour of this.

Adding fuel to this debate was the NHS and Community Care Act, which came into effect in 1990. This demanded that nurses took on more new tasks, which required greater management, leadership and research skills (Robinson et al, 1999).

The UKCC (now the NMC) on the other hand were in favour of increasing the number of graduate nurses only (UKCC, 1999) but not a move to an all graduate profession. The arguments put forward by the UKCC were very similar to those arguing for an out right move and focused on: clinical decision making, flexibility and role diversity, the academic closeness of the current diploma to graduate level, government targets for involvement in higher education, increasing demand for graduate places, an increasing competitive labour market and to meet the career ambitions of young people (UKCC, 1999).

Despite no agreement that moving to an all graduate profession is the best way forward for nurse education, the number of universities providing degree level education is increasing. In 1990 there were only 14 universities in the UK providing four year degree level (usually honours) nurse education programmes (Robinson, 1991, as cited by Meerabeau, 2001). In 1994 three year undergraduate ordinary nurse degree programmes were introduced (Robinson et al, 2003). These are predominately provided by the new universities. However, even in 1999, the English National Board (ENB) (cited in Burke and Harris, 2000) reported that only 10% of an occupational group of half a million had a degree. This figure will increase substantially in Scotland in particular, as a result of the changes in the provision of pre-registration nurse education.

The debate has generated much emotion and strongly held views on both sides of the argument, much of which is based on anecdotal evidence. The following is a summary of the main arguments for and against using empirical evidence where available.

## 1.5. Arguments for an all degree profession

The RCN (2004c) put forward the following arguments in favour of an all degree profession: to meet increasingly complex health needs requires motivated and highly skilled individuals, to meet the government target of 50% of young people going to university, to be able to adapt to the ever increasing technology within health care, to achieve academic parity with other health professionals and to provide higher quality care. This latter reason referred to evidence from Swindells and Willmott's (2003) study and is discussed in chapter two. However, is it appropriate to use 'meeting a government target' as an argument for moving to an all graduate profession? Are these not separate arguments?

Winson (1993, p.41) as part of a larger study interviewed heads of departments from four universities, four polytechnics and four colleges of nursing to compare degree and diploma courses. All the heads of departments hoped that the nurse studying for a diploma would go on to take a degree and that nursing would become an all graduate profession.

Likewise the Council of Heads and Deans (2002) has given its commitment towards moving towards an all graduate profession for several reasons including: the diminishing attraction of diploma courses, the potential for higher wages for graduates and because of the ever increasing evidence which suggests graduates offer greater value for money. This latter point is discussed further in chapter two.

Robinson et al (2003) recently carried out a major study comparing the careers and competencies of graduates and diplomates. This study summarised many of the arguments for an all degree profession in the literature review. These related to

recruitment, status and competencies. These included that recruitment is easier into degree programmes (UKCC, 1999 as cited by Robinson et al, 2003) and that diploma level programmes attract less able students unable to attain at degree level (Fletcher, 1997, as cited by Robinson et al, 2003). The above has implications for status (Robinson et al, 2003). Degree level status would achieve parity with other professions (RCN, 1995 as cited by Robinson et al, 2003). Finally, they concluded that nurses require education beyond diploma level to function in today's health system (Clarke and Warr, 1995, and RCN, 1995, as cited by Robinson et al, 2003).

However, their own study found no difference between graduates and non-graduates in clinical competence, during the first three years after qualification, though the graduates had greater career aspirations (Robinson et al, 2003). These findings are discussed further in chapter two.

Anecdotal evidence also suggests that many qualified nurses go on to 'top-up' their diploma to a degree using their own resources (Anon., 2003a and Scott H., 2003a) Actual figures do not seem to be available. However, they are reported to be very popular. These top-up degrees are often done in a specialist topic relevant to the practitioners' work or interest.

Scott H. (2003a), who is Editor in Chief of the British Journal of Nursing, gave a well balanced personal account of the arguments for and against. The arguments for included: that the profession would be better educated, which will improve patient care, that it will increase the status of nursing, increase career opportunities and will bring the educational level of nurses to the same as other professionals nurses work with on a daily basis. Scott's H. (2003a) arguments against are discussed below.

### 1.6. Arguments against an all degree profession

Again Robinson et al (2003) summarised many of the arguments against an all graduate profession in their literature review. These were similar themes to the arguments for and included: recruitment, career pathways, retention and

competencies. It was feared that nursing would not recruit from such a wide social background (Payne, 1994, as cited by Robinson et al, 2003). Studying for a degree may deter potential applicants (Newton, 1998, as cited by Robinson et al, 2003). It was feared graduate nurses will work at a higher level and a hierarchical system will develop. This may have implications for retention of graduate nurses as they will have more transferable skills (Akid, 2001, as cited by Robinson et al, 2003). Finally, they cite evidence that graduates will lack clinical skills (Watson and Thompson, 2000, as cited by Robinson et al, 2003).

Scott H. (2003a) reported that at the RCN Congress in 2003, delegates (that is, registered nurses) debated and rejected the proposal that nursing should become an all-graduate profession, despite the College itself supporting such a move.

Scott H. (2003a) proposed that the main argument against an all graduate profession focused on the shortfall of nurses. It was feared that having an all-graduate profession will narrow rather than widen the entry gate into nursing because many potential students will not have sufficient academic abilities to study at degree level. This is perhaps a problem of nurses own making because the entrance requirements have been lowered into nursing and the academic qualification at the end of the course increased. However, Scott H. (2003a) also noted that students with minimum entrance qualifications can still make excellent nurses and develop their skills over time. However, Nelson (2002) argued that nurse shortages should not be used as an excuse for delaying raising academic standards. This was because nurse shortages are not a new problem and history has suggested that raising educational standards increases nursing as a career option.

It was also reported that some student nurses at the annual congress believed that an all graduate profession would narrow rather than widen the entry gate into nursing (Anon., 2003a).

Hence Scott H. (2003a) fears that nursing is in a catch-22 situation. Increase its status by becoming an all-graduate profession or continue to recruit students with varying

academic abilities. This she argues has to be seen in the *'general confusion among nursing in relation to what its role should be in modern health care, and consequently what preparation is required for that role.'* (p. 2).

Scott G. (2003) believes there is a recent resurfacing of fears that nursing is currently too academic and as a result basic nursing care is lacking in today's hospitals. Again, recent anecdotal evidence in the media appears to support this.

Burke and Harris's (2000) research on nurse employers found that only 3 out of 34 echoed the desire for an all graduate profession. Their findings identified the importance of degree education for nurses to develop the attributes of '*leadership, assertiveness and reflective, critical skills*' (p.626). However, they did not think it necessary for all, or even most, nurses to be equipped with these skills because it was believed that many nursing activities did not require these skills. Some of the statements made by the nurse employers, of whom only four were nurses, demonstrated limited understanding of the role of the nurse, for example, *'Nursing is the same as it always was, wiping bums and a bit of TLC'* (p.625). Hence, the validity of these statements was questionable.

Clarkes (2004) has suggested that nurse education does not belong in universities at all. His opinionated article provided arguments against this move. He believes pre-registration student nurses, (on the adult branch in particular), are 'uncomfortable' with learning in universities. He suggested there are a number of reasons for this including that student nurses are treated differently from all other students in that they receive bursaries whilst other students do not. In addition, they have supernumerary status and yet work a 40 hour week whilst on placement. Finally, because the programmes are so heavily governed by statutory requirements, they do not fit into the university system. Both education and professional bodies monitor nursing courses. Their roles are described as interlinked (Le Var, 1997a), raising the question who is in control of nurse education, the NMC who set the professional standards or HE who set the academic standards? Clarkes (2004) even proposes a withdrawal from universities and a return to training schools.

A further difference between pre-registration nurse education and other disciplines is that many institutions have two nurse intakes per year. Hence, neither the students nor nurse lecturers' diaries fit into the academic calendar.

## 1.7. Commitment towards an all degree profession in Scotland, England, Northern Ireland and Wales

In Scotland, England, Northern Ireland and Wales a variety of provision of nurse education exists. These differences exist because of political devolution (UKCC, 1999) and demonstrate a differing commitment towards an all degree profession throughout the U.K. The provision in each country is discussed in turn.

In Northern Ireland a four year pre-registration (ordinary or honours) degree programme was commenced in 2002 as the only point of entry to the nursing register (National Implementation Committee, 2001). This is based on the academic calendar and hence more fully integrates student nurses into the university system. This four year programme was considered 'essential' to ensure the newly qualified nurses had the clinical competencies required to meet increasingly more complex health care needs in the future (An Bord Altanais, 2004). It has meant that in Ireland for one year only there will be no nurses graduating. However, towards the end of year three the students are no longer supernumerary but commence a continuous twelve month placement as paid employees. Hence this system should not worsen any nurse shortages. This placement is followed by a 'final' exam.

In Wales it was reported that all pre-registration nurse programmes of education would be at degree level from 2004 (Taylor, 2002).

In Scotland there has been a recent move towards providing more three year degree courses within the new universities. The first university to do so was the study site. This site first offered transfer from a diploma to a degree programme in 2003. Some additional resources have been provided to universities for this extra workload. The transfer may be offered to all students or only those who meet criteria. Each

university can set its own criteria. Hence, students are recruited into a diploma programme and then offered the ability to transfer to a degree programme. This has meant that the minimum entrance requirements required for a degree, seven points, instead of five for a diploma, are not necessary. A target of 80% of student nurses graduating with a degree, at the point of registration, has been set for 2005 (NHS Scotland, 2001, p.46). In effect universities will be offering degree programmes with a minority exiting with a diploma.

This system therefore has maintained a broad range of entrance qualifications whilst increasing the academic standard at the end of the course. This was essential to ensure that potential student nurses who may not have met the entrance requirements for a degree were not prevented from entering nurse education. However, if all students transfer to the degree option, the course will become a degree programme and may require the entrance qualifications to be raised. This may jeopardise entrance into this particular provision of pre-registration nurse education and the programme be a victim of its own success. Therefore, there are benefits to not all students accepting transfer.

The traditional universities in Scotland continue to provide four year degrees. Winson (1993) noted that was it more economical to prepare a graduate on a four year course than to prepare a three year registered nurse on a three year diploma course who then undertook a degree. Today it will be even more economical to prepare a graduate on a three year degree course.

England has not made any commitment to move towards an all graduate profession (RCN Congress, 2003). The majority of nurses therefore will continue to exit with a diploma for the foreseeable future.

The RCN (2002a) have been pursuing the expansion of an all graduate preparation in all four countries of the UK. More recently the RCN (2004d, p.2) have taken this a step further and are seeking 'formal commitment' for an all graduate profession at the point of registration. This they see as a necessary foundation for the nursing

practice of the future in all four countries (RCN, 2004b, p.11). They believe this can be achieved so long as students are given appropriate support (p.6). However, the level of support required is as yet unclear. Hence, lecturers current workload may increase, and potentially students' learning experience be compromised until appropriate support is in place.

### 1.8. Commitment towards an all graduate profession abroad

The above demonstrates that a diversity of nurse education currently exists within the U.K., with a definite trend towards an all degree profession. Taking a wider international perspective a similar trend was also noted. It was felt that to include a brief summary of what was happening abroad was relevant to provision of nurse education in the U.K. for two main reasons. Firstly, because of nurse shortages in this country, many nurses are recruited from abroad (Buchan, 2002 and RCN, 2003a). A change in the minimum educational requirement within the U.K. therefore has implications for international recruitment. Secondly, increasingly more European Directives are having implications for all countries within the European Union (E.U.).

One particular E.U. Directive, which may impact on all nurse education, is the Bologna Declaration (1999). Many EU countries have signed up to this. The declaration relates to recognising two main systems of education: undergraduate (degree) and postgraduate. The undergraduate programme must last a minimum of three years. This has implications for all EU countries wishing to meet its objectives, but also to countries that wish to continue to promote mobility of highly desirable professionals, such as qualified nurses.

Spain would appear to be using the Bologna Declaration to strengthen its argument for a move to an all degree nursing profession (Yarnoz, 2002). However, Spain faces a greater challenge than the U.K. In Spain the diploma is currently both the minimum and maximum academic qualification for registered nurses (Yarnoz, 2002, p.314). Despite pre-registration nurse education integrating into higher education in 1977,

long before the UK, it has remained as a three year diploma course ever since. However, nursing organisations within Spain are universally lobbying for a degree in nursing. Their arguments are based on

*'the legitimacy of the development for all academic disciplines, the need to carry on nursing research which increases our own body of knowledge, and the need to improve the management of nursing care, teaching and advanced nursing care.'* (Yarnoz, 2002, p.315).

The preferred option to implement the degree course is a 3 plus 2 years degree, that is, three year diploma plus an optional two extra academic years for the degree (Yarnoz, 2002, p.315). This five year programme is noted to be equivalent in length to a medical degree. This is much longer than the degree option for undergraduate student nurses in the U.K., but similar to the 'top-up' system for post registration nurses who tend to do a three year diploma followed by two years part-time degree study.

Thinking even further a field, there are parallels between the U.K. and Australia in that Australian nurse education began to move into the higher education system in 1985 and was completed by 1990 (Crookes, 1997). However, the difference is that in Australia almost all universities now offer three year degree undergraduate programmes (BBC News/Health/Nurses, 1999). These have been reported to be both popular and successful.

New Zealand would appear to have always been ahead of its time. It was the first country in the world to have a Professional Nurse Register, nurse education moved into polytechnics in 1973 and since 1999 all pre-registration nurse education has been at degree level (Lusk et al, 2001).

In the United States (US) degree level education has been available since the 1920s for a small number of nurses (Lusk et al, 2001). However, the American Nursing Association (ANA) recommended the baccalaureate degree as the minimum

educational requirement for all nurses almost 40 years ago (Spear, 2003). It was argued this was not an elitist idea and was also not an unreasonable expectation for any profession. The '1965 ANA position paper' in which this was stated has been reported by Nelson (2002) to be one of the most frequently cited articles in nursing history.

Further resolutions were put forward in the U.S. in 1978 and 1982 but both failed (Nelson, 2002). Similar to the U.K., Nelson (2002) has questioned why no agreement has as yet been reached. Therefore an all degree profession in the U.S. has never happened and there are still three ways to become registered as a nurse: baccalaureate degree, associate degree and diploma programmes. In the U.S. graduate nurses are expected to be different although they perform similar roles as diplomates and associates, whereas in the U.K. they are expected to do the same job although not necessarily be the same. Nelson (2002) also reported that the National Advisory Council on Nurse Education and Practice has recommended that by 2010, at least two-thirds of U.S. nurses hold a baccalaureate degree. In 2000 it was estimated that 29.3% held a degree, still well below target. In addition Smith and Crawford (2002, cited in Spear 2003, p. 244) reported that some employers prefer to hire experienced nurses with a degree to provide bedside care as well as for management positions. Interestingly, the armed forces have a baccalaureate degree only policy (Nelson, 2002). It was also reported that many hospitals have a degree preferred policy for newly hired nurses (American Association of Colleges of Nursing (AACN), 2000, as cited by Spear, 2003, p.244).

Only one state in the United States: North Dakota requires baccalaureate degree programmes to register (Nelson, 2002). On the other hand, Canada now requires all registered nurses to have a degree (Spear, 2003, p. 243).

### 1.9. The future of nurse education?

The Project 2000 Report was published in 1986, almost twenty years ago. Many advances in health care delivery have occurred since. This final section considers

whether it is time to move beyond the diploma exit award for the majority of student nurses, as set out in Project 2000, towards a degree exit award for the majority, if not all nurses in the U.K, as recommended by the RCN (2004b). In addition, this section considers what the future role of the nurse is likely to entail and therefore what appropriate preparation will be required. A series of RCN (2004a,b, e and f) discussion papers provide much of the 'vision' for the future nurse and the future of nursing for the next 10-15 years. These are referred to where appropriate. However, the RCN (2004a, p.7) also recognises the limitations of defining the future of nursing until agreement is reached on the definitions of generalist, specialist and advanced roles of nursing. These have been debated for some time and aim to make more effective use of nursing skills (RCN Labour Market Review, 2002, p.5). These will also improve the career structure for nurses.

As mentioned previously, the preparation and the appropriateness of preparation for the role of the nurse and the delivery of health care are interlinked. Hence, the future of nursing and the future of nurse education must develop in partnership (MacLeod Clark, 1998).

Pre-registration nurse programmes are primarily about preparing a student who is fit to register (UKCC, 1999). In the preparation of students the NMC has clearly acknowledged that students must be able to perform particular 'skills'. However, the NMC has not specified the theory required in relation to those skills nor whether that theory should be at diploma or degree level. Nevertheless, skills and theory are not mutually exclusive (Cutcliffe, 2003).

Taking into account what the future role of the nurse is going to be also requires considering an individuals fitness for purpose and the scope of professional practice (UKCC, 1999). These are recognised as functions of pre-registration education in the broadest sense, but functions, which must be taken into consideration.

The RCN (2003b) recently published an updated definition of nursing in which it was acknowledged that what nursing is and the scope are difficult to define. This was

because governments, employers and changes in the practice of other health professionals influence the scope of nursing. Likewise the UKCC (1999) also previously emphasised that the definition of nursing and the scope cannot be fixed because of the constant changes in health provision. These cannot be too restrictive if the profession is keen to expand its role. However, others caution that the scope of nursing must expand only for the right reasons. Some would suggest this is not always the case, as will be discussed shortly.

The UKCC Education Commission commissioned a report: Healthcare Futures 2010 to look at the trends that were likely to impact on the health agenda and so on the future role of nursing (Warner et al, 1998, as cited by UKCC, 2001). This report recognised the need for redefinition of professional roles to meet patients' new and challenging health care needs in the future.

There perhaps has been no greater redefining of professional roles than the recent introduction, in 2000, of Nurse Consultants (Guest et al, 2001). Nurse Consultants are defined as clinical nurse specialists, who provide expert advice, undertake research, educate other staff and provide clinical excellence (RCN, no date). This is indeed a new professional status for nursing. The NHS Wales (2004) has specified that the minimum qualification for a Nurse Consultant post is a Masters or equivalent.

Cliffords (2000) prediction of the future of nursing also includes the introduction of nurse surgeons and nurse anaesthetists in this country (in the U.S specialist trained nurses have administered anaesthetics for many years). Indeed, in 2004 it was reported that the first nurse in the world was trained in a U.K. hospital to perform epidurals (Heap, 2004).

It would seem the future of nursing holds many opportunities for the high achievers but what about the 'rank and file'? Here it would seem there are also many opportunities for those willing to take on new and expanded roles e.g. nurse-led services, such as, endoscopy clinics or nurse prescribing. Some of these extended

roles are due to the transfer of what are deemed to be 'inappropriate duties' for junior doctors to nurses and also include taking blood or administering intra venous drugs. This has happened partly because of a requirement within the EC Working Directive for the UK and Ireland to reduce junior doctors working hours from 70 hours and more a week to 48 hours per week, by 2009 (Anon, 2003). Furthermore, this directive also means that nurses in the future will be working more on their own without the back-up of 'medics' (Kapborg, 1998). This added responsibility and autonomy will require highly competent and well qualified nurses. However, Clifford (2000) emphasised that caution is required. The ever expanding role of the nurse must have relevant boundaries based on patient needs and not on what might be seen as cost cutting measures.

Nevertheless, a similar pattern is happening regarding the transfer of what are now considered 'inappropriate duties' for registered nurses, although some might debate this, to untrained staff including, washing and dressing, feeding and toileting. Some Health Care Assistants (HCAs) also now record vital observations. However, duties for HCAs can include venepunctures, ECGs, venous cannulation, resuscitation, heparisation before dialysis and catheterisation (O'Dowd, 2004, p.22). These clinical skills were previously the domain of registered nurses or other qualified health professionals. The health care assistant role is therefore very varied and dependent on the area of employment (NHS Careers, no date). It is expanding so rapidly that calls for legislation are strongly voiced (O'Dowd, 2004; RCN, 2002b and Council of Deans and Heads, 2002).

In the economic review, Securing our Future Health, otherwise known as the Wanless Report, it has also been suggested that work currently carried out by GPs now needs to be re-assessed so that nurses, pharmacists and other professionals can take on more of their work (Wanless, 2002, p.109). It was estimated that by 2020, nurses will be carrying out 20% of the work currently performed by GPs and junior doctors (p.91). This will be done by expanding the number of nurse-led services. This requires education and training and will be costly (Buchan and Calman, 2004, p.19). In turn HCAs will undertake 12.5% of current registered nurses work (p.91).

In conclusion, substantial changes in the roles of health care workers are predicted over the next twenty years with corresponding increases in the numbers of appropriate staff.

In addition, Buchan and Calman (2004, p.19) warn that as more nurses take on more 'advanced' roles, the current shortage of 'generalist' nurses may be worsened and more tasks will be 'offloaded' to unqualified staff. Hence, this will simply move problems down the line. With the continual blurring of role boundaries the RCN (2004e) cautions that nursing services must remain holistic and not 'segmented into tasks' for which nurses lose responsibility.

Hence, the future of nursing seems to be concerned with widening scope, but this is being built on a system of education encouraging wider entrance gates into nursing and more flexible modes of delivery of nurse education (NHS Scotland, 2001, p.45). With this in mind, the future of nurse education faces the challenge of preparing nurses who are fit to register, fit for practice (Crotty, 1993 and Macleod Clark, 1998) and able to adapt to the ever widening scope of nursing practice in the future.

It has been recognised that calculating the number of nurses needed and the correct mix of experience and competencies are difficult to achieve, despite the existence of workload and workforce planning tools (NHS Scotland, 2004). This would appear to be further compounded by the fluctuation of numbers of nurses leaving nursing. The number has on one recent occasion outnumbered the number joining the register. Please see Table 1, taken from the NMC: Statistical analysis of the register (2004, p.3).

| ***Number of nurses*** | ***2000*** | ***2001*** | ***2002*** | ***2003*** | ***2004*** | ***Totals*** |
|---|---|---|---|---|---|---|
| **Number of newly registered nurses** | 21,418 | 25,123 | 30,693 | 31,775 | 34,617 | **143,626** |
| **Number of nurses leaving the register** | 21,118 | 27,602 | 18,719 | 30,219 | 19,717 | **117,375** |

**Table 1. Number of nurses joining and leaving the NMC register.**

However, overall just over twenty six thousand more new nurses have registered than left since 2000. Nevertheless, the majority of these nurses exited with a diploma. Hence, are these nurses able to take on the new advanced and specialist nursing roles of the future?

Deans, Congdon and Sellers (2003) carried out a study involving 543 academics from thirty English universities to identify their expectations for nurse education in the year 2008. The conclusions reached were that workforce requirements rather than educational needs would drive nursing curricula in the year 2008!

## 1.10. Summary

There is much to learn from the past, including that change seems to be inevitable, although sometimes it seems to happen slowly (Lorentzon, 2003). Some nurses have argued for a return to the 'good old days'. For example, Birchenall (2002) has suggested that the recent well publicised return of the 'Matron' to hospitals and indeed the use of this title, is a desire for the return of respect, power and influence on the wards by nurses. However, it is perhaps too easy to remember the past through rose coloured glasses.

Such 'ties' with the past suggest that many believe nursing is a practical occupation rather than a profession. Indeed, many students, registered nurses and nurse lecturers alike all continue to refer to nurse 'training'! Furthermore, many aspects of training still exist, most specifically, the full working week, except this is no longer paid employment.

This look into the past has also highlighted that nurse shortages are not a new problem (Wade and Hallett, 2003 and Kenny, 2004). Hence, arguments against an all degree profession based on worsening recruitment and hence nurse shortages are perhaps not valid. Perhaps the answers to these particular problems are best met by quite different solutions, for example, Wade and Hallet (2003) and the RCN (2004c) suggest salary and working conditions need to be improved to improve these

perennial problems. In addition, attracting more males into the profession may also improve nurse shortages, though this will in itself not be easy.

With regard to previous arguments against moving to an all degree profession these have included that not all nurses would be academically able. However, so many nurses who have gained either RGN or Project 2000 Diploma qualifications do go on to top-up to degrees. Hence, this argument would appear to be unfounded. Many students have successfully transferred from the diploma to the degree programme. However, as yet little is known about which types of students successfully graduate with a degree by the transfer route. If the majority are successful, regardless of entrance qualifications then this again reduces the argument against an all degree profession because many nurses would not be academically able.

A further fundamental problem seems to be the struggle to ensure that nurse education produces nurses that have the clinical skills to function in an ever changing NHS. More recently this has been complicated by the governments push to increase the number of students at university and to widen the entry gates into nursing, (HMSO, 2003), to reduce attrition (Auditor General, 2001) and to increase the flexibility to become a nurse, whilst continually the RCN pushes to raise the exit award to a degree (RCN, 2004a,c). Finally, the future vision of nursing requires nurses to take on yet more skilled work. These are difficult tasks, which perhaps cannot all be addressed simultaneously.

Crotty (1993) provides an interesting insight into the influence of educational theory on the change of emphasis from nurse 'training' to 'education'. The difference between the two being that training focused on a well-defined course with a definite end point whereas education is a more divergent process of developing knowledge, skills and values which does not have a predetermined end point. Instead, education was described by Burnard and Chapman (1990, as cited by Crotty, 1993) as focusing on the development of critical ability and flexibility.

Pre-registration nurse education most definitely does have a pre-determined end

point. Nurses need to be fit to register. Nurses also need to be flexible and have critical analysis skills with emphasis on employability for now and the future. Hence, it would seem both are appropriate in pre-registration programmes for different reasons. Students have gained from the move to an education paradigm because for the first time student nurses who successfully complete the Project 2000 programme attain both a professional and an academic qualification. Nevertheless, it is clear the NMCs greatest emphasis is on the need for students to be competent in clinical skills rather than on the achievement of a particular academic qualification. Educational and training theories therefore appear to be somewhat at odds with each other and the right balance between the two may not yet have been reached.

Nurse education in the UK seems to have been more cautious in embracing an all graduate profession than other countries throughout the world. This is particularly so in England. Lusk et al (2001) has suggested that a continued elite university system may not yet wish to fully welcome nursing and so be delaying progress. Indeed, it seems nurses themselves are not yet ready to embrace an all degree profession.

However, as more and nurses obtain a degree, this may need to be recognised in the professional registration system. This would perhaps depend on if the two continue to do the same job or if the two types of nurse diverge in the future and have distinct roles. This is a point discussed further in Chapter two. Furthermore, if nursing continues to educate nurses at both degree and diploma level will this result in a two tier system, as happened with the introduction of Enrolled Nurses.

However, what has been clear is that nursing does indeed adapt itself quite readily, perhaps too readily, to meet developments in health care and thus society's needs. Nevertheless, might nursing be neglecting its own needs in terms of establishing nursing as a profession? Project 2000 was implemented in 1986 only because the government was finally convinced that diploma level education was required to meet future health needs. Is it possible that now degree level education will be required to meet the future needs of nurses in their expected roles of the future?

# SETTING THE DEBATE IN CONTEXT: A DEGREE OF HARMONY

# CHAPTER TWO: The same but different!

## 2.1. Introduction

Student nurses deciding which programme of pre-registration nurse education to study can choose between a three year diploma, a three year degree, introduced in 1994 (Robinson et al, 2003), predominately in the new universities, or a four year degree programme, predominately in the traditional universities i.e. pre 1992.

The actual exit awards also differ between universities and include: a Diploma of Higher Education (Nursing), Bachelor of Science (Nursing), Bachelor of Nursing or Bachelor of Nursing with Honours (usually four years) and Bachelor of Arts (Robinson et al 1999). Hence, not only is there diversity of entrance qualifications but diversity of the title of exit qualification also.

However, regardless of whether a student nurse exits a pre-registration course with a diploma or a degree the subsequent professional registration is the same.

This means there are wide variations in the costs and price per student for the same professional qualification (Auditor General, 2001) as a result of the different academic qualifications. Unless there are additional benefits, then this questions the 'value added'. Value added is widely used to account for the additional gains achieved by students who commence from different starting points (Lifelong Learning Research Group, 2002, p.12); however in this context the author is referring to the value added as a result of a higher academic award to do the same job.

The difference between a diploma and a degree is, in most cases, sixty academic points based on the Scottish system and would be an equivalent amount in other nations. This is not a huge difference. So why are there two academic qualifications for the same professional registration?

Logic would suggest that there must be differences for both to exist, but there must also be similarities for the two to prepare nurses to do the same job. These similarities are explicitly stated in the NMC (2002) publication: Requirements for pre-registration nursing programmes. This contains details of the competency based approach to nurse education as recommended by the UKCC (1999) Fitness for Practice document. The competencies required to practice as a nurse are the same regardless of the level of course taken. The minimum clinical hours to meet these competencies are also the same for either programme. Yet interestingly, Girot (2000a) questions whether the profession is in fact aspiring to two different levels of competence with two different academic awards rather than just one level of competence with two different academic awards.

If there is one level of competence and two theoretical levels then this suggests that theory and practice are separate entities (Girot, 2000a). However, the acquisition of both academic and clinical skills are of equal importance in pre-registration programmes, each having equal time spent on both. The integration of theory and practice are also essential in nursing. Nevertheless, the simultaneous assessment of both theory and practice are impossible in the academic setting, other than in a skills laboratory. This involves the teaching, practice and assessment of skills and knowledge within a simulated environment, and is used by many schools of nursing. Clinical assessments do assess both knowledge and clinical skills. However, the assessment of knowledge is not formal. Furthermore, clinical practice has only recently been accredited with academic points. For example, in the study site this began in 2003, although other institutions have being accrediting clinical practice longer. This again suggests theoretical knowledge carries greater importance in HE than clinical competence.

Indeed, research for the English National Board for Nursing, Midwifery and Health Visiting carried out by Gerrish et al (1997) found that some universities were not supportive of academic points for clinical practice unless written coursework was included. They found university regulations exerted considerable constraints over clinical practice assessments. Hence, this is why variation exists between institutions.

Furthermore, it tends to be, if not always, the theoretical component that is altered in a degree programme to make up the extra academic points, not the clinical component. This is because it has been suggested that it is the level of critical thinking that distinguishes nurse graduates from diplomates (Jinks, 1994, as cited by Swindells and Willmott, 2003).

Indeed the Scottish education system, the Quality Assurance Agency for Higher Education (2001) states explicitly the outcomes for all Scottish diplomas and degrees. These subject benchmarks, as they are also referred to, are broadly similar, regardless of the exit award; however, as above, the outcomes for the degree are achieved following a more critical understanding of the chosen subject area.

Nevertheless, research by Girot (2000b) found no significant difference in the critical thinking skills between graduates and non-graduates. However, nurses exposed to the academic process (which included undergraduate and graduate nurses) were found to be better decision-makers in practice than those who were not (non-graduate registered nurses).

Therefore, it cannot be assumed that simply because a degree is a higher academic award that it adds value to a nurses 'clinical' care. This is perhaps particularly relevant in a profession that values practical skills so highly. Nevertheless, more 'critical' practitioners may make nurses better 'clinical' decision makers and hence raise standards of patient care (Flatt, Holyoake and Singleton, 2002).

Much of the research reviewed for this study reported on the differences between nurses educated to diploma or degree level. These included differences in demographics, career prospects and aspects of clinical practice. Hence, it would seem clinical differences are expected, though existing evidence suggests these differences are minimal, if they exist at all. However, if the competencies aimed for in either programme are the same, then why should there be differences in clinical skills? On the other hand, the additional theoretical content in degree programmes

must make a difference. Otherwise why are nurses studying to a higher level? The question is, to what, or to whom is it making a difference?

This chapter has three main sections based on the above. The first examines the demographic differences between nurses studying at diploma and degree level. The second attempts to establish what difference a degree makes and to whom. The third considers the factors promoting or hindering degree level nurse education. However, many of the studies reviewed were based on pre-registration students entering quite distinct degree or diploma programmes or post registration students. No studies directly related to the aim of this study were found. This was because the ability to transfer from a diploma to a degree programme was a recent change in pre-registration nurse education. However, a number of themes within the literature contributed to the theoretical underpinning of this study. The first was in relation to previous statistical relationships found between age, entrance qualifications and academic achievements and hence would similar patterns be found in the study population in relation to those choosing to study at degree level? The second was the benefits students were likely to expect from obtaining a degree and the third the factors likely to promote or hinder degree level education at a university offering transfer from a diploma to a degree exit qualification.

Both the methods and the findings used in the above studies were critically evaluated in order to help design this study.

Finally, the data collection problems highlighted from these studies were considered and a SNEDS proposed as a possible solution.

## 2.2. Demographic differences between degree and diploma student nurses

A number of previous studies have examined whether different types of student nurses choose to enter diploma or degree programmes. This type of research was of interest to this study because similar types of students may also accept transfer from diploma to degree programmes. This was important to consider because of the

possible future impact on recruitment and selection of student nurses as a result of increasing the exit award. For example, it may be that because the entrance qualifications for a diploma are lower than for a degree that students will not choose to study at degree level because they will not have confidence in their academic ability.

One of the first studies to examine the demographic differences between student nurses entering three different types of courses was carried out 1989-1991 (Soothill, Bradby and Williams, 1994). The courses were the conventional Registered General Nurse (RGN) (Pre Project 2000), and the Project 2000 diploma and degree courses. A questionnaire was used to collect the data from 444 students. Fifty three per cent were mature students, defined as 21 or above. Twenty per cent were married. Approximately one half (exact figure not given) wanted to study near to their home.

Unfortunately this study offered little insight into the differences between the three subgroups, based on type of course entered into, because very little data were analysed using these subgroups. Nevertheless, interesting conclusions were reached, although there was little supporting evidence provided. These emphasised that there were more similarities than differences between the respondents in each cohort. The reason given for this was that students did not differentiate between the courses as much as expected. The researchers felt domestic responsibilities and access to home, amongst others, were more important than the nature of the course. Nevertheless, the researchers acknowledged that other factors might have influenced their decision, which were not included in the study including: lack of educational qualifications (real and imagined), motivation and personality factors.

A second more recent study carried out by Winson (1995) not only included demographic variables but also explored the motivation of students undertaking either a diploma or a degree pre-registration course and reason(s) for choosing nursing as a career. All the students were within the first six weeks of their training. Differences between the students studying for a degree or a diploma included: 80%

of those on the degree course compared to 54% on the diploma were under 21. Ninety per cent were single on the degree course compared to 69% on the diploma.

The students entering the degree course had higher entrance qualifications than the students entering the diploma course. The latter were provided in colleges or 'new' universities. It was reported that half of the students on the diploma course had the entry qualifications for a degree course but still choose the diploma. Reasons given by students included: wanting to be close to home,* the majority of the students giving this reason were married,* and others preferred a 'practical training'. The latter was reported as a misconception because both degree and diploma courses must meet the minimum requirement of time spent in clinical placements. However, variation in clinical hours exists (Winson 1993) and some institutions will be above the minimum requirement. The students studying for a degree were more likely to have high career aspirations: defined as becoming a clinical nurse specialist or going into teaching, management or research.

## 2.3. Predictors of success in ether programme.

Studies have also been carried out in an attempt to predict which students were more likely to succeed in their respective course. This type of study was of interest because in some institutions, as was the case originally in the study site, transfer to the degree programme was based on previous academic performance on the diploma programme.

Previous research suggested demographic variables, in particular, age, entrance qualifications and previous academic achievement, during nurse programmes can all be predictors of future academic performance. Indeed, it has been suggested that the best predictor of future success was past success (Grant, 1986, as cited by Lewis and Lewis, 2000, p.234). In relation to the wider student population, the National Audit Office (2002, p.11) also reported that *'the most important factor affecting* (English) *institutions' achievement rates is students' entry qualifications.'* However, the evidence located in the literature for student nurses was not consistent.

Houltram (1996) examined the relationship between age, entry mode and academic performance on the Project 2000 Common Foundation Programme (CFP) for students on diploma programmes only. The study data were collected from the front pages of the application forms and lists of published results. It was reported that much of the analysis was done manually. To collect the data from these two sources to carry out this study appeared time consuming and labour intensive.

The literature review carried out by Houltram (1996) found only American nursing and more general educational articles. The higher education research reported relationships between age, entry qualifications and academic performance with regard to mature students. However, the findings were not unequivocal and were based on students in general not just nursing students. It reported that the majority of nursing literature relating to prediction of student nurses' academic performance was American. Sophisticated predictor variables were used in some of these studies, including the final Grade Point Average (GPA).

Houltram (1996) reported on three studies, which did not find age to be a significant predictor of successful academic outcome. He also reported on one study that did link age and successful academic outcome on a baccalaureate nursing degree programme. In addition, he cites two studies that found previous academic achievement to have the most significant relationship with level of achievement and completion of the programme.

Houltram's (1996) own study was quasi-experimental in design. The hypothesis was *'there is a relationship between entry age, entry qualifications and academic performance on the Common Foundation Programme (CFP) of the diploma in Higher Education/Registration course for nurses'* (p.1091). The sample was two whole cohorts undertaking the CFP for the diploma in Higher Education/Registration within a college of nursing (n= 258). Students were defined as mature if aged 22 and over. Hence, conventionally aged students were defined as aged 17-21. Further classifications were made between those possessing formal educational entry qualifications (five GCSEs + or the equivalent and those without the formal

educational entry qualifications e.g. DC (Dennis Child) entry test (for applicants who did not possess 5 points by other means).

Houltram's own findings indicated that mature students, whether formally qualified or not, did well. Younger students without formal qualifications did worse of all. Houltram's findings supported his hypothesis. There was a significant relationship between age and successful academic performance and regardless of entry qualifications, age was still significantly related to academic performance. However, there was little evidence to suggest entry qualifications were related to academic performance. Again, Houltram's findings were reported to have implications for recruitment and selection, suggesting that these should be based on proven academic ability or on the age of the candidate if unqualified. Likewise, such findings may have bearing on those who are offered, accept or succeed on a degree transfer programme.

Kevern (1999) carried out a study to identify the demographic characteristics of students entering the pre-registration diploma course and the relationship between these characteristics and retention and academic achievement. It is the latter, which is of particular interest to the author's study. Kevern's (1999) study was classed as an audit because it used only routinely collected data retrieved from electronic records. This consisted of demographic and entry qualifications. The sources of the academic achievement data were not specified.

It was reported to be one of the first British studies to consider both academic achievement and completion rates for pre-registration students. Three hundred and fifty five students from four study centres from one college of nursing were included in the study. The mean age was 27 standard deviation (s.d.) 8. Almost half were mature students, in this study this was defined as aged 26 or over and only 24% were aged 20 or under. It was perhaps a sign of the changing demographics of students that mature students were defined as an older age band in this study. The entrance qualifications of the students were diverse and included one third with the minimum

of five O levels, 23% had at least two A levels or a degree, 14% sat the DC Test and the remainder were not specified.

The associations between age, highest entry qualification and course completion were not statistically significant. The relationship between age and assessment scores during the CFP was significant, in that, younger nurses scored lower than their older peers. The more mature students also scored better in the branch programme although this is reported to not be statistically significant. Students with higher entrance qualifications attained significantly higher scores in the CFP and the branch programmes.

Hence, in this study age made a significant difference to assessment scores in the CFP only and entrance qualifications made a significant difference in both the CFP and branch programme. The question now is if these students did well in the CFP, which at that time was 18 months (now 12 months) and the branch, then are they likely to consistently do well, that is will similar students do well and be offered, accept and be successful in the degree transfer option. Likewise, the students who performed poorly are they likely to continue to perform poorly.

Similar findings were reported by Ofori (2000) in a study comparing age and type of entry qualifications and performance in biological, social and behavioural sciences in nursing assessments. The very mature, that is, aged greater than 34, performed significantly better than their younger counterparts. On the other hand, there was no significant difference in relation to type of entrance qualifications.

Wharrad, Chapple and Price (2003) carried out the first study to determine the relationship between academic outcomes and pre-entry qualifications and subsequent progression through a four year degree course only. More importantly this study also discussed the progression and academic outcomes of students with conventional and non-conventional qualifications. This was important because of the increasingly complex range of educational qualifications which allow entry into nursing degree courses. However, they acknowledged a lack of studies examining if any of these

qualifications were predictors of academic success and acknowledged that with the increasing number of mature students with non-conventional qualifications, nurse educators are having to select and recruit candidates with little supporting evidence.

Students in this study aged over 21 were considered as mature students. One hundred and eighty one students from six cohorts who commenced their training between 1990-1995 were included in the study. Only 16 were mature students. One hundred and forty seven successfully graduated with a degree, 146 with honours. These were young, well educated nursing students and not typical of some institutions now offering degree courses. The mean number of GCSEs within the six cohorts ranged from 8.7 to 9.2. The mean number of GCSE A grades from 2.7 to 4.9. Thirty four students did not complete the course. Forty five per cent, 15 out of 29 with non-conventional entry requirements withdrew or did not achieve the required academic standards for progression. The authors concluded that students with non-conventional qualifications achieved lower marks throughout the course. In addition, mature students on the degree course with non-conventional qualifications were more likely not to complete the course. However, six mature students with ACCESS qualifications successfully completed the degree course. The effects of age only were not included in the analysis.

The findings would seem to partly contradict the work of Kevern and Houltram. However, the students were a different demographic mix.

Again it is of interest to note the data collection methods. Entrance qualifications and academic achievements during the programme were entered onto an EXCEL spreadsheet during the study. This again raises issues of manpower and additional resources to do this.

## 2.4. What difference does a degree make?

Having considered what the differences are for students entering the course, the next question is what, if any, difference a degree makes at the end of the course?

However, if the students entering into degree courses are different to begin with i.e. younger and more highly qualified, and the courses are different then how much of the difference relates to the programme or the demographics?

In the study site the students remain in the same course for the majority of its duration. Indeed, the course remains the same until the point of transfer. Therefore, any difference between (choice of) exit award and demographics is more valid. In addition, the value added, this time in its usual sense, may be greater because the students entering into a diploma course may have lower entrance qualifications, but can exit with a degree. However, can it be assumed that a degree from one institution is equivalent to another, or a graduate from a traditional university is similar to a graduate from a new university? When graduates were fewer in number they were an elite group, whereas as the numbers increase, they will become more the norm (Robinson et al, 2003, p.144). Hence, will any differences that previously existed remain the same?

Birchumshaw (1989) carried out a review of the literature on how graduates and non-graduates were compared. Birchumshaw's (1989) review was somewhat dated as the number of universities providing degree level nurse education has increased substantially since this was carried out. The four types of evaluation considered were studies comparing two or more types of nurse education, comparing competencies, comparing performance, defined as 'competence on the job' and comparing attitudes and approaches to nursing care.

In this review Birchumshaw (1989) acknowledged that each of these types of evaluation were complex and a number of methodological weaknesses were highlighted. For example, in relation to comparing nurse education programmes, both the process and outcome were evaluated; however both were found to have problems, which were similar in nature. These related to the constant 'tweaking' of courses from one cohort to the next making process and outcome evaluation difficult. Comparing the 'end-products' of nurse education was also difficult because nurse education programmes are different in content and length from one university to the

next. Yet, a number of studies have compared nurses based on the education system they attended.

The Higher Education Quality Council (HEQC) (1997, as cited by ENB, 1999) and Robinson et al (1999) also reported on a lack of comparable standards between undergraduate nurse programmes.

In relation to the other three forms of evaluation, Birchumshaw (1989) questioned the ability to define competence, performance and quality of care and to measure these. She also believed little account was taken of other variables that may alter these, for example the workplace, experience or subsequent training, rather than assuming it was the original nurse education. Birchumshaw (1989) also noted that patients' viewpoints were not considered though recognised the ethical dilemma this would place both staff and particularly patients in.

Hence these words of caution must be taken into account when trying to compare graduates and diplomates.

Robinson et al (2003) compared the careers and competencies of qualified nurses from three year diploma and degree courses. The nurses were assessed for competence using self and line manager assessments. Comparisons were made at qualification, after 6 months, 18 months and 3 years in relation to diversity, career plans, continuing professional development, satisfaction with working life and retention. However, the appropriateness of these comparisons was debatable because the sample sizes for the graduate cohorts (n ranged from 53-111) were very much smaller than the diplomate cohorts (n ranged from 900-1596). The reason given for the small graduate cohorts was reported to be a limited time scale. As a result of these small samples, much of the analysis was descriptive. The researchers acknowledged the limitations of the study and that they had interpreted the results with caution. Nevertheless, quite profound conclusions were reached.

Six of the seven research questions for this study related to nurse careers. The remaining one was on the competencies of a nurse. The priorities of the researchers were not how skilled a nurse was, but whether a nurse would remain in post. This is a very relevant concern but one which seemed to take precedence over patient care.

Robinson et al (2003, p.129) also acknowledged that the tool used to measure competency, the Nursing Competencies Questionnaire (NCQ), was at a 'development stage'. It is used to score nurses on eight constructs: assessment, planning, intervention, cognitive ability, ego strength, leadership, professional development and social participation.

The NCQ had been developed by Bartlett et al (2000). They had found statistical differences between graduates and diplomates in only one out of eight constructs (leadership) at graduation, three out of eight constructs (assessment, professional development and ego strength) at six months and six out of eight constructs at one year after graduation. Hence, as time went on the graduates appeared to become more competent than the diplomates. However, the limitations of measuring competence using a self-completed questionnaire were recognised in this study. This study also had small samples (n= 52 graduates and n=28 diplomates).

The results of Robinson et al's (2003) study demonstrated that the self and line-manager ratings of nursing competencies were usually unrelated. This suggested a lack of criterion validity. There were also few differences found in competencies between the diplomate and graduate nurses. The differences that were found were reported to be subjective and focused on the graduates greater career ambitions and lower satisfaction with their work. Nevertheless, fewer diplomates (27%) than graduates (37%) indicated **loyalty** to the NHS as the reason for preferring to work in the NHS.

The conclusion reached by the researchers was that the needs of graduates in the NHS could not yet be met and more career posts were required e.g. Nurse Consultant posts. Hence, increasing the number of graduates was not recommended (Robinson

et al, 2003, p.143). The researchers concluded that moving towards an all graduate entry was 'high-risk' due to the potential problem of retaining graduate nurses in the NHS. These conclusions appeared to not be justified based on the findings.

A further more recent study carried out by Swindells and Willmott (2003) to identify if there was a difference between the performance of graduate and diplomate nurses used a rating scale completed by assessors, structured interviews and self-reporting. However, only the rating scale was reported on because it was stated the study was based on a *'quantitative framework'... 'rather than the subjective views of the nurses themselves'* (Swindells and Willmott, 2003, p.1100). It was therefore unclear why the self-reporting data were collected. It was also not stated if the assessors knew if the person they were assessing was a graduate or diplomate which may have biased their opinion. However, presumably they must have known as they were assessing nurses within their own team. The assessors role, their qualifications nor inter rater reliability were discussed. There was also a confusing sentence in which it was unclear who was assessing who:

*'The assessors may have been assessed by other assessors if the assessor happened to be a graduate but they did not assess themselves.'* (Swindells and Willmott, 2003, p.1100).

The scale consisted of 42 items of which 21 were reported to have indicated highly significant differences between graduates and diplomates. Yet nine out of these 21 items had p values above 0.05. Hence, their conclusions that a graduate adds value to practice is perhaps less than that expected from the researchers findings as presented in this article. Furthermore, the researchers also concluded that the differences were only significant when years of experience and the level at which this experience was gained were included (Swindells and Willmott, 2003, p.1100). Nevertheless, the three areas in which graduates performed better than diplomates were summarised in relation to cognitive, reflective and practice domains.

## 2.5. Factors promoting or inhibiting degree level study

Again the literature review did not locate any directly applicable studies only a number of studies indirectly linked to the aim and objectives of the author's study. These related to constraints and effects for qualified nurses taking a degree who were undertaking this additional study whilst working. This is a similar situation to which students on the three year degree transfer option, in the study site find themselves in, because they are working a 40 hour week (2.5 hours are for reflection, therefore the total working week is 37.5 hours) on the wards whilst studying for four additional modules which their counterpart diploma students are not. In addition, many may also be working part time in paid jobs to meet family and personal commitments.

Motivational factors have been mentioned briefly above in Winson's (1993) research and will be discussed again in this section. A number of studies have used this concept to explore why registered nurses seek further education, this often being a top-up degree. Indeed, research by Bartlett (1999) found that graduates expressed a greater interest in pursuing higher degrees than diplomates. However, an individual requires a degree before they can pursue a higher degree, and this may influence their answer.

Murray (1938 as cited by Gross, 2001) has identified theories of motivation, in relation to the need for achievement. He described ambitious people as those *'concerned with standards of excellence, high levels of performance, recognition by others and the pursuit of long-term goals'* (Murray, 1938, as cited by Gross, 2001, p.129).

Is this not the type of person the NHS needs? Indeed, the findings of Robinson et al (2003) were that graduate nurses were more ambitious but it was feared the NHS could not fulfil these ambitions. However, is it wrong to prevent nurses from studying at degree level because it is feared they will be too motivated or ambitious? Perhaps the NHS should be doing more to meet the needs of such highly motivated and qualified nurses (Scott H., 2003b).

Dowswell et al (1998) used a qualitative approach to examine the motives of 29 nurses, midwives and allied professional staff for participation in post registration degree courses and the effects on their home and work life. The results of the study were not generalisable to students on full time courses but shed further insight into the factors motivating nurses to undertake degrees. Participation was associated with both professional and personal factors, which were further divided into, 'push' and 'pull' factors. The personal push categories related to the need to fill gaps in their previous qualifications and increase self-esteem. The personal pull related to personal continual development. The professional push categories were work pressures to study and to keep up with changes within nurse education. The professional pull category related to wanting promotion. The respondents described largely negatives changes in their home, family and financial situation as a result of studying on the course. The authors concluded that continuing to depend on the willingness of post registration students to pay for their further studies was neither efficient nor equitable as a means to ensure lifelong learning. Conclusions similar to those reached by Davey and Robinson (2002) as discussed below.

Davey and Robinson (2002) carried out a Department of Health (DOH)-funded longitudinal study into the careers of RGNs who qualified in 1990-91. These nurses therefore all trained prior to Project 2000 and did not register with a diploma. The points required to top-up to a degree were therefore greater than topping up from diploma level, as the RGN training was only recognised as being equivalent to 200 points. The effort required therefore was greater also. Six hundred and twenty nurses were included in the study. These nurses were sent regular questionnaires over an eight year period on a wide range of career issues involving choices and constraints in obtaining degrees. Forty six per cent did not plan to undertake a degree. The main reason for this was combining paid work with studying. Women with childcare responsibilities reported this, in particular. For respondents with no children at home and men the most frequently cited reason for not choosing to study for a degree was because it would not lead to a salary increase and that a degree would not enhance their clinical skills. Within the eight year time span 22% of respondents had obtained a degree or were in the process of obtaining one. A further 20% planned or hoped to

take a degree in the future. For those who had or were taking a degree the main effects were increased self-confidence, enhancement of clinical skills and better career prospects. Indeed, 80% said it had increased their self-confidence. Sixty five per cent thought it had enabled them to consider a wider range of job opportunities within nursing/health care. However, 35% thought that it had enabled them to consider job opportunities outside nursing/healthcare, with 8% having gone on to find such jobs. Thirty one per cent of respondents thought that having a degree had 'created' tensions with their peers who did not have a degree. Men were more likely than women to be 'degree-minded'. The authors point out that this had to be treated with caution, as only 6% of the 620 were men.

The above studies are of interest to the current proposed study for several reasons. Firstly, they provide data on why some nurses choose not to study for a degree. Secondly, they explore the constraints qualified nurses face in obtaining degrees after qualification, hence they provide more arguments as to why students may prefer to choose to study for a degree as an undergraduate. Thirdly, it may be that those who accept transfer to the degree, do so because they are more ambitious. Finally, some of the constraints faced post qualification may be relevant pre-registration also.

A further study by Ehrenfeld et al (1993) involved a mailed questionnaire survey in 1988 of 709 graduates from the Tel Aviv University, Israel to analyse the changes in worklife since completion of a post basic graduate programme and the factors promoting or impeding study in this programme. The response rate was rather poor at 47%, though satisfactory for a postal questionnaire. The students had graduated between 1982 and 1988. These were all graduate nurses, who had achieved this by returning to a post basic graduate programme. This would appear to be equivalent to our top-up system. The programme was part time and could take two to nine years to complete. However, what the basic qualification was to begin with was not stated. The paper is slightly difficult to follow and may be because of differences in use of language. However, the findings are of interest.

The mean age of respondents was 32 years (range 21-54). A high percentage were working (93%) compared to a previous study in which 78% of non-graduate nurses were working (Bergman et al, 1975, as cited by Ehrenfeld et al, 1993). Many of these nurses were reported to be in senior positions and change of job level was reported to be due to the degree studies. However, 72% of respondents remained in the same area of practice. Five major motivational factors to study at degree level were: professional advancement, to increase knowledge, to obtain a degree, personal growth and improvement of practice (Ehrenfeld et al, 1993, p.84). Respondents did report difficulties in relation to family, study and combining the two, but were highly satisfied with the course. Respondents reported many positive factors as a result of the degree study: many found more positive attitudes towards them at work, many were stimulated into further study, gained self confidence, had initiated changes at work and expanded knowledge. Though a little dated, this research emphasised both the extrinsic (e.g. career goals) and intrinsic factors (e.g. personal and professional growth) motivating nurses to study at degree level (Ehrenfeld et al, 1993).

A similar more recent exploratory longitudinal survey was carried out in Australia involving four cohorts of post registration nurses studying for a degree in a Sydney University between 1990 and 1993 (Pelletier, 1998). A total of 666 nurses were invited to take part, 480 did, giving a response rate of 72%. The study aimed to determine factors which motivated registered nurses to return to study for a degree and those, which hindered it. Information on the nurses' career plans was also sought. The most important reasons for returning to graduate study in descending order were: personal or job satisfaction, increased professional status and improved job opportunities. Family and work commitments were reported as possible problems to hinder graduate study. Pelletier (1998) concluded that graduate students expected to gain increased personal and job satisfaction and that a degree would provide advantages in a competitive environment. On the other hand, he reported financial reward was not a motivating factor. He reported this was probably with good reason, as unlike other professions, higher qualifications are not financially rewarded. This is possibly about to change as a result of the new grading system being introduced into the NHS for nurses: Agenda for Change (RCN, 2005). Pelletier (1998) also

suggested satisfaction was achieved simply from the empowering environment of graduate education.

Personal satisfaction was also the most common reason given by American Nurses returning to top-up to a baccalaureate degree (Leonard, 2003). The second was a desire to attend graduate school and the third the desire for career advancement. This was a small U.S. study involving only 36 post registration students. The average age was 39 years, the majority were female, married, parents and working full-time in nursing. The research is described as a survey though the methods are not given. The researcher refers to the article as sharing the respondents written responses. Yet the article refers to what nurses said, presumably meaning written! This is a poorly structured article.

### 2.6. Data collection problems

In several of the studies discussed previously a number of data collection difficulties were noted. The methods of data collection were often clumsy and time consuming. Large amounts of data are generated during undergraduate programmes. Student nurses in particular have not only academic assignment data but clinical assessment data also. More efficient administrative systems need to be developed (Stevens, 1999) which can more readily facilitate secondary data analysis of educational information. In addition, the data could be used to generate hypotheses for research, for examining trends and for audit (Graves, 1998b, as cited by Stevens, 1999). These systems could then be used to advance 'evidence-based teaching' by investigating the relationships between learner characteristics and academic success/outcomes. The above is discussed further in the methods section.

## 2.7. Summary

In essence, this chapter has considered the benefits of obtaining a degree and for whom: the patient, the nurse or the profession? There appears to be evidence to support benefits for all three parties, albeit the evidence is contradictory at times.

Previous researchers acknowledge that predicting academic success is an important issue for nurse education. Evidence reported on in this chapter has helped to shed light on the factors which may help predict student nurses' success at degree level.

Despite the difficulties in returning to obtain a degree, many registered nurses see the need to do this for personal, clinical and professional reasons. These reasons may also be relevant to student nurses. In addition a number of factors promoting or inhibiting this were discussed which may also be relevant to this study.

However, because some universities now have transfer between diploma and degree programmes, there is a huge overlap of education for the student nurses on these courses. Indeed, identical educational programmes may exist for the majority of these courses. This means more relevant comparisons between those who choose to exit with a diploma or degree are possible including the perceived benefits based on their choice. The latter are discussed in more detail in chapter 3.

# SETTING THE DEBATE IN CONTEXT: A DEGREE OF HARMONY

# CHAPTER THREE: A Degree of Choice!

## 3.1. Introduction

As stated previously, universities in Scotland, which until 2003 had only offered diploma courses, can now offer student nurses transfer from diploma to degree pre-registration programmes, if the appropriate resources are put in place. This offer may be open to all student nurses or restricted policies may exist. Each institution sets the criteria for transfer. In the study site, for example, when this research began, only students who met specific academic criteria, that is, a student had to obtain at least four B1 grades out of eight assignments/exams at the first attempt in year 2, were offered transfer from the diploma to the degree programme (University of Paisley, 2001, p.63). However, several months after this study commenced this changed and the academic criteria no longer had to be met. In effect all students were given the option to transfer so long as they successfully completed year two of the diploma programme and there were no clinical, professional or attendance issues. This was a decision unconnected to this research. However, regardless of whether all or only a select group of students were offered, not all accepted transfer.

One of the objectives of this study was to understand the factors promoting or impeding this transfer. This chapter tries to understand why some students accepted and others did not by looking much more closely at this issue from a student's perspective. By focusing on both the positive and negative aspects of this choice it was hoped a greater understanding of what contributed to a student's decision would be achieved.

In chapter two the factors promoting or inhibiting degree level education for qualified nurses were discussed. These were also considered as possible factors which may relate to students' reasons to transfer or not. These studies focused on age, entrance qualifications, academic achievements and personal, clinical and

professional reasons.

In this final chapter of the literature review the attitudes and possible promoting or inhibiting factors for student nurses are more specifically discussed. In addition, the links between attitudes and behaviour, or whether there are links between attitudes and behaviours are considered.

## 3.2. Students' choice

It would seem that because the debate on an all degree profession has not been resolved, one solution as discussed above, has been to allow students to choose whether they accept transfer onto a degree programme or not. These are students who may or may not have had the entrance qualifications for a degree programme. Hence, not everyone may agree with this policy, because students may accept who are not academically able and subsequently fail. However, there are several advantages to this system of choice. Firstly, students are still enrolled into a diploma programme, hence the entrance requirements do not need to be raised, but effectively the university is offering a degree programme, as the aim is that only a minority (20%) will exit with a diploma. The university regulations require a minimum of seven points to enrol for a degree programme and five for a diploma. Hence, secondly the wide entrance gates into nursing have been maintained and the academic award at the end of the course has been raised for those who wish and are able.

Furthermore, many of the student nurses would not have met the entrance qualifications to study for a degree by a more traditional route. This system therefore should not put off potential students applying for nursing who may believe they lack the academic ability to study at degree level or students who are keen to study at degree level. In addition, students are given the opportunity to study at degree level at no additional financial cost to themselves, unlike many post registration nurses who need to pay. Finally, students can decline to transfer to the degree route and still register as a nurse.

However, so long as this choice remains, the initial main priority for universities would seem to be to more fully understand which students accept. The second, which students succeed at degree level, or perhaps more importantly which do not. However, as the RCN aim to move to an all degree profession at the point of registration, the first issue would seem to be of greater immediate interest. In addition, the latter issue could be easily analysed by carrying out an audit. This could be carried out by checking student files; however it would be more efficiently carried out if the appropriate data were all stored on a computer database.

Hence, this chapter is concerned with student choice, that is, why some students accepted transfer and others did not. In addition, this chapter considers if students' attitudes towards obtaining a degree influenced their decision.

### 3.3. What are students' attitudes towards obtaining a degree?

The first two chapters of this study have suggested that attitudes towards degrees in nursing and moving towards an all degree profession vary widely. In addition, the evidence provided on the benefits of having a degree in terms of clinical practice is also contradictory. Despite this many registered nurses that the students work with and/or are mentored by have already or perhaps are in the process of 'topping up' to a degree. Hence, student nurses may be influenced during their training by the general debate on a move to an all degree profession, the perceived benefits of having a degree and by the attitudes of significant others e.g. mentors and lecturers.

Previous literature has suggested that there are three, though debatable, main differences and hence perhaps three main advantages to obtaining a degree: career, professional and clinical practice enhancement. Not all students have accepted transfer, so perhaps not all agree with the potential benefits. If, for example, it was believed that the greatest perceived benefit of obtaining a degree was career enhancement, then it may be argued that some student nurses entering the profession may not perceive a degree to be necessary because they have less desire to climb the career ladder. Some students may believe it is necessary for career enhancement, but

prefer to obtain a degree as continued professional development (CPD) and therefore not necessary at the point of registration. It may be that some students have fewer expectations that they will climb the career ladder, perhaps due to their mature age on entering the profession or because they have entered nursing with non-conventional qualifications.

A counter argument to that may be that the mature students may be even more determined to study for a degree in order to keep up or compete with their younger counterparts. Anecdotal evidence would also suggest that mature student nurses are often the most enthusiastic students and often act as inspiration to their younger counterparts.

However, for a very long time having a degree has not been 'the norm' to practice as a nurse. Therefore to some students, who have had a desire to be a nurse for a long time, but perhaps lacked conventional qualifications and have returned to study to gain non-conventional qualifications in order to enter nursing, may seem unnecessary.

On the other hand, many young people, just leaving school, now want a degree. A degree is a recognised commodity regardless of the subject. Many job advertisements simply refer to a 'graduate'.

A nursing 'degree' is therefore no different, and even though it exists to educate people for a specific purpose, the offer of a degree may be a 'passport' to jobs outside nursing. This has been suggested in the past, though evidence from the RCN (1995) and Birchumshaw (1989, as cited by Burke and Harris, 2000) denied this was a problem. However, this evidence is somewhat dated now. Indeed, more recently the Council of Deans and Heads (2002) acknowledged that competitive salaries and better career prospects are attracting nurses away from nursing. Robinson et al (2003) also feared that the NHS could not meet the needs of an all graduate profession and graduates would leave the NHS. In more general terms, the

expectation of career development as a graduate is great. However, as more and more graduates are produced due to mass education, career prospects may only diminish.

Nevertheless, nurses do not pay for their fees, and in Scotland are given a bursary, unlike other students. Hence, obtaining a 'nursing' degree has additional benefits for students as a route to better paid graduate jobs, as it will be a less expensive route. Furthermore, in nursing there is no distinction between diplomates and graduates pay. Hence, an unwanted consequence of increasing the number of nurses with degrees may be that more nurses leave nursing for higher paid graduate jobs elsewhere and so worsen the retention of registered nurses.

On the other hand, a degree may be more appealing to younger students and may even increase recruitment of younger students. However, previous research discussed in chapter two suggested that mature students did better in their studies, although this was not consistent.

A study by Timmins and Kaliszer (2002) involving 110 third year student nurses on a diploma course in Ireland to determine student 'stressors' found that the most stressful areas for these students were financial followed by academic-related concerns. The authors' findings supported previous research and highlighted the need to avoid academic 'overload'.

This is an important consideration because the additional academic degree level study may further enhance the levels of stress faced by third year students. The amount of time spent in clinical placements must still meet the minimum requirements. Much of the extra study is done during private study time, when the diploma students can instead consolidate existing knowledge. Fear of additional stress therefore may be a reason for students to decline transfer to the degree, or alternatively students may defer the extra stress until they have qualified and are earning money and so reduce the additional financial constraints they may face as undergraduates.

Many student nurses have worked as HCAs prior to commencing their 'training'. Hence, some may have a better insight into the career structure within nursing and believe that a degree is potentially more beneficial.

It may be that for some students the degree is now accepted as the 'gold standard', regardless of its impact or not on career development or clinical practice. Therefore, to simply receive this recognised professional and academic standard will be intrinsically satisfying and enough to motivate an individual's behaviour (White, 1959, as cited by Gross, 2001).

This is similar to the concept of empowerment described by Williamson and Grankowski (1996). They used cognitive theory to link attitude and motivation to intrinsic and extrinsic empowerment. Intrinsic empowerment was described as individually valuing and being interested in a particular activity, whereas extrinsic was concerned with pleasing others or to obtain a reward. Linked to the concepts of both intrinsic and extrinsic empowerment is the motive for achievement.

To some extent all students are externally motivated (Myers, 1995, p.421-422), as all to a greater or lesser extent wish to achieve the reward provided at the end of a course! However, is it the more ambitious who want to achieve the higher academic award of a degree?

Our society, whether it is in relation to nursing or any other career, now expects high standards. It may also be that young people today simply expect to achieve 'degree' level education.

On the other hand, it is also possible that simply because it is being offered that students accept, regardless of their attitudes. The simple conclusion being to do 'their degree' before registration when there are no financial costs. This is not an unreasonable decision knowing that many registered nurses are returning to 'top-up' to a degree and do this often at their own expense. It therefore may seem to be the

norm to students to be expected to achieve a degree at some point in their career and preferably pre-registration.

Students are also very up to date and therefore aware of the rapid anticipated changes to service delivery and their impact on the scope of nursing in the future and therefore may perceive a degree as necessary.

The above also has to be weighed up with the inevitable assumption that eventually even more nurses than ever before will have a degree as a result of the current policy to increase the number of students exiting with a degree. Competition for jobs therefore can only increase. Students may believe employers will prefer degree educated nurses, as was the case for some of the employers in Burke and Harris's (2000) research. As degrees become more the norm for nurses this preference may increase further.

Attitudes towards obtaining a degree therefore may have both similarities and differences to current registered nurses and may be influenced by age, entrance qualifications, academic achievements and motivational factors.

Hence, it is possible that those who accept a degree place have different attitudes to those who do not. It would also be logical to assume that nurses who accept a place on a degree programme have more positive attitudes than those who do not. However, the theories on the links between attitudes and behaviour are not always straightforward as are discussed in subsequent sections.

### 3.4. Marketing the degree option

The difference between a diploma and a degree is 60 points. In the study site, this consists of four 15 point theory modules during year three. Please see Table 2 overleaf.

In the study site all modules are worth 15 academic points each. Three hundred points are required to achieve a diploma: 20 modules. In the study site the student has achieved this once they have completed up to and including year 3 theory. Hence, the two clinical placements in year three carry no academic currency but are again still essential to meet the professional requirements of number of hours in clinical placement. This is perhaps another reason as to why nursing does not quite fit into a university setting. However, this also means these points are not counted towards the degree academic points. Hence, students are still required to carry out a further four theoretical modules at Level 3 to achieve a degree. This is the same whether transferring as pre-registration students or returning post registration to 'top-up'.

The clinical assessments have only counted as academic points towards the exit award since 2003 in the study site. Previously these carried no academic currency, though were and remain essential for professional registration, and instead students were required to complete a further two theoretical assignments in years 1 and 2.

| | ***Diploma*** | | | ***Degree*** | | |
|---|---|---|---|---|---|---|
| | **No. of Theory Modules** | **No. of Clinical Placement/ Oral Assessments** | **Total for Diploma** | **No. of Theory Modules** | **No. of Clinical Placement/ Oral Assessments** | **Total for Degree** |
| **Modules in Year 1 SCQF♦ Level 7** | 4 | 4 | 8 | 4 | 4 | 8 |
| **Modules in Year 2 SCQF Level 8** | 4 | 4 | 8 | 4 | 4 | 8 |
| **Modules in Year 3 SCQF Level 9** | 4 | ***2** | 4 | 4 plus 4 during placements | ***2** | 8 |
| **Total Modules** | 12 | 8 | 20 | 16 | 8 | 24 |
| **Total Points** | 180 | 120 | 300 | 240 | 120 | 360 |

♦ Scottish Credit and Qualifications Framework

* These clinical placement modules do not count as academic points towards the diploma or degree.

**Table 2. Number of modules and corresponding academic points for Diploma and Degree in the study site.**

This is an interesting situation for two reasons. Firstly, if the final clinical assessment points counted as academic points the degree option would be easier to achieve. Secondly, the pre-2003 diplomates who return to 'top-up' by completing four more theory modules (at Level 9), actually had already completed four more assignments. However, these were two in year 1 and two in year 2 and therefore at the lower SCQF levels. This was because at that time none of the four clinical placements (from years one and two), as currently do, counted towards their diploma.

Regardless of this latter anomaly, mixed messages about the value of clinical practice towards academic points currently exist.

Tied in with the above is the way in which the degree programme is marketed to students. Marketing is about linking a service with customers (wikipedia, no date). This is achieved by applying psychological techniques, often based on market research.

Marketing can be divided into four main aspects, the four P's: product, price, promotion and place (wikipedia, no date). Each needs to be taken into consideration. The four P's are considered a little dated, as their focus lacks consumer satisfaction and customer loyalty matters, (Hastings et al, 2002); however they do seem to have relevance for a one off transaction, such as obtaining a degree. This is not to suggest that consumer satisfaction is unimportant.

Each of these four main marketing aspects can be applied to the offer of degree transfer. The first aspect is the product and consists of the four extra modules and the four corresponding assignments. The modules are: Understanding Research Applied to Nursing, Independent Studies which is a 30 point double module consisting of a Literature Review and Research Proposal and one Options Module (University of Paisley, 2001). The emphasis therefore is on research, a topic that perhaps seems less relevant to student nurses at the start of their career. This is in contrast to post registration students 'topping up' to a degree who have a much wider selection of modules to choose from with no necessity to complete any research modules. These

are listed in the School of Health, Nursing and Midwifery 2004/2005 prospectus and allow nurses to choose modules relevant to their area of work or interest.

The second aspect is the price. Contrary to normal marketing philosophy there is no financial cost for the product to the pre registration student nurse; however there is a price to those marketing the product. Universities have received extra funding although this may not necessarily result in increased staff numbers.

The promotion refers to the encouragement or not to students to accept the offer. This has to be realistic in terms of the students' capabilities. The resources for lecturers to meet the extra demands of students have to be in place also. Hence, the promotion of the product may be influenced by the ever increasing workload of lecturers, increased number of students and now further support for a variety of academically able and not so able students at degree level. In addition, if there was a 100% uptake the course would become a degree course and the entrance qualifications may require to be increased.

The RCN (2001) carried out a 'spot-check' on nurse education using questionnaires and focus groups. It was reported approximately 700 lecturers responded to the questionnaire. The conclusions reached were that workload in particular, was amongst the top three high priority issues for nurse lecturers. The requirements of student supervision were seen to be not fully acknowledged in many nurse lecturers' contracts. This was reported to be because student to staff ratios were as high as 30/40:1 instead of the ideal 12:1. The increased workload of degree and student supervision can only increase lecturers' workload further.

Finally, the place: depending on the university, the modules may be offered in only one campus if more than one exists, day or evening and may or may not be part of the top-up degree system for registered nurses. Being in the same class as qualified staff could be inhibiting for students. In addition, these factors may influence the ease of access, availability of places and relevance of modules offered.

## 3.5. Measuring attitudes

There are four fundamental questions which psychologists have tried to answer for many years: where do attitudes come from, how can they be measured, how and why do they change and how do they relate to behaviours (Roger et al, 1995 as cited by Gross, 2001). The answers to these questions were important to this study in order to understand how or if students' attitudes towards obtaining a degree related to their actual behaviour.

An attitude is described as '*a single sentence that expresses a point of view, a belief...*' (Oppenheim, 1992, p.174).

However, many definitions exist. The three-component model, consisting of the affective, emotive and behavioural components of an attitude assumes the three parts are highly related (Gross, 2001).

The affective component of the attitude is included in the statement, the emotive component in the rating and the behavioural component is not always measured (Burns, 2000) but is often the component which is being predicted.

The attitudes individuals hold are not always logical.

## 3.6. How can attitudes be measured?

It is because attitudes are described as hypothetical constructs that it is impossible to measure them directly (Gross, 2001). Instead, it is assumed that attitudes can be measured by an individual's belief about an object/attribute (Stahlberg and Frey, 1988, as cited by Gross, 2001). Hence, attitudes are often measured using an attitude scale made up of statements or beliefs on the object/attribute in question.

One of the most common methods of measuring attitudes is to use the Likert Scale (Banyard and Philips, 1994, p.384). Burns (2000) suggested that all attitude statements making up this scale could have 'I believe that.....' before each one.

These are then rated on a 3, 5 or sometimes 7 point scale ranging from strongly disagree to strongly agree (Burns, 2000, p.556) This assumes that attitudes can be given a numerical score and analysed using quantitative analysis. This type of scale is useful because it measures both the content and strength of an attitude (Banyard and Philips, 1994, p.384).

Measuring specific content of attitudes is not easy because there are often many aspects which make up the content of a particular attitude. When creating an attitude scale therefore it is important to measure the whole attitude and not just part of it. The development of an attitude scale therefore can be time consuming and should involve a detailed literature review of the subject, as was carried out for this study. The development of the attitude scale used in this research is discussed in the methods section.

### 3.7. How and why do attitudes change?

Attitudes tend to be fairly stable and can remain so throughout a person's lifetime. However, attitudes and the intensity of attitudes vary between individuals. Sometimes attitudes change and sometimes particularly for example in health promotion, attempts are made to change attitudes in order to promote healthy behaviours. It is not always easy to change attitudes because some are more resistant to change. However, Oppenheim (1992, p.178) believes that attitudes can be changed (and acquired) by *'absorbing, or reacting to, the attitudes of others.'* Attitudes have also been reported to be strongly influenced by peer pressure and custom (Siriwardena, 1995).

Theories of persuasive communications are also put forward as a means to change attitudes (Gross, 2001). The four main components of this are: the source, the message, the recipient and the situation (Hovland and Janis, 1959, as cited by Gross, 2001) and all require careful consideration.

In relation to attitudes towards obtaining a degree and also more widely a move to an all degree profession, many mixed attitudes exist as discussed in previous chapters. In trying to absorb these mixed messages, students may be confused. Hence if a university wished to increase the number of students accepting transfer to a degree, and the attitudes of the students were important to whether they accepted or not, it may be beneficial to promote positive attitudes towards degree level education. This will require being honest, in that debate exists over the benefits of obtaining a degree and of moving to an all degree profession. However, the advantages to the individual, simply in terms of individual achievement are also important to emphasise.

Successful communication also requires the recipient to listen, comprehend, accept and act on the communication (McGuire, 1969, as cited by Gross, 2001). In addition, the quality of the communicator and the communication need to be high particularly when the attitudes are important to the individual (Gross, 2001).

### 3.8. How do attitudes relate to behaviours?

The final crucial question is whether attitudes are related to behaviours.

As discussed previously, attitudes are described in terms of three components: beliefs, feelings and behavioural intents (Oppenheim, 1992). Attitudes therefore, are in theory, determinants of behaviour. However the relationship between attitudes and actual behaviours is not always simple and in general it is agreed that attitudes are just one determinant of behaviour (Gross, 2001). Other determinants include the consequences of the behaviour and habit. On the other hand, Rhodes and Courneya (2003, p.58) suggested '*past behaviour actually reflects habit*'.

Even more confusingly Gross (2001) implied that having the same attitude could be expressed in a number of different ways. However, Ajzen and Fishbein (1977, as cited by Gross, 2001) believe that specific attitudes can predict a specific behaviour and that problems only arise when specific attitudes are used to predict a more

general behaviour or vice versa. This is referred to as the principle of compatibility, and consists of the target, action, context and time being assessed at identical levels of generality (Ajzen, 1988, as cited by Gross, 2001).

It is also believed that conflicts between attitudes and behaviours can exist resulting in compromises (Gross, 2001). Stroebe (2000, as cited by Gross, 2001) also questioned the consistency of behaviours and suggested that relating attitudes to a single behaviour is not reliable. More recent theories e.g. Hogg and Vaughan (1995, as cited by Gross, 2001) suggest that a simple relation between attitudes and behaviours does not exist. However, Gross (2001) believes strong attitudes are more likely to influence behaviour.

Hanson (1980, as cited by Robson, 2002) reviewed forty six attitude to behaviour link studies and found that twenty did not demonstrate a positive relationship. Hence, the majority did, but a substantial minority did not.

Hicks carried out two studies of particular interest into the attitudes of nurses and midwives towards research. Hicks (1995a, 1995b and 1996) found that where specific attitudes were measured there was a significant correspondence with the related behaviour. These studies were particularly interesting because of the use of psychological theories to demonstrate not only the link between attitudes and behaviours but also to explain discrepancies between the two.

The first theory used was the Theory of Reasoned Action (Ajzen and Fishbein, 1980). This hypothesises that the 'intention', to carry out a behaviour is influenced by attitudes and is dependent on how strong that individual and close others, believe, is their ability to obtain a 'good' outcome. Please see Figure 1 overleaf.

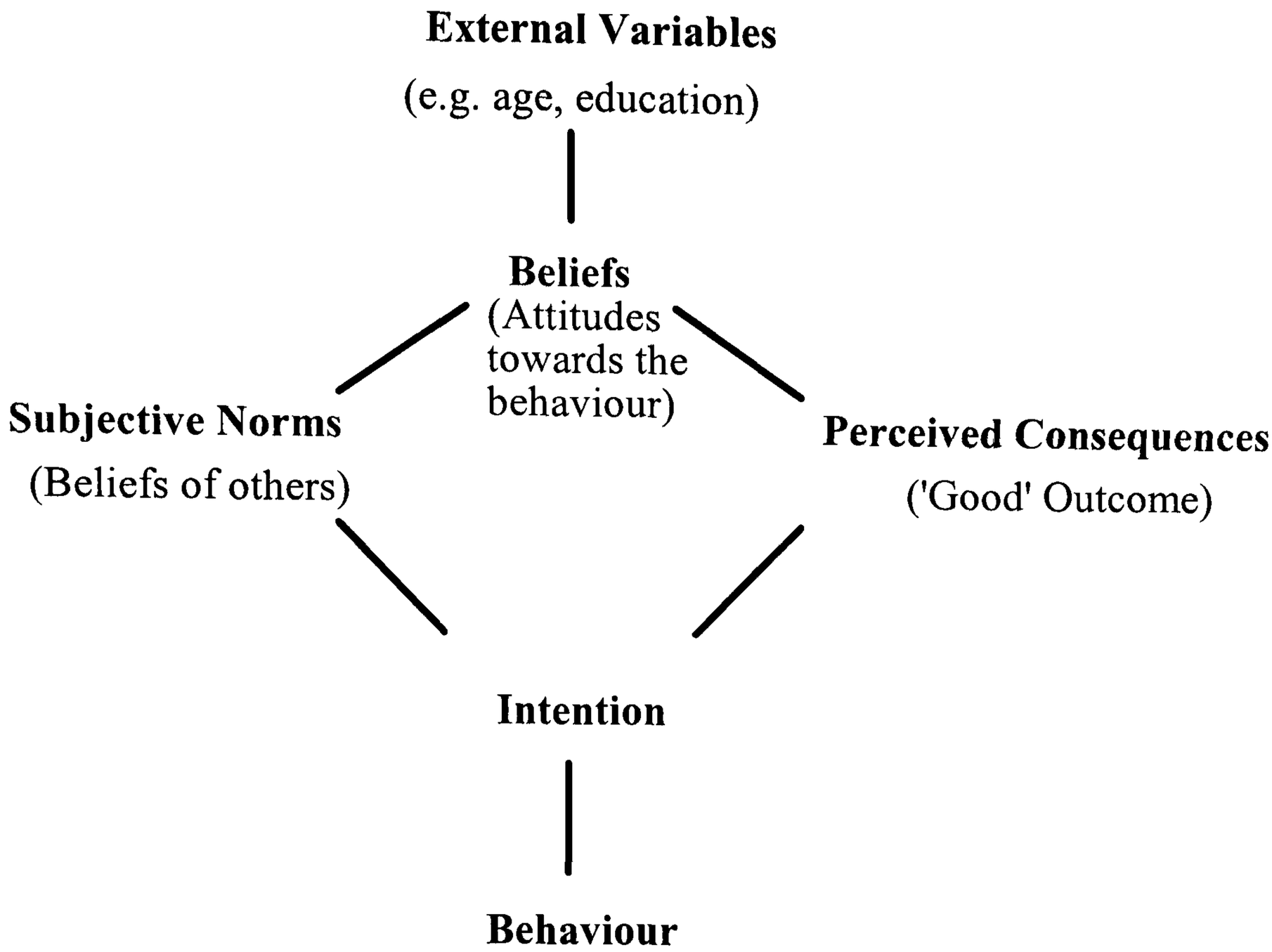


**Figure 1. Theory of Reasoned Action (Ajzen and Fishbein, 1980)**

(Words in brackets are author's own words)

This theory makes two assumptions; firstly that humans are capable of rationale decisions and secondly based on the information available will then make a 'reasonable behavioural decision' (Fishbein, 1980, as cited in Tseng, 2000, p.1). The determinant of this behaviour is an individual's intention. Intention is determined by attitudes.

Hence, according to this theory, it is the interaction of attitudes with intentions that best predicts an individual's behaviour (Banyard and Hayes, 1994, p.389). However, it is acknowledged that individuals do not always behave consistently with their intentions, hence this theory recognises the powerful influence of another factor: the subjective norm (Naidoo and Wills, 1994). This is the social pressure to perform or not a specific behaviour (Fishbein and Ajzen, 1975, and Ajzen and Madden, 1986, as cited in Tseng, 2000, p.1) and may include, for example social pressure from significant others (Naidoo and Wills, 1994, p.185) e.g. lecturers and peers.

Conforming to social norms involves acting in a predictable manner for a particular social group (Baynard and Chapman, 1994, p.415). Social norms within a profession, such as nursing, would appear to be a relevant factor in helping to determine student nurses' attitudes towards obtaining a degree. In addition, peer group pressure is also a major source of information about social expectations which may or may not be congruent with an individual's attitudes. Conforming to social norms is strengthened by being part of a large cohesive group (Myers, 1995, p.622), such as a cohort of third year student nurses, who have many shared experiences, both good and bad. Hence, there are many reasons for students to be influenced by their peer group, in particular, to conform to the majority decision to accept transfer or not. This is referred to as social facilitation (Myers, 1995, p.627). In addition, the group will provide the individual with valuable information and resources to help achieve the desired behaviour, that is, the degree qualification. This is referred to as informational social influence (Myers, 1995, p.622). This however may be lost if the student does not obtain the degree at the same time as the majority of their particular cohort. However, this may be rekindled post registration when many nurses return to 'top-up' as part of their own CPD.

This theory sees behaviour as not a completely rational process but instead sees the individual within a social context (Naidoo and Wills, 2001 p.89). This provides a better predictor of the relationship between attitudes and behaviours by linking a number of concepts and in particular attitudes and subjective norms (Naidoo and Wills, 2001).

A second theory known as the Theory of Planned Behaviour is based on a revised version of the Theory of Reasoned Action. It not only believes that attitudes, intentions and subjective norms are important but that behaviour is also controlled by perceived control (Naidoo and Wills, 2001, p.89). Please see Figure 2. overleaf.

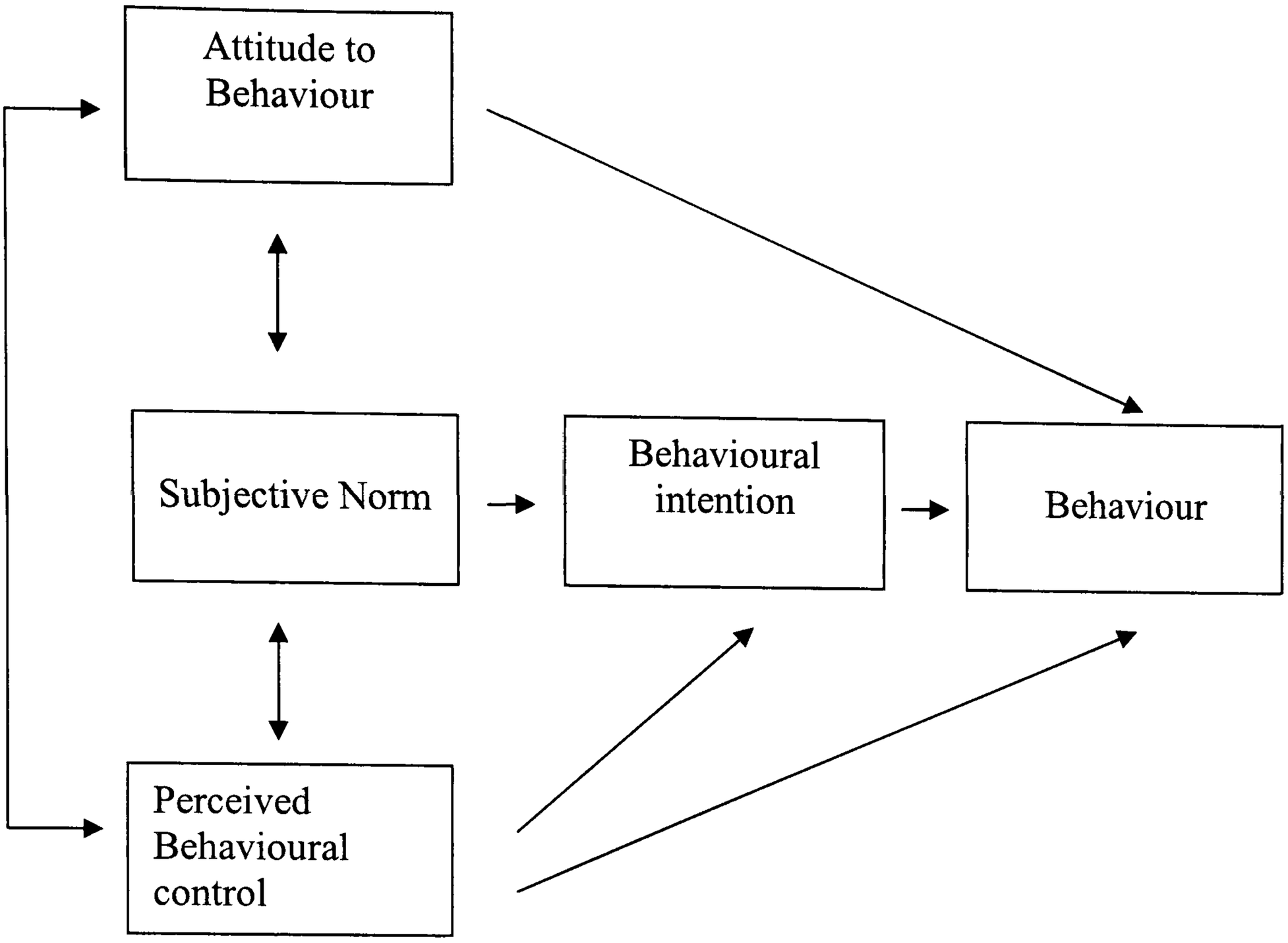


**Figure 2. The Theory of Planned Behaviour**

(Taken from Naidoo and Wills, 2001, p.90)

Naidoo and Wills (2001) described this theory in terms of the attitudes as the positive or negative evaluation of behaviour as well as the beliefs about the outcome of performing a behaviour. The subjective norms are described *as 'both the perception of social norms and pressures to perform a behaviour, and an evaluation of the individual's motivation to comply with this pressure'* (Naidoo and Wills, 2001, p. 89). Hence, it is similar to the previous theory. However, the additional predictor of intention and behaviour within this model is the individual's perceived control over performance of behaviour (Rhodes and Courney, 2003, p.57). Perceived control is described as the individual's perception of how easy or difficult it is to perform the behaviour. Naidoo and Wills (2000) described this in terms of overcoming both internal e.g. abilities and external control factors e.g. time.

Where Hicks (1995b) found some discrepancies between attitudes and behaviours,

these she explained using Ajzen and Madden's Theory of Planned Behaviour. Hicks suggested that an individual's beliefs about their abilities, together with the opportunities and obstacles related to the behaviour were critical determinants in whether or not that behaviour was adopted. This was because Ajzen and Madden's Theory (1986, as cited by Hicks, 1995b) would suggest that a positive attitude is more likely to lead to the desired behaviour by the creation of facilitating factors.

In other words, because the link between attitudes and behaviours is a psychological theory, it is by definition, individually oriented (Naidoo and Wills, 1994). Focusing on an individual denies the effect the wider environment also plays on the individual's behaviour. Thus, measuring attitudes may contribute, if not predict how people make decisions; however, the factors promoting or inhibiting a particular behaviour within an environment are also extremely important. Therefore, a positive or a negative attitude may not necessarily result in the predicted behaviour because of the obstacles or benefits to the behaviour. Hence, in relation to students accepting transfer or not to the degree programme, this theory suggests that not only attitudes towards obtaining a degree be measured but the factors promoting or inhibiting this behaviour also, to more fully understand why a behaviour was adopted or not. In addition, it would seem important that students and significant others believe in their ability to study at degree level.

In relation to the student nurses the Theory of Planned Behaviour would predict that if an individual believed obtaining a degree would be beneficial (the attitude) and believed in their academic ability (perceived control) as did significant others (subjective norm) and believed there were few obstacles in their way which they could overcome (perceived control), then this would predict a high intention to obtain a degree (behavioural intention) (Naidoo and Wills, 2001). However, Naidoo and Wills (2001) also state that the model could predict behaviour without the influence of intentions. The following scenario can demonstrate this: if someone did not believe they could obtain a degree because they were academically unable, this would be a better predictor of their behaviour than their intention to obtain a degree.

However, in relation to the subjective norm, the lecturers' beliefs in students' abilities may initially have been demonstrated by offering transfer only to those who met academic criteria. However, now all students are offered transfer and the belief in their ability becomes more of an individual issue (internal control) for which they may not feel able to judge for themselves nor subsequently seek advice. Nevertheless, student nurses are taught and encouraged to be reflective practitioners able to identify and address their own strengths and weaknesses. However, the perceived benefits of accepting transfer may outweigh any perceived deficits in their academic abilities.

In conclusion, a fuller understanding of the above may help develop more effective promotional campaigns for degree programmes. For example, it is possible that improved attitudes could be achieved by appropriate communication and marketing techniques. Hence, what may be required is marketing which fosters more positive attitudes. In addition, by choosing appropriate strategies which aim to reduce identified obstacles and increase the opportunities, the success of the implementation of degree programmes may be enhanced.

A final theory put forward by psychologists is that our behaviours may affect our attitudes (Myers, 1995). By this, it was suggested that individuals will come to believe in what they do. This is because individuals feel '*motivated to justify their actions*' (Myers, 1995, p.618). If our behaviours are different to our attitudes then this causes tension, referred to as cognitive dissonance. Hence, individuals often bring their behaviours and attitudes into line to resolve this. It is possible therefore, that because student nurses make their intentions known that they have accepted transfer to the degree programme, perhaps in themselves not fully knowing why, they then justify this extra hard work by believing, for example, it will be beneficial to their future career and provision of patient care.

## 3.9. Summary

This chapter has considered the students' perspective of obtaining a degree. However, because of the lack of previous evidence to base this on, this was theoretical in nature. Two similar theoretical concepts guided this chapter: the Theory of Reasoned Action and the Theory of Planned Behaviour. These will be used to help explain the relationships between attitudes and behaviours in relation to accepting transfer to the degree programme or not. In addition, a number of both personal and environmental factors have been highlighted as potential factors influencing student transfer.

If attitudes or potential/perceived obstacles are found to influence accepting transfer to the degree programme, then by encouraging more positive attitudes and reducing any obstacles, more students may be encouraged to accept and hence increase the number of students graduating with a degree. This may also increase the likelihood of achieving an all graduate profession at the point of registration.

Marketing theory was also briefly discussed to more fully understand what and how this optional increased workload can be best offered, keeping in mind the contradictory evidence of the benefits of a degree and hence the arguments for and against an all degree profession.

Finally, this chapter acknowledged the difficulties in measuring attitudes and relating attitudes to behaviours. Hence, the methods, as detailed in the next chapter, aimed to develop as valid and reliable an attitude towards obtaining a degree scale as possible.

# CHAPTER FOUR: METHODS

## 4.1. Ethical Considerations

An Ethical Approval form, research summary and student information leaflet were submitted to the University of Paisley Research Ethics Committee in 2003. Permission to carry out the study was granted following minor amendments. Copies of these documents were also sent to the Dean of School of Health, Nursing and Midwifery and Director of the School of Nursing prior to submission.

A second Ethical Approval form was also submitted to the University of Strathclyde, Department of Educational Studies in 2003 as requested. No objections to the carrying out of the study were raised.

The author is also a lecturer and known to the students from one of two campuses used in the research. The author does not teach on the second campus. However, being a lecturer on the programme may have made it more difficult for students to refuse to take part, particularly in the campus where the lecturer teaches. The author tried to overcome this in a number of ways, which are discussed below. This meant in effect, this was 'insider research'. This type of research has both advantages and disadvantages (Rabbitt, no date). The advantages include being familiar with the environment and privy to insider information. The disadvantages include coming to the research with possible bias or preconceived ideas. The methods used in this study were chosen to ensure such potential disadvantages did not influence the study in any way and are also discussed below.

All students were asked to participate in the instrument development, pilot or main study as groups, so that no one student felt under pressure to agree. Students were informed both verbally and in writing that participation was entirely voluntary. They were assured that all questionnaires were answered anonymously. This information

and more on the study itself e.g. length of time expected to complete the questionnaire were provided on an information sheet. Please see Appendices 1-Instrument Development, 2-Pilot and 3-Main Study. This information leaflet underwent minor alterations during the development and revising of the study design.

The students were informed that they could withdraw at any time and could decline to answer any specific question(s) on the questionnaire. Students were assured that whether they participated or not, the outcome of their studies would not be altered in any way. Having explained all of the above, the students' willingness to complete and return the questionnaire was taken as informed consent. The researcher left the room whilst the students completed the questionnaire, and returned afterwards to collect the questionnaires from the sealed box provided.

Clear and concise instructions on how to complete the questionnaire were printed on the questionnaire. The questionnaire data were subsequently kept in a locked filing cabinet in the researcher's office. To maintain confidentiality only the researcher and the supervisor had access to the raw data. No individual student was identifiable from this data.

## 4.2. Data Protection Issues

In order to not breach the Data Protection Act principles, (HMSO, 1998) all research data were collected from their primary source i.e. using the student nurse survey questionnaire. The Data Protection Act (1998) refers to the processing of sensitive personal data, such as, ethnic origin. There was no such sensitive data included in the questionnaire.

## 4.3. Methodology

This section discusses the methodology used in the study design. This is followed by the specific methods used. In addition, alternative methods which were deemed

inappropriate, and why, are discussed also.

There are two main approaches to research: the scientific and the naturalistic (Scott and Usher, 1999). This study is predominately based on a scientific approach. The methods used in keeping with this approach are predominately quantitative. However, a qualitative method was used in the early stages of the study to develop the questionnaire, which was then tested quantitatively. The two are compatible (Scott and Usher, 1999) and complemented each other to bring greater validity to the study.

Combining the two methods was thought necessary because not a lot was known about students' attitudes towards obtaining a degree, or the factors promoting or impeding it. Hence, it was important to use a study method that was student focused and was not approaching the subject from a qualified nurse or educationalist perspective only.

Hence, the instrument development, pilot and main study all used a questionnaire, but in different ways. There are data collection methods common to both qualitative and quantitative studies, for example questionnaires, and it is the way in which they are used that determines whether the study is one or the other.

In the instrument development questionnaire a qualitative method was used to collect text-based data, that is, in a non-numerical form. This provided rich data on which to develop the pilot and main study questionnaires. This ensured all dimensions of the concepts of students' attitudes and why students did or did not wish to study at degree level were taken into account. However, this qualitative data could be quantified or counted at a later stage, if required, by for example using content analysis (Coolican, 2004). Likewise, as a result of the analysis of the quantitative data collected in the main study, recommendations for future research could be made to further explore this using a qualitative method.

In contrast to the instrument development questionnaire, the pilot and main studies questionnaire surveys were based on a positivist epistemology (Scott and Usher, 1999). A positivist epistemology is a philosophy of knowledge on which the scientific approach and hence methods of data collection are used in a quantitative manner as a means to construct knowledge. This refers to the assumption that human experience and behaviour can be measured as observable facts and the relationship between these observations analysed using statistical relationships (Coolican, 2004, p.45). This requires strict control of the observation, measurement and analysis of data to more fully understand relationships between variables in an objective way. This approach therefore puts great emphasis on validity and reliability of the data and how it is collected. Positivism also assumes that there is only one reality which, when measured objectively, is the truth. This is known as realism. There are criticisms of positivism because it is felt that it can produce artificial results which are not applicable to the realities of everyday life (Coolican, 2004). This therefore contrasts with the qualitative approach in that in the latter the data collection methods permit natural responses which permit new theories to emerge or be constructed (Coolican, 2004, p.220). Hence, in a qualitative approach the way an individual perceives the world and hence knowledge is unique to each individual. However, the more unstructured the approach and data collection methods used to understand an individuals experience, the more skill is required by the researcher to construct meaning from this experience, without distorting it with the researchers own interpretation of the participants' responses.

Therefore, the different approaches both offer advantages and disadvantages. However, by using a combination the best of both were incorporated into this study design.

### 4.4. Advantages of questionnaire surveys

Questionnaire surveys are commonly used by educational researchers and offer many advantages as well as disadvantages (Scott and Usher, 1999). The type of survey used in this research was based predominately on an interpretative study to provide

explanations of the survey data (Robson, 2002). In addition, there were some correlational aspects in which relationships between phenomena were analysed (Scott and Usher, 1999).

The advantages of questionnaire surveys include that they can involve large numbers of participants (Scott and Usher, 1999) and are relatively efficient and straightforward to design (Robson, 2002).

Questionnaires are also useful when respondents are required to answer honestly, but may wish to keep their answers anonymous (Anon, 1997). This research therefore used an anonymous questionnaire to overcome any inhibitions of students speaking out in front of a lecturer. Anonymity was guaranteed by identifying each questionnaire with a code number. It was hoped that this would yield more complete data. In addition, the use of an anonymous questionnaire avoided the possibility of interviewer bias, that is, that the lecturer as researcher did not influence the manner in which the data were collected.

To be able to achieve the above in this study required creating a standardised questionnaire which all participants would understand in the same way (Scott and Usher, 1999). However, by restricting the respondents to a set of pre-determined responses it was essential to ensure that all possible responses were included in the questionnaire (Scott and Usher, 1999).

Further advantages included that the quantitative data could be entered onto computer and analysed fairly easily. As a result, a relatively large sample was used and therefore increased the validity of the study. In addition, reliability was good because each person was asked the same questions (Parahoo, 1993/94, p.108).

Questionnaires are also useful when resources and money are limited.

## 4.5. Disadvantages of questionnaire surveys

Common faults in questionnaire design, which may decrease the reliability of questionnaires include: the intended meaning of a question not being obvious to all participants, the questions having different meanings for different respondents and the use of double negatives (Scott and Usher, 1999). In addition, if relying on memory, the results may not always be valid or reliable. Questionnaires therefore need to be constructed, where possible, to prevent such problems occurring. In this study, piloting was therefore carried out to highlight any such difficulties. This involved careful development, testing and revising as necessary using processes, which highlighted in particular potential misunderstandings of meaning. This can be time-consuming but is essential (Oppenheim, 1992). This can be difficult if questionnaires are distributed by post and a researcher unaware to whom the questionnaires are distributed. However, in this research the questionnaires were distributed in person to all third year students. They were then all asked to complete the questionnaire anonymously as well as provide anonymous feedback on the completion of the pilot questionnaire itself. This is discussed further on pages 83 and 93.

However, questionnaires may offer limited scope for answers as questionnaires often force participants to choose one answer (Parahoo 1993/94, p.109). In addition, if self-completed, a researcher cannot probe nor encourage the participant to expand on any particular answer, which may exclude potentially useful information.

However, as the third objective of this study was to collect data that could be used in a computerised dataset, it was not appropriate to collect qualitative data, which could not be easily entered onto a dataset, nor easily analysed. However, following analysis, statistical relationships found may require further qualitative exploration to more fully understand their meaning (Wilson and Butterworth, 2000). Hence, SNEDS may generate research hypothesis requiring further more detailed qualitative study.

## 4.6. Other methods considered

Data collection during the main study could have been based on a qualitative design using focus groups. Again these are useful for exploring topics and easy to organise (Roberts, 1997). They provide a rich source of data, despite usually only involving eight to ten participants. However, they are often tape recorded, which has the disadvantage of requiring hours of transcribing. In addition, despite carefully choosing the right venue and creating the right atmosphere in order to help the students to relax, it was felt that some students might be embarrassed to speak out in such a small intimate group with a researcher who was also their lecturer. Furthermore, if the students were at all unhappy about an aspect of the degree transfer, particularly the students not offered transfer (as was the case during the instrument development stage, and was initially expected, by the author, to remain school policy), then they may not speak openly, fearing this may influence their future studies in a negative way. Hence, this method raised the issue of interviewer bias. The use of a tape recorder may further inhibit participants (Coombes, 2001). Students may have preferred not to participate and therefore there were implications for the response rate. On the other hand, focus groups have advantages over questionnaires in that they are more flexible, allowing a researcher to drop unproductive questions and develop new lines of enquiry (Wilson and Butterworth, 2000) which would not be possible with a questionnaire, though can be picked up by appropriate piloting techniques.

Another option was to use individual structured interviews to collect data (LoBiondo-Wood and Haber, 2002). These also have the advantage over questionnaires of being more flexible. However, the perceived disadvantage was that students might be even more inhibited in a one to one interview, with a lecturer. Again, this method was deemed not suitable.

Another method considered was to collect some data from student records e.g. entrance qualifications and academic achievements, that is, secondary data analysis from a variety of sources and the remainder from a questionnaire. These could have

been linked without breaching confidentiality by coding and recoding. However, the students may have feared that anonymity would be compromised and this would again have implications for the response rate. The retrieval of data from student files was also not without difficulties in terms of time, particularly as the data would need to be retrieved from a number of sources. Hence, sometimes it is necessary to collect data from participants that may be available elsewhere (Burns, 2000).

In conclusion, practical and ethical considerations (Playle, 2000) and the objectives and the resources available influenced the design of the study.

The next section describes the development of the questionnaire used in the study. Some results are included in the methods section because these were part of the process to develop the questionnaire and because this follows the natural ordering of events.

### 4.7. To carry out a Survey Questionnaire

A relevant tried and tested questionnaire was not located in the literature hence a new questionnaire was developed. The questionnaire was designed using three main stages to ensure validity and reliability:

1. literature review,
2. instrument development and
3. pilot study involving a test-retest.

In addition, two experts commented on content and face validity, as recommended by Jeffreys and Smodlaka (1996) and Beyea (1999).

Details of the instrument development and pilot study are provided in Sheward (2004). A brief summary of this and additional material not included in this article are provided overleaf.

## INSTRUMENT DEVELOPMENT AND PILOT

### 4.7.1. Instrument Development Questionnaire

An instrument development questionnaire was developed to ask students their main reason(s) for accepting a place or not on the degree programme. Please see Appendix 4. This was distributed to 47 third year student nurses in January 2004 and 44 completed this, giving a response rate of 94%. At the time of distribution of this questionnaire, only students who had met academic, professional, clinical and attendance criteria were offered transfer to the degree programme. Eighteen (41%) accepted a place, nine (21%) did not and seventeen (39%) were not eligible. Those who were not offered a place were asked whether they intended to study for a degree at a later date and the reason(s) for this decision. The information gathered from this questionnaire was used to establish content validity of the questionnaire used in the pilot.

Hence, in the initial development stage of the pilot questionnaire a naturalistic approach was used. This has been described as a useful prerequisite to quantitative methods (Pope and Mays, 1995). This meant that, in the instrument development questionnaire open response questions were used to allow participants to provide their own answers without any restrictions (Scott and Usher, 1999). These data could have been analysed quantitatively or qualitatively. However, Scott and Usher (1999) caution that when using a naturalistic approach the reconstruction of the participants' original responses must be accurate. Having more than one researcher interpreting the data and comparing results would achieve this. However, in this study there was very little reconstruction of the participants' original responses, instead their own words were retained and used to construct statements and questions for use in the pilot and main study questionnaires. Please see Tables 3, 4 and 5 for details of responses. The number of times a particular response was given is included. However, all reasons given, regardless of how often, were used in the pilot questionnaire, none were excluded.

Those who were eligible and accepted a place on the degree programme gave the following reasons:

| ***Reasons given for accepting transfer to a pre-registration degree programme*** | ***Total number of student nurses to give this reason*** |
|---|---|
| Preferable to returning to studying later | 11 |
| Because in studying mode now | 8 |
| Because funded | 7 |
| Good opportunity | 4 |
| Increase choice of jobs | 3 |
| Career development | 2 |
| Motivated now | 2 |
| No commitments at present | 2 |
| Accepted standard | 2 |
| Personal achievement | 2 |
| Belief in academic ability | 2 |
| Specific job | 1 |
| Improving patient care | 1 |
| Do degree in 6 months rather than 2 years | 1 |

**Table 3. Reasons for accepting transfer to a pre-registration degree programme.**

Interestingly, only one respondent referred to improving patient care! The remainder focused on ease of obtaining a degree, personal satisfaction and career development.

Those who were eligible but did not accept a place on the degree programme gave the following reasons:

| ***Reasons given for not accepting transfer to a pre-registration degree programme*** | ***Total number of student nurses to give this reason*** |
|---|---|
| Want to concentrate on practical placements | 5 |
| Too stressful in last 6 months | 4 |
| Too much workload | 3 |
| Other personal commitments | 2 |
| Want to increase clinical knowledge | 2 |
| Not enough experience in clinical placements yet | 1 |
| Lack of knowledge | 1 |
| Did not like assignments | 1 |
| Want to do degree at a later date | 1 |
| Want to increase clinical skills | 1 |
| Module options limited | 1 |
| Modules taught a distance away | 1 |
| Want to concentrate on gaining confidence in wards before qualifying | 1 |
| Want more nursing experience | 1 |
| Prefer to choose modules relevant to choice of specialist area in future | 1 |
| Did not want change of personal tutor on degree programme | 1 |

**Table 4. Reasons for not accepting transfer to a pre-registration degree programme.**

These focused on wanting to increase/concentrate on clinical skills/placements, too much stress and academic concerns.

Of the seventeen who were not eligible for transfer, sixteen gave the following reasons for wanting to study for a degree at a later date:

| ***Reasons given for wanting to study for a degree at a later date by those not eligible for transfer to a pre-registration degree programme.*** | ***Total number of student nurses to give this reason*** |
|---|---|
| Improve future career | 9 |
| Wish to do degree in specialist/relevant field | 6 |
| Increase knowledge | 3 |
| To gain more academic qualifications | 2 |
| Expected to have a degree | 2 |
| Keep up to date | 1 |
| Improve patient care | 1 |
| Need more experience first | 1 |
| Personal achievement | 1 |
| Employers want it | 1 |
| Increase professional status | 1 |

**Table 5. Reasons for wanting to study for a degree at a later date given by those not eligible for transfer to a pre-registration degree programme.**

These reasons were similar to those accepting transfer.

The reasons given related to the concepts contained within the Theories of Reasoned Action and Planned Behaviour, e.g.

- Attitudes e.g. to increase professional status,
- Social norms e.g. expected to have a degree, and
- Perceived behavioural control e.g. belief in academic ability

This initial exploratory stage gave the author a 'feel' for the students' attitudes towards obtaining a degree, or not, and motivating factors. These were used, in conjunction with the literature review (Oppenheim, 1992), for two purposes. The first, to create checklists based on the factors influencing the decision to accept, or not, a place on the degree programme. The second, to create further attitude

statements based on the students' responses themselves. The above aimed to ensure content validity of the pilot questionnaire.

### 4.7.2. Development of the Pilot Questionnaire

The pilot questionnaire consisted of four sections. These were:

1. An attitude towards obtaining a degree scale,
2. A checklist of the factors influencing the decision to accept a place on the undergraduate degree programme
3. A checklist of the factors influencing the decision to not accept a place on the undergraduate degree programme and
4. Demographic questions including: age, gender, entrance qualifications and academic achievements in years one and two.

Some of the development and testing of the attitude scale were based on techniques used by Hicks (1995) in developing an attitude to research scale and are discussed in subsequent sections.

In addition, students were asked to complete a questionnaire on the completion of the pilot questionnaire itself. This asked for comments on the design, layout and wording of the questionnaire and whether any major topic was omitted. This was used to further determine both face and content validity. This was particularly useful in a self completed questionnaire because the author was otherwise limited to checking which questions were omitted or only partly completed to determine problems. The author could have asked the students for verbal feedback but this would have breached anonymity and confidentiality.

All of the above contributed to the construction of the pilot questionnaire whilst also adhering to a number of general guidelines on questionnaire development (Streiner and Norman, 1989; Oppenheim 1992; Scott and Usher, 1999; Burns, 2000; LoBiondo-Wood and Haber, 2002; StatPac, 2003 and Coolican, 2004). These

included: grouping questions logically, making the questionnaire as easy to complete as possible and including clear instructions (Burns, 2000). In addition, the questionnaire was kept short by not asking inappropriate questions to ensure a good response rate (StatPac, 2003).

The following is a more detailed description of the development of each individual section of the pilot questionnaire.

### 4.7.3. Attitude scale

No existing attitude scale was found and hence a new attitude scale was developed for this study. This was based on the Likert Scale. There are two main types of attitude scale: the Likert and the Thurstone. However, the Likert was reported to be easier to construct (Gross, 2001). In addition the reliability (Burns, 2000 and Gross, 2001) and validity of Likert scales were reported to be higher (Burns, 2000, p.560).

Despite their advantages, in that they are relatively easy to construct, complete and then analyse, there are many criticisms of attitude scales in general, as well as criticisms of Likert scales in particular.

A general criticism of attitude scales is whether attitudes can be measured using verbal statements (Burns, 2000, p.564). That they can be is one of the main assumptions of attitude scales (Gross, 2001). Two further assumptions are that all statements have the same meaning for all respondents and that a numerical score can then be given to an attitude.

A further problem with using attitude scales is that participants may not answer honestly but instead give the answers they think they should give, known as social desirability effect (Gross, 2001, p.352). Ensuring anonymity and reinforcing the importance of answering honestly can overcome this. In addition, participants need to be encouraged to answer what is important to them, that is, their own attitudes. This will help increase validity.

A further concern referred to as response acquiescence set or bias (Coolican, 2004, p.179) can occur when participants simply respond with a positive response to everything. To try to avoid this, statements should be arranged with an unpredictable mixture of positive and negative statements.

A final disadvantage of the Likert scale, in particular, is that the total score of an individual can have multiple meanings because of the many combinations in which the same score may be achieved (Burns, 2000). In addition, an attitude scale assumes attitudes are one dimensional (Coolican, 2004). Instead an individual may have a mixture of both positive and negative attitudes that cannot meaningfully be averaged out on a bipolar scale (Burns, 2000, p.560).

### 4.7.4. Development of the attitude to obtaining a degree scale

An initial 33 item towards obtaining a degree scale was developed based on the literature review and instrument development stages of this study, as detailed previously. The larger the number of items in the scale the greater the reliability (Coolican, 2004). Coolican (2004, p.180) suggested that for specific topics, twenty items were sufficient, and for broad topics, forty items were required. A number in between was used in this study - 33 items. This number also took into consideration the time needed to manage larger numbers and the patience of the respondent if the questionnaire became too long.

These statements consisted of both positive and negative statements. Positive referring to pro-obtaining a degree. However, because of the differences in attitudes and contradictory research held towards degree level education, these categories were debatable. However, rather than the author deciding on the direction of the students' responses based on a conceptual framework, the direction of the responses was based on the empirical evidence provided by psychometric tests, based on the students' responses themselves. This is discussed further on page 89. To indicate agreement or disagreement with these statements a 5-point Likert Scale, which ranged from strongly agree to strongly disagree, was used.

### 4.7.5. Development of checklists

Two lists on the factors influencing the decision to accept or not a place on the degree programme were created. These were based on students' responses in the instrument development questionnaire and the literature review. The two lists consisted of 23 factors, plus an 'other' option in each. 'Other' categories were used during the pilot to further validate the checklists by preventing the exclusion of potentially useful information. Five of the factors in this checklist were taken from work previously carried out by Davey and Robinson (2002). The students were also asked to choose the one main factor promoting or impeding undergraduate education at degree level from these lists.

### 4.7.6. Development of demographic section

This section was based on the literature review and aimed to collect relevant demographic data which may have influenced the decision to accept transfer or not to the degree programme. These were considered to be: age, gender, marital status, having a part-time job, dependent children and/or relatives living with the participant, previously working as a HCA, entrance qualifications and academic achievements. This section was created by generating an initial item pool, drafting the order of questions and statements, choosing appropriate response formats including numbering and deciding on labelling (Streiner and Norman, 1989). Please see Appendix 5 for a copy of the pilot questionnaire used.

### 4.7.7. Questions on the pilot questionnaire itself.

These questions were taken from Bell (1993, p.85). Please see Appendix 6.

### 4.7.8. Pilot Sample

In March 2004, the questionnaire was piloted on all 45 third year student nurses present on the day of the pilot. They were all based in one of the two university

campuses. These students were from a different cohort to those included in the instrument development questionnaire. By the time of the pilot a change in school policy meant that all third year student nurses were now offered a place on the degree programme. The response rate was 100%. Of these 38 (84%) accepted transfer to the degree programme and 7 (16%) did not.

### 4.7.9. Evaluation of the pilot responses

An evaluation of each section of the pilot questionnaire is described below.

1. Attitude towards obtaining a degree scale: the responses for all statements contained in the 33 item scale prior to psychometric testing are shown in Table 6.

| ***STATEMENT*** | ***Strongly Agree*** ***Count/ Percent*** | ***Somewhat Agree*** ***Count/ Percent*** | ***Undecided*** ***Count/ Percent*** | ***Somewhat Disagree*** ***Count/ Percent*** | ***Strongly Disagree*** ***Count/ Percent*** |
|---|---|---|---|---|---|
| 1. Will help nurses develop their career | 14 (42%) | 20 (44%) | 5, (11%) | 1 (2%) | 0 (0%) |
| 2. Will help nurses consider jobs outside nursing | 16 (36%) | 15 (33%) | 13 (29%) | 1 (2%) | 0 (0%) |
| 3. Will increase self confidence | 22 (49%) | 18 (40%) | 2 (4%) | 3 (7%) | 0 (0%) |
| 4. Will increase knowledge | 21 (47%) | 17 (38%) | 5, (11%) | 1 (2%) | 1, 2.2% |
| 5. Will be more satisfying than obtaining a nursing diploma | 18 (40%) | 17 (38%) | 3 (7%) | 4 (9%) | 3 (7%) |
| 6. Ought to be essential for all student nurses | 2 (4%) | 5 (11%) | 18 (40%) | 7 (16%) | 13 (29%) |
| 7. Ought to be essential for all nurses | 1 (2%) | 11 (24%) | 18 (40%) | 7 (16%) | 8 (18%) |
| 8. Will increase professional competence | 1 (2%) | 18 (40%) | 8 (18%) | 12 (27%) | 6 (13%) |
| 9. Is only essential for nurses who are ambitious. | 1 (2%) | 12 (27%) | 6 (13%) | 18 (40%) | 8 (18%) |
| 10. Will (not) make nurses better at their jobs | 16 (36%) | 15 (33%) | 5 (11%) | 8 (18%) | 1 (2%) |
| 11. Will increase professional status | 13 (29%) | 16 (36%) | 13 (29%) | 3 (7%) | 0 (0%) |
| 12. Will improve the patient care provided by nurses | 1 (2%) | 6 (13%) | 9 (20%) | 15 (33%) | 14 (31%) |
| 13. Will not help nurses consider a wider range of job opportunities in nursing | 0 (0%) | 2 (4%) | 16 (36%) | 19 (42%) | 8 (18%) |
| 14. Is the gold standard for nurses | 2 (4%) | 11 (24%) | 18 (40%) | 9 (20%) | 3 (7%) |

cont'd overleaf

| STATEMENT | Strongly Agree<br>Count/ Percent | Somewhat Agree<br>Count/ Percent | Undecided<br>Count/ Percent | Somewhat Disagree<br>Count/ Percent | Strongly Disagree<br>Count/ Percent |
|---|---|---|---|---|---|
| 15. Is what employers of nurses want | 7 (16%) | 19 (42%) | 13 (29%) | 5 (11%) | 1 (2%) |
| 16. Is essential to be a good nurse | 0 (0%) | 0 (0%) | 4 (9%) | 21 (47%) | 20 (44%) |
| 17. Is easier as a student nurse because in studying mode | 14 (31%) | 20 (44%) | 5 (11%) | 6 (13%) | 0 (0%) |
| 13. Will not help nurses consider a wider range of job opportunities in nursing | 0 (0%) | 2 (4%) | 16 (36%) | 19 (42%) | 8 (18%) |
| 18. Will be difficult for many nurses because they lack the academic ability | 10 (22%) | 16 (36%) | 2 (4%) | 15 (33%) | 2 (4%) |
| 19. Will increase nurses' clinical skills | 0 (0%) | 10 (22%) | 7 (16%) | 17 (38%) | 11 (24%) |
| 20. Is more likely if nurses are funded. | 22 (49%) | 15 (33%) | 4 (9%) | 4 (9%) | 0 (0%) |
| 21. May put some nurses off training to be nurses if becomes essential | 11 (24%) | 18 (40%) | 7 (16%) | 8 (18%) | 1 (2%) |
| 22. May cause problems with qualified staff who do not have a degree. | 12 (27%) | 22 (49%) | 9 (20%) | 2 (4%) | 0 (0%) |
| 23. May cause problems with other students who are not studying for a degree | 5 (11%) | 19 (42%) | 10 (22%) | 10 (22%) | 6 (13%) |
| 24. Will make nursing a more attractive career option if becomes essential | 3 (7%) | 19 (22%) | 12 (27%) | 14 (31%) | 6 (13%) |
| 25. Will be easier as a student nurse than post registration | 12 (27%) | 14 (31%) | 9 (20%) | 9 (20%) | 1 (2%) |
| 26. Will increase choice of nursing jobs | 11 (24%) | 16 (36%) | 8 (18%) | 10 (22%) | 0 (0%) |
| 27. Will not improve job opportunities in the future. | 1 (2%) | 4 (9%) | 10 (22%) | 20 (44%) | 10 (22%) |
| 28. Is an excellent opportunity as a student nurse | 26 (58%) | 14 (31%) | 5 (11%) | 0 (0%) | 0 (0%) |
| 29. Should be recognised on the Nursing and Midwifery Council (NMC) Register | 22 (49%) | 12 (27%) | 8 (18%) | 3 (7%) | 0 (0%) |
| 30. Should mean higher pay than for nurses with a diploma | 17 (38%) | 7 (16%) | 13 (29%) | 6 (13%) | 2 (4%) |
| 31. Will promote a two tier system in nurse education. | 7 (16%) | 20 (44%) | 14 (31%) | 4 (9%) | 0 (0%) |
| 32. Is necessary to further a career in nursing | 7 (16%) | 12 (27%) | 15 (33%) | 9 (20%) | 2 (4%) |
| 33. Will be difficult for many nurses because they lack confidence in their academic ability | 12 (27%) | 25 (56%) | 5 (11%) | 3 (7%) | 0 (0%) |

**Table 6. Responses to 33 attitude statements, based on Pilot Study.**

This initial 33 item scale then underwent standard psychometric testing to check the reliability and stability of the scale. The following is a description of this testing.

All the statements were reversed to follow the convention that the more positive the attitude the higher the score: 5-strongly agree, 4-somewhat agree, 3-undecided, 2-somewhat disagree and 1-strongly disagree. Only those who had completed every attitude statement in the pilot were included (n=45, that is, the entire sample).

Reliability analysis using Cronbach's Alpha was then performed. This is a statistical measurement of how consistently individuals score on individual items compared to other items on the scale. If individuals vary on how they score then the test is seen to be unreliable. This is also referred to as homogeneity, that is, that participants answer consistently high or low for each item (Coolican, 2004). A good reliability score would be an alpha value of between 0.75 and 1 (Coolican, 2004, p.189).

A common method is to compute alpha for the scale and then, to compute alpha when each item in turn is deleted from the scale (Coolican, 2004, p.189). This was carried out, thus deleting the items in turn that most improved alpha. This was repeated until a satisfactory alpha value was achieved. In addition, the scoring for statements which were found to have a negative correlation were reversed (n=5). These were statements 10, 13, 21, 23 and 27.

The initial alpha for the 33 items was 0.79. Twelve items were then deleted. These were statements 8, 9, 13, 14, 18, 19, 20, 21, 22, 23, 27 and 31. The 21 remaining statements were thought to be the most useful.

The scale was now reduced to a 21 item scale. The final 21 items and alpha values are shown in Table 7. The Cronbach's Alpha for this scale was 0.88, thus showing good internal reliability (Coolican, 2004). These remaining 21 items all scored in one direction: positively.

| *Attitude Statements* | *Item-Total Correlation* | *Alpha if Item Deleted* |
|---|---|---|
| 1. Will help nurses develop their career | 0.4623 | 0.8788 |
| 2. Will help nurses consider jobs outside nursing | 0.3062 | 0.8825 |
| 3. Will increase self confidence | 0.3123 | 0.8824 |
| 4. Will increase knowledge | 0.3967 | 0.8803 |
| 5. Will be more satisfying than obtaining a nursing diploma | 0.5089 | 0.8773 |
| 6. Ought to be essential for all student nurses | 0.3501 | 0.8825 |
| 7. Ought to be essential for all nurses | 0.3230 | 0.8828 |
| 8. Will not make nurses better at their jobs | 0.4649 | 0.8788 |
| 9. Will increase professional status | 0.5375 | 0.8763 |
| 10. Will improve the patient care provided by nurses | 0.4595 | 0.8787 |
| 11. Is what employers of nurses want | 0.5515 | 0.8758 |
| 12. Is essential to be a good nurse | 0.4523 | 0.8794 |
| 13. Is easier as a student nurse because in studying mode. | 0.4939 | 0.8775 |
| 14. Will make nursing a more attractive career option if becomes essential | 0.4563 | 0.8789 |
| 15. Will be easier as a student nurse than post registration | 0.7151 | 0.8699 |
| 16. Will increase choice of nursing jobs | 0.6169 | 0.8734 |
| 17. Is an excellent opportunity as a student nurse | 0.6276 | 0.8754 |
| 18. Should be recognised on the Nursing and Midwifery Council (NMC) Register. | 0.6897 | 0.8716 |
| 19. Should mean higher pay than for nurses with a diploma | 0.6273 | 0.8727 |
| 20. Is necessary to further a career in nursing | 0.5763 | 0.8748 |
| 21. Will be difficult for many nurses because they lack confidence in their academic ability | 0.2775 | 0.8831 |

**Table 7. Attitude to obtaining a degree scale: Item-Total Correlations based on pilot results.**

The mean score for each participant was then calculated by adding together the scores for the 21 statements. The scale mean was 63, that is, 21 x 3 (the mid score). Since there were 21 items, the maximum possible score was 5 x 21 = 105 and the minimum score was 1 x 21 = 21. The mean attitude score for the pilot sample was 73.1, s.d. 11.5. This was above the scale mean.

An independent samples t-test was used to compare the mean scores for those who accepted a place on the degree programme and those who did not. There was a significant difference between the two groups. The mean score for those who did not accept transfer was below the scale mean, whereas the mean score for those who accepted was above. However, the number who did not accept was small. Nevertheless, it demonstrated that the scale had potential predictive validity. Please see Table 8.

| ***Student decision*** | ***No. in sample*** | ***Mean standard deviation (s.d.)*** | ***p-value*** |
|---|---|---|---|
| Accepted transfer to degree programme | 38 | 75.2 s.d. 10.0 | **0.004** |
| Did not accept transfer to degree programme | 7 | 61.9 s.d. 13.1 | |

**Table 8. Attitude scale means for those who accepted transfer to the degree and those who did not.**

2. Checklists of the factors influencing the decision to accept a place or not on the undergraduate degree programme

The students completed the checklists with no major difficulties. All factors were reported to have influenced the participants' decisions. Hence, only one factor was removed because it was deemed to be too similar to factor 13. Please see Appendix 5, section D, question 1, factor 7.

A small number commented that they did not know which modules were offered for the options module in the degree programme. Please see Appendix 5, section C,

question 1, factor 22. However, on checking course documents this information was widely available and was explained to the students by the BSc Programme Leader prior to the students making their choice to transfer or not. Hence, this question was not removed.

A number of participants commented that this section should have included a factor on the combined pressures of workload, family and work. This was therefore added.

As stated previously, the students were also asked to choose the one main factor influencing their choice to accept or not. However, only a few students completed this question or several gave more than one answer, when only one was asked for. The question was reworded and three boxes were provided into which the students were asked to write the corresponding numbers for the three main factors that either influenced their decision to accept, or not, a place on the degree programme.

3. Demographic questions

In section E, questions 6 and 7 were poorly answered. Please see Appendix 5. Students commented that they found it particularly difficult to remember their school results. These sections relied on memory. These data were important for several reasons: the completeness and accuracy of the data being collected and to be able to relate other sections of the questionnaire to the participants' entrance qualifications and academic achievements. Minor alterations to the layout of section 6 were made to help ease completion and aid memory.

Anonymous academic results are displayed publicly on notice boards. As the year 2 results were still publicly available on the notice board for the students who would be asked to participate in the main study, it was decided to make these anonymous results available to the participants to aid completion of section 7.

## 4.8. Feedback from participants based on completion of the pilot questionnaire

This questionnaire asked for feedback from participants on the completion of the questionnaire itself. Please see Appendix 6. Overall the pilot questionnaire was reported to take approximately 10 minutes or less to complete, as estimated. The only reported ambiguous questions were the attitude statements that contained 'not'. Following the reduction of the 33 item scale to 21 items, only one statement still had 'not' in it. This was removed from the statement prior to the main study.

Options to add 'other' were included in several sections of the questionnaire. These had not been completed frequently, indicating that most possible answers had been included in the questionnaire. Only one person objected to answering one of the questions, E7, because it took too long.

In addition to the comments already discussed, several participants also reported that a question should have been included on the change of policy, in regard to offering transfer to the degree programme to all students rather than only those who met academic criteria. Several students reported that they felt this was unfair because they had worked hard to get good grades and this change in policy had reduced the value of the degree. This was an issue particularly relevant to the pilot cohort because in year 2 of their course they thought the degree would only be offered to those who met the criteria, but by year three this had changed and was subsequently offered to all students in their cohort. This meant this particular cohort was slightly biased and the author contemplated whether this was a valid attitude statement which ought to be added or not. However, other institutions now providing transfer from diploma to degree programmes are only offering it to students who meet relevant academic criteria. Hence, an attitude statement was added for the main study.

LoBiondo-Wood and Haber (2002) do not recommend relying on reliability and validity scores to construct a questionnaire. Indeed, in this study the participants' anonymous feedback provided useful information to further refine the questionnaire.

## 4.9. Retest of the attitude towards obtaining a degree scale.

The 21 item scale was re-administered to the same pilot sample in April 2004, five weeks after the original administration. Please see Appendix 7. This facilitated comparing the scores between the two tests, that is, test-retest reliability using Pearson's correlation coefficient (Coolican, 2002, p.323).

Out of the 44 students present, 39 returned a questionnaire giving a response rate of 87%. To be able to anonymously match both sets of responses for the retest, each questionnaire had a unique number. This matched a number on a detachable slip. The students had been asked to detach this slip prior to returning the original pilot questionnaire in the box provided. At the retest the students were asked to staple this number to the repeated questionnaire. Three questionnaires had to be excluded from the retest analysis because the questionnaire numbers were missing. These questionnaires therefore could not be matched with the originals. The 36 actual useable questionnaires gave a response rate of 82% for the retest. All students completed every statement in the attitude scale.

The total item scores for 20 out of the 21 items only were correlated with 20 out of the 21 items for the retest. One of the statements was excluded from this analysis (number 6 in Table 6) because this was the statement that had contained 'not' in the pilot. The 'not' was removed for the retest. Hence, the two statements were not strictly comparable. The item-total correlations carried out on the retest data found that the scoring for this statement required to be reversed compared to the pilot result, thus re-confirming the direction of the scoring for this item.

Test-retest reliability for the 20 remaining statements, otherwise referred to as stability, measured using Pearson's correlation coefficient was 0.64. The test-retest should be above 0.7 (Kline, 1993). This therefore was a moderately satisfactory result. It was felt there might have been actual changes in students' attitudes to account for this moderate result. This is discussed further on page 97 and in Sheward (2004).

## 4.10. Revising of the Pilot Questionnaire

As a result of the pilot the revised questionnaire provided a more precise measure of attitudes towards obtaining a degree and the factors promoting or impeding transfer to a degree programme.

Further discussion with an expert on 'research on university students' resulted in one further question being added. This was on whether anyone in the immediate family had previously studied for a degree. It was suggested that this was relevant because many of the students at this new university are first generation university students and therefore may not necessarily consider it the 'norm' to study at degree level. This was seen to stem from socio-economic barriers, which have traditionally prevented students accessing HE and have been related to low self confidence and negative attitudes towards the value of education (Lifelong Learning Research Group, 2002, p.10). This therefore was seen as a potential factor to influence whether students accepted transfer or not.

## 4.11. Analysis of the Pilot Data

The pilot also facilitated testing out of some of the key statistical tests to be performed on the main study data (Eaton, 1997, p.17).

## 4.12. Main Study

The subsequent questionnaire used in the main study can be seen in Appendix 8.

- Sampling frame

There are two university campuses which provide pre-registration nursing programmes. Both of these are essentially regional institutions, drawing most of their students from the local area. Both regions are situated in large towns but also draw students from remote and rural areas. However, one of the campuses is very close to a city centre. This campus therefore may draw its students from the inner city area also. The above may influence the demographics of the student population.

- Sample size

All third year student nurses from one cohort (adult branch) were asked to participate in the main study. These student nurses were based between the two university campuses: (n = 51 and n = 62 respectively). These numbers were the total number of third year student nurses present on the day of the survey.

Using a complete census of one cohort meant it was possible to make inferences regarding other third year cohorts within the school student nursing population. However, it was more difficult to generalise further because of the diverse nature and context of nursing education as discussed in previous chapters, that is, external validity was more difficult to achieve.

- Inclusion/exclusion criteria

All third year student nurses from the adult branch currently registered on the programme at the time of the distribution of the questionnaire were included.

- Method of assignment to study groups

All students were asked to complete the same questionnaire. Within this

questionnaire, filter questions were used to exclude respondents from questions not which were not relevant to them, that is, students who did or did not accept transfer.

- Timing of the distribution of the questionnaire

The questionnaire was distributed to students whilst they were on campus for ease of distribution. This meant the timing of the study was limited. Furthermore, the author waited until the students had completed the official acceptance to transfer or not to the degree programme. This was distributed and discussion about the degree option facilitated by the BSc Programme Leader.

At the time of the main study, the BSc Programme Leader gave the students more time to consider their decision to accept transfer or not, than was given during the pilot. Again this was a decision unrelated to the research, but was as a result of students from previous cohorts, in both campuses, changing their minds and withdrawing their acceptance. One of these campuses was involved in the pilot. During this pilot, a test-retest of the attitude scale was carried out, as discussed previously. A small number of students who had withdrawn their acceptance had reported to the author following the retest that their attitudes had changed since the original test. The author thought this might have compromised the stability of the scale (Sheward 2004). Hence, it was hoped this increased decision time would increase the reliability of the main study results.

## 4.13. Analysis of the Main Study Data

The statistical package used for analysis was the Statistical Package for Social Sciences (SPSS) for Windows, version 11.5. The data frequencies were checked for rogue numbers and range checking (Campbell and Machin, 1993 and Hinton, 1995). One in nine questionnaires were checked for data entry errors. No errors were found.

Again, the scoring was reversed for the positive statements within the attitude scale to follow the convention that the higher the score the more positive the attitude.

Categorical data were presented as counts and percentages, continuous variables as means and standard deviations (Hallet, 1997). All percentages were rounded up or down to the nearest whole number.

In the pilot and main study, standard psychometric procedures were used to test the validity and reliability of the attitude scale including: Pearson's correlation and Cronbach's Alpha coefficients. Cronbach's Alpha was discussed previously on page 89.

Pearson's correlation is a parametric measure of association between variables (Coolican, 2004, p. 469). Pearson's correlation coefficients can range from -1.0 to +1.0 (LoBiondo-Wood and Haber, 2002, p. 358). A zero coefficient meaning there is no relationship between variables. If there was a perfect positive relationship between two variables the coefficient would be 1, if there was a perfect negative relationship then the coefficient would be -1. Significance was measured at the p=0.05 level. In addition Pearson's correlation coefficient was used to test for associations between subgroups. The subgroups were based on the following: age, gender, marital status, having a part-time job, having dependent children and/or relatives living with the participant, previously working as a HCA, entrance qualifications, academic achievements, previous member of the family studying at degree level in any subject and having positive or negative attitudes towards obtaining a degree.

One-sample and two independent-samples t tests were used to test for significant differences between mean scale scores for subgroups (Lo-Biondo and Haber, 2002, p. 356). These parametric tests were applied after confirming a normal distribution of the attitude scores. Significance was measured at the p=0.05 level. One way analysis of variance (ANOVA) was used to test for significant differences between more than two subgroups. The large sample in the main study facilitated the standardisation (Coolican, 2004) of the attitude scale for third year student nurses based on the calculation of confidence intervals.

# CHAPTER FIVE: RESULTS

## 5.1. Introduction

The results of the main study are presented in this chapter. The attitude to obtaining a degree scale underwent detailed analysis during the pilot, retest and main study. Hence, where applicable, summaries of the pilot and retest as well as the main study data are presented. This is possible because of the similarities between these three parts of the study. Where there are differences these are highlighted.

## 5.2. Response Rate

One hundred and thirteen questionnaires were distributed in the main study. One hundred and five were completed and returned giving a response rate of 93%. Fifty of these were from the first campus and 55 from the second.

## 5.3. Description of demographic data

The mean age of participants was 31 years s.d. 8.4. The ages ranged from 20-48 years. Four respondents did not complete their age. Please see Table 9 overleaf.

Regardless of which definition of a mature student was used, that is, over 22 or over 26, the majority were defined as mature: 79 (75%) were over 22 and 62 (59%) were over 26. Hence, only 22 (21%) were 22 or under and 39 (37%) were 26 or under.

Six respondents were male (6%) and the majority, 99 (93%) were female. The age sex distribution is also shown in Table 9 overleaf.

| *Agegroup* | *Male Count* | *Female Count* | *Totals Count* |
|---|---|---|---|
| Age not specified | 0 | 4 | 4 |
| 20-29 years | 4 | 42 | 46 |
| 30-39 years | 2 | 33 | 35 |
| 40-49 years | 0 | 20 | 20 |
| Total | 6 | 99 | 105 |

**Table 9. The age sex distribution: total numbers.**

Just under half the respondents were single (Table 10.)

| *Marital status* | *Count/Percent* |
|---|---|
| Married | 37 (35%) |
| Single | 50 (48%) |
| Divorced | 10 (10%) |
| Widowed | 2 (2%) |
| Other | 5 (5%) |
| Total | 104 (99%)* |

* 1 missing (1%)

**Table 10. Marital Status.**

Just over the majority had a part-time job (Table 11).

| *Currently have a part-time job* | *Count/Percent* |
|---|---|
| Yes | 55 (52%) |
| No | 48 (46%) |
| Total | 103 (98%) * |

* 2 missing (2%)

**Table 11. Part-time job.**

Just under the majority had previously worked as a HCA (Table 12 overleaf).

| *Worked as Health Care Assistant prior to commencing nurse training* | *Count/Percent* |
|---|---|
| Yes | 48 (46%) |
| No | 55 (52%) |
| Total | 103 (98%) * |

* 2 missing (2%)

**Table 12. Previously worked as Health Care Assistant.**

The participants were asked to complete their first diet grades for the year 1 and year 2 assignments/assessments. There were high percentages of missing data in this section of the questionnaire, particularly in the year 1 data. In Table 13 the percentage of missing data for year 1 ranged from 26% to 39%. In Table 14 the percentage of missing data for year 2 was better and ranged from 19% to 23%.

The results for three participants in Table 13 and two in Table 14 were coded as errors because they completed different assignments to those listed in the questionnaire. This was due, for example, to a participant transferring in from another institution. These results are not shown in these tables.

| *Year 1 Assess* | *A Count/ Percent* | *B1 Count/ Percent* | *B2 Count/ Percent* | *C Count/ Percent* | *D Count/ Percent* | *E Count/ Percent* | *Pass* Count/ Percent* | *Fail* Count/ Percent* | *Missing Count/ Percent* |
|---|---|---|---|---|---|---|---|---|---|
| **F.Skills** | 24 (23%) | 20 (19%) | 5 (5%) | 5 (5%) | 0 (0%) | 0 (0%) | 7 (7%) | - | 41 (39%) |
| **CD/CM** | 19 (18%) | 25 (24%) | 10 (10%) | 12 (11%) | 0 (0%) | 1 (1%) | 2 (2%) | - | 33 (31%) |
| **DOH** | Assignment marked pass or fail. | | | | | | | | |
| **PPD** | 17 (16%) | 19 (18%) | 15 (14%) | 15 (14%) | 2 (2%) | 0 (0%) | 3 (3%) | 1 (1%) | 30 (29%) |
| **PC1** | 12 (11%) | 3 (3%) | 3 (3%) | 0 (0%) | 0 (0%) | 0 (0%) | 47 (45%) | - | 38 (36%) |
| **PC2** | Assignment marked pass or fail. | | | | | | | | |
| **CA1** | 14 (13%) | 3 (3%) | 3 (3%) | 0 (0%) | 0 (0%) | 0 (0%) | 45 (43%) | 1 (1%) | 37 (35%) |
| **CA2-Oral Exam** | 21 (20%) | 8 (8%) | 5 (5%) | 2 (2%) | 0 (0%) | 0 (0%) | 40 (38%) | 0 (0%) | 27 (26%) |

* Participants who wrote either pass or fail instead of a grade.

F.Skills - Foundation Skills, CD/CM - Care Delivery and Care Management, DOH - Dimensions of Health, PPD - Personal and Professional Development, PC1 and 2 - Primary Care Assignments 1 and 2, CA 1 and 2 - Further assignments related to Clinical Placements.

**Table 13. Academic achievements during year 1 of nurse training.**

Neither of the year 1 clinical assessments at this time carried academic points. All of the above were theory based assignments.

| *Year 2 Assess* | *A Count/ Percent* | *B1 Count/ Percent* | *B2 Count/ Percent* | *C Count/ Percent* | *D Count/ Percent* | *E Count/ Percent* | *Pass* Count/ Percent* | *Fail* Count/ Percent* | *Missing Count/ Percent* |
|---|---|---|---|---|---|---|---|---|---|
| Core Skills | 38 (36%) | 21 (20%) | 15 (14%) | 7 (7%) | 0 (0%) | 0 (0%) | 1 (1%) | 0 (0%) | 21 (20%) |
| HT1 | 35 (33%) | 30 (29%) | 10 (10%) | 10 (10%) | 0 (0%) | 0 (0%) | 2 (2%) | 0 (0%) | 22 (21%) |
| HT2 | 21 (20%) | 23 (22%) | 20 (19%) | 14 (13%) | 1 (1%) | 0 (0%) | 3 (3%) | 1 (1%) | 20 (19%) |
| PPD | 14 (13%) | 13 (12%) | 16 (15%) | 36 (34%) | 1 (1%) | 0 (0%) | 1 (1%) | 1 (1%) | 21 (20%) |
| CA1 | 71 (68%) | 3 (3%) | 3 (3%) | 0 (0%) | 0 (0%) | 0 (0%) | 1 (1%) | 0 (0%) | 24 (23%) |
| CA2 | 56 (53%) | 12 (11%) | 3 (3%) | 5 (5%) | 0 (0%) | 0 (0%) | 2 (2%) | 0 (0%) | 24 (23%) |
| Oral Exam 1 | 40 (38%) | 20 (19%) | 11 (11%) | 8 (8%) | 0 (0%) | 0 (0%) | 3 (3%) | 0 (0%) | 21 (20%) |
| Oral Exam 2 | 17 (16%) | 15 (14%) | 23 (22%) | 21 (20%) | 2 (2%) | 0 (0%) | 3 (3%) | 1 (1%) | 21 (20%) |

* Participants who wrote either pass or fail instead of a grade.

HT1 - Health Targets 1, HT2 - Health Targets 2, PPD - Personal and Professional Development, CA1 and 2 -Clinical Placement Assessments 1 and 2.

**Table 14. Academic achievements during year 2 of nurse training.**

The two second year clinical placement assessments now carried academic points.

In the above table it can be seen that these two clinical placement assessments: CA1 and CA2 are the only two assessments for which the majority of students achieved 'A' passes. These were grades given by clinical mentors.

All of the above sections of the questionnaire were poorly completed. However, the results for the first four modules in each of Tables 13 and 14 are published on notice boards. The year 2 results only are summarised in Table 15 for comparison. These give a more accurate reflection of the academic achievement of this cohort including the number of academic fails. These data are based on 116-120 students: the total

number of students to complete these year 2 assignments at first diet. A small number of extensions are excluded from these figures (n = 7 max.). The data in Table 15 cannot be related to any individual study data.

Year 1 results are not shown because these included Adult and Mental Health branch students. These groups could not be separated from each other based on the published lists available.

| | *A* *Count/ Percent* | *B1* *Count/ Percent* | *B2* *Count/ Percent* | *C* *Count/ Percent* | *D* *Count/ Percent* | *E* *Count/ Percent* | *Totals* |
|---|---|---|---|---|---|---|---|
| **Core Skills** | 48 (41%) | 31 (27%) | 30 (26%) | 6 (5%) | 1 (1%) | 0 (0%) | 116 |
| **HT1** | 37 (31%) | 33 (28%) | 27 (23%) | 14 (12%) | 9 (8%) | 0 (0%) | 120 |
| **HT2** | 18 (16%) | 24 (21%) | 33 (29%) | 29 (25%) | 9 (8%) | 3 (3%) | 116 |
| **PPD** | 16 (14%) | 16 (14%) | 27 (23%) | 38 (33%) | 14 (12%) | 5 (4%) | 116 |

**Table 15. Published year 2 results for main study cohort.**

These student nurses performed well in their Core Skills exams. This exam assesses the students' theoretical knowledge of core clinical skills as the name of the module suggests e.g. intravenous infusions, catheterisation and drug administration. The higher number of good passes in this assessment also perhaps suggests these students are more clinically orientated.

Participants were asked to give details of their academic qualifications. Thirty eight participants (36%) did not complete this section. The 67 participants to complete this section had a wide range of qualifications.

Fifty seven (85%) reported having between one and eight 'O' or Standard grades. Of these 40 (70%) reported having five or more. This is the minimum requirement for entry into nursing based on formal educational qualifications.

Thirty four participants (51%) out of the 67 who completed this section reported that they had between one and six 'Highers'. The majority had one or two. Fifteen (22%) had three or more. Ten (15%) participants reported having four or more Highers. Four is the approximate entrance qualifications for pre-registration nursing in traditional universities.

A summary of the highest qualification for participants who completed this section is given in Table 16 overleaf. These have to be interpreted with caution. The students had a wide variety of qualifications, particularly the mature students, making it difficult to determine, on occasions, what was the highest one. The Scottish Credit and Qualifications Framework (SCQF, no date) was used to attempt to determine the highest qualification. This states that standard grades may be at foundation, general or credit level. Foundation level is the lowest standard grade. However, students were not asked, nor did they distinguish between these three levels. Intermediate 1 is equivalent to general standard grade, which is equivalent to SVQ 1. Intermediate 2 is equivalent to credit standard grade, which is also equivalent to SVQ 2. SVQ 3 is equivalent to a higher grade. Finally advanced Highers are equivalent to Higher National Certificate. In addition a small number of mature applicants had Access qualifications. These courses are increasingly provided by a wide variety of colleges to increase access to HE (UCAS, no date). The SCQF guidelines refer to Access courses as being one year National Certificate (NC) courses. Hence, NCs would appear to be equivalent to Access using this definition and would increase the number of students classified as Access students in this study.

| *Highest Qualification* | *Count/Percent* |
|---|---|
| Degree | 2 |
| HND | 3 |
| HNC | 12 |
| 1 Advanced Higher | 1 |
| Three or more Highers | 12 |
| Two Highers | 4 |
| One Higher | 9 |
| SVQ Level 3 | 3 |
| Four Intermediates | 2 |
| Eight O/Standard Grades | 2 |
| Five to seven O/Standard Grades | 3 |
| Four or less O/Standard Grades | 2 |
| SVQs Level 2 | 1 |
| DC Test | 2 |
| ACCESS to Nursing | 6 |
| NC, NVQs or Scotvecs | 3 |

**Table 16. Highest Qualification.**

The majority of participants were first generation students at a university (Table 17).

| *Anyone in immediate family previously studied for a degree in any subject* | *Count/Percent* |
|---|---|
| Yes | 35 (33%) |
| No | 66 (63%) |
| Total | 101 (96%)* |

* 4 missing (4%)

**Table 17. Participants who had an immediate family member who had previously studied for a degree in any subject.**

Just under the majority had dependent children living with them (Table 18 overleaf).

| *Dependent children living with participant* | *Count/Percent* |
|---|---|
| Yes | 45 (43%) |
| No | 58 (55%) |
| Total | 103 (98%)* |

* 2 missing (2%)

**Table 18. Dependent children living at home with participant.**

Finally participants were asked if they had dependent relatives living with them. The majority did not (Table 19).

| *Dependent relatives living with participant* | *Count/Percent* |
|---|---|
| Yes | 10 (10%) |
| No | 93 (89%) |
| Total | 103 (98%)* |

* 2 missing (2%)

**Table 19. Dependent relatives living at home with participant.**

### 5.4. Attitudes to obtaining a degree

The participants were asked to indicate the level of agreement with 22 statements, which measured attitudes towards obtaining a degree. Table 20 overleaf provides the frequency and percentage of answers for each statement. One hundred and three people completed every statement. One person missed one statement. One further participant omitted the scale completely.

Twenty one of these statements were used in the pilot and retest and the remaining one was added as a result of evaluation of the students' responses of the pilot questionnaire as detailed on page 93.

| *STATEMENT* | *Strongly Agree* *Count/ Percent* | *Somewhat Agree* *Count/ Percent* | *Undecided* *Count/ Percent* | *Somewhat Disagree* *Count/ Percent* | *Strongly Disagree* *Count/ Percent* |
|---|---|---|---|---|---|
| 1. Will help nurses develop their career | 36 (34%) | 40 (38%) | 18 (17%) | 7 (7%) | 3 (3%) |
| 2. Will help nurses consider jobs outside nursing | 34 (32%) | 37 (35%) | 26 (25%) | 4 (4%) | 3 (3%) |
| 3. Will increase self confidence | 40 (38%) | 44 (42%) | 18 (17%) | 2 (2%) | 0 (0%) |
| 4. Will increase knowledge | 47 (45%) | 45 (43%) | 9 (9%) | 3 (3%) | 0 (0%) |
| 5. Will be more satisfying than obtaining a nursing diploma | 36 (34%) | 40 (38%) | 10 (10%) | 10 (10%) | 8 (8%) |
| 6. Ought to be essential for all student nurses | 11 (11%) | 15 (14%) | 30 (29%) | 24 (23%) | 23 (22%) |
| 7. Ought to be essential for all nurses | 10 (10%) | 16 (15%) | 30 (29%) | 26 (25%) | 22 (21%) |
| 8. Will make nurses better at their jobs | 3 (3%) | 13 (12%) | 22 (21%) | 36 (34%) | 30 (29%) |
| 9. Will increase professional status | 34 (32%) | 34 (32%) | 20 (19%) | 10 (10%) | 6 (6%) |
| 10. Will improve the patient care provided by nurses | 4 (4%) | 13 (12%) | 23 (22%) | 35 (33%) | 29 (28%) |
| 11. Is what employers of nurses want | 10 (10%) | 23 (22%) | 50 (48%) | 11 (11%) | 10 (10%) |

cont'd overleaf

| *STATEMENT* | *Strongly Agree* *Count/ Percent* | *Somewhat Agree* *Count/ Percent* | *Undecided* *Count/ Percent* | *Somewhat Disagree* *Count/ Percent* | *Strongly Disagree* *Count/ Percent* |
|---|---|---|---|---|---|
| 12. Is essential to be a good nurse | 3 (3%) | 4 (4%) | 5 (5%) | 37 (35%) | 55 (52%) |
| 13. Is easier as a student nurse because in studying mode | 21 (20%) | 31 (30%) | 24 (23%) | 16 (15%) | 12 (11%) |
| 14. Will make nursing a more attractive career option if becomes essential | 5 (5%) | 18 (17%) | 38 (36%) | 25 (24%) | 18 (17%) |
| 15. Will be easier as a student nurse than post registration | 20 (19%) | 25 (24%) | 35 (33%) | 14 (13%) | 10 (10%) |
| 16. Will increase choice of nursing jobs | 13 (12%) | 34 (32%) | 34 (32%) | 13 (12%) | 10 (10%) |
| 17. Is an excellent opportunity as a student nurse | 50 (48%) | 35 (33%) | 14 (13%) | 1 (1%) | 4 (4%) |
| 18. Should be recognised on the Nursing and Midwifery Council (NMC) Register | 39 (37%) | 26 (25%) | 28 (27%) | 6 (6%) | 5 (5%) |
| 19. Should mean higher pay than for nurses with a diploma | 30 (29%) | 25 (24%) | 21 (20%) | 14 (13%) | 14 (13%) |
| 20. Is necessary to further a career in nursing | 21 (20%) | 32 (31%) | 30 (29%) | 11 (11%) | 10 (10%) |
| 21. Will be difficult for many nurses because they lack confidence in their academic ability | 21 (20%) | 47 (45%) | 25 (24%) | 7 (7%) | 4 (4%) |
| 22. Should only be offered to student nurses who achieve good grades for their assignments in years 1 and 2 | 17 (16%) | 14 (13%) | 31 (30%) | 29 (28%) | 13 (12%) |

**Table 20. Participants' responses to the attitude statements in the main study.**

The results for the 21 statements used in the pilot, retest and main study are shown in Table 21 overleaf for comparison. These demonstrate a fairly consistent response set.

| *STATEMENT* | *Method* | *Strongly Agree* *Percent* | *Somewhat Agree* *Percent* | *Undecided* *Percent* | *Somewhat Disagree* *Percent* | *Strongly Disagree* *Percent* |
|---|---|---|---|---|---|---|
| 1. Will help nurses develop their career | Pilot | 42% | 44% | 11% | 2% | 0% |
| | Retest | 31% | 59% | 10% | 0% | 0% |
| | Main | 34% | 38% | 17% | 7% | 3% |
| 2. Will help nurses consider jobs outside nursing | Pilot | 36% | 33% | 29% | 2% | 0% |
| | Retest | 33% | 46% | 15% | 3% | 3% |
| | Main | 32% | 35% | 25% | 4% | 3% |
| 3. Will increase self confidence | Pilot | 49% | 40% | 4% | 7% | 0% |
| | Retest | 28% | 54% | 5% | 8% | 5% |
| | Main | 38% | 42% | 17% | 2% | 0% |
| 4. Will increase knowledge | Pilot | 47% | 38% | 11% | 2% | 2% |
| | Retest | 28% | 39% | 23% | 8% | 3% |
| | Main | 45% | 43% | 9% | 3% | 0% |
| 5. Will be more satisfying than obtaining a nursing diploma | Pilot | 40% | 38% | 7% | 9% | 7% |
| | Retest | 28% | 39% | 15% | 13% | 5% |
| | Main | 34% | 38% | 10% | 10% | 8% |
| 6. Ought to be essential for all student nurses | Pilot | 4% | 11% | 40% | 16% | 29% |
| | Retest | 5% | 18% | 41% | 15% | 21% |
| | Main | 11% | 14% | 29% | 23% | 22% |
| 7. Ought to be essential for all nurses | Pilot | 2% | 24% | 40% | 16% | 18% |
| | Retest | 10% | 13% | 44% | 18% | 15% |
| | Main | 10% | 15% | 29% | 25% | 21% |
| 8. Will (not) make nurses better at their jobs | Pilot (not) | 36% | 33% | 11% | 18% | 2% |
| | Retest | 0% | 10% | 13% | 46% | 31% |
| | Main | 3% | 12% | 21% | 34% | 29% |

cont'd overleaf

| *STATEMENT* | *Method* | *Strongly Agree* *Percent* | *Somewhat Agree* *Percent* | *Undecided* *Percent* | *Somewhat Disagree* *Percent* | *Strongly Disagree* *Percent* |
|---|---|---|---|---|---|---|
| 9. Will increase professional status | Pilot | 29% | 36% | 29% | 7% | 0% |
| | Retest | 31% | 33% | 26% | 10% | 0% |
| | Main | 32% | 32% | 19% | 10% | 6% |
| 10. Will improve the patient care provided by nurses | Pilot | 2% | 13% | 20% | 33% | 31% |
| | Retest | 3% | 13% | 13% | 46% | 26% |
| | Main | 4% | 12% | 22% | 33% | 28% |
| 11. Is what employers of nurses want | Pilot | 16% | 42% | 29% | 11% | 2% |
| | Retest | 23% | 41% | 33% | 3% | 0% |
| | Main | 10% | 22% | 48% | 11% | 10% |
| 12. Is essential to be a good nurse | Pilot | 0% | 0% | 9% | 47% | 44% |
| | Retest | 0% | 3% | 18% | 31% | 49% |
| | Main | 3% | 4% | 5% | 35% | 52% |
| 13. Is easier as a student nurse because in studying mode. | Pilot | 31% | 44% | 11% | 13% | 0% |
| | Retest | 15% | 46% | 21% | 13% | 5% |
| | Main | 20% | 30% | 23% | 15% | 11% |
| 14. Will make nursing a more attractive career option if becomes essential | Pilot | 7% | 22% | 27% | 31% | 13% |
| | Retest | 10% | 26% | 26% | 21% | 18% |
| | Main | 5% | 17% | 36% | 24% | 17% |
| 15. Will be easier as a student nurse than post registration | Pilot | 27% | 31% | 20% | 20% | 2% |
| | Retest | 18% | 26% | 36% | 13% | 8% |
| | Main | 19% | 24% | 33% | 13% | 10% |
| 16. Will increase choice | Pilot | 24% | 36% | 18% | 22% | 0% |
| | Retest | 18% | 46% | 26% | 8% | 3% |
| | Main | 12% | 32% | 32% | 12% | 10% |

cont'd overleaf

| *STATEMENT* | *Method* | *Strongly Agree* *Percent* | *Somewhat Agree* *Percent* | *Undecided* *Percent* | *Somewhat Disagree* *Percent* | *Strongly Disagree* *Percent* |
|---|---|---|---|---|---|---|
| 17. Is an excellent opportunity as a student nurse | Pilot | 58% | 31% | 11% | 0% | 0% |
| | Retest | 49% | 36% | 8% | 8% | 0% |
| | Main | 48% | 33% | 13% | 1% | 4% |
| 18. Should be recognised on the Nursing and Midwifery Council (NMC) Register. | Pilot | 49% | 27% | 18% | 7% | 0% |
| | Retest | 31% | 44% | 23% | 3% | 0% |
| | Main | 37% | 25% | 27% | 6% | 5% |
| 19. Should mean higher pay than for nurses with a diploma | Pilot | 38% | 16% | 29% | 13% | 4% |
| | Retest | 21% | 23% | 28% | 26% | 3% |
| | Main | 29% | 24% | 20% | 13% | 13% |
| 20. Is necessary to further a career in nursing | Pilot | 16% | 27% | 33% | 20% | 4% |
| | Retest | 15% | 36% | 26% | 15% | 8% |
| | Main | 20% | 31% | 29% | 11% | 10% |
| 21. Will be difficult for many nurses because they lack confidence in their academic ability | Pilot | 27% | 56% | 11% | 7% | 0% |
| | Retest | 26% | 44% | 15% | 15% | 0% |
| | Main | 16% | 13% | 30% | 28% | 12% |

**Table 21. Responses to attitude statements, based on Pilot (n=45), Retest (n=39) and Main Study (n=104).**

The majority of participants did not strongly agree with any one statement. The majority disagreed with one statement only. Fifty two per cent disagreed that obtaining a degree 'is essential to be a good nurse'.

Those who indicated they strongly or somewhat agreed and those who indicated they strongly or somewhat disagreed were added together.

The majority of student nurses AGREED with the following eleven statements (Table 22 overleaf) in descending order, that obtaining a degree:

| *Attitude Statement* | *Percent to agree with statement* |
|---|---|
| 1. Will increase knowledge | 89% |
| 2. Is an excellent opportunity as a student nurse | 82% |
| 3. Will increase self confidence | 81% |
| 4. Will be more satisfying than obtaining a nursing diploma | 73% |
| 5. Will help nurses develop their career | 73% |
| 6. Will help nurses consider jobs outside nursing | 68% |
| 7. Will increase professional status | 65% |
| 8. Will be difficult for many nurses because they lack confidence in their academic ability | 65% |
| 9. Should be recognised on the Nursing and Midwifery Council (NMC) Register. | 63% |
| 10. Should mean higher pay than for nurses with a diploma | 53% |
| 11. Is necessary to further a career in nursing | 51% |

**Table 22. The attitude statements the majority of students agreed with.**

Furthermore, most student nurses DISAGREED with the following three statements, in descending order, that obtaining a degree:

| *Attitude Statement* | *Percent to disagree with statement* |
|---|---|
| 1. Is essential to be a good nurse | 89% |
| 2. Will make nurses better at their jobs | 63% |
| 3. Will improve the patient care provided by nurses | 62% |

**Table 23. The attitude statements the majority of students disagreed with.**

The reliability of the scale in the pilot and retest were based on 21 statements only. Hence, only these items were included in the majority of the main study analysis for comparison.

The scoring was reversed so that the more positive the attitude the higher the score. As in the pilot, the item to total correlations were then checked using Cronbach's

Alpha. Please see Table 24 below. This was to reconfirm the reliability of the 21 scale. Only respondents who had completed all statements were included in this analysis (n=103). As in the pilot all items correlated positively.

| ***Attitude Statement*** | ***Item-Total Correlation*** | ***Alpha if Item Deleted*** |
|---|---|---|
| 1. Will help nurses develop their career | 0.5696 | 0.9069 |
| 2. Will help nurses consider jobs outside nursing | 0.3738 | 0.9110 |
| 3. Will increase self confidence | 0.3695 | 0.9108 |
| 4. Will increase knowledge | 0.4605 | 0.9094 |
| 5. Will be more satisfying than obtaining a nursing diploma | 0.6383 | 0.9051 |
| 6. Ought to be essential for all student nurses | 0.6416 | 0.9050 |
| 7. Ought to be essential for all nurses | 0.6453 | 0.9049 |
| 8. Will make nurses better at their jobs | 0.6483 | 0.9050 |
| 9. Will increase professional status | 0.6025 | 0.9060 |
| 10. Will improve the patient care provided by nurses | 0.6493 | 0.9049 |
| 11. Is what employers of nurses want | 0.5082 | 0.9082 |
| 12. Is essential to be a good nurse | 0.5112 | 0.9082 |
| 13. Is easier as a student nurse because in studying mode. | 0.5723 | 0.9068 |
| 14. Will make nursing a more attractive career option if becomes essential | 0.6546 | 0.9049 |
| 15. Will be easier as a student nurse than post registration | 0.6225 | 0.9055 |
| 16. Will increase choice of nursing jobs | 0.6100 | 0.9059 |
| 17. Is an excellent opportunity as a student nurse | 0.5377 | 0.9076 |
| 18. Should be recognised on the Nursing and Midwifery Council (NMC) Register | 0.6409 | 0.9051 |
| 19. Should mean higher pay than for nurses with a diploma | 0.5207 | 0.9085 |
| 20. Is necessary to further a career in nursing | 0.5184 | 0.9081 |
| 21. Will be difficult for many nurses because they lack confidence in their academic ability | 0.1446 | 0.9155 |

**Table 24. Attitude to obtaining a degree scale: Item-Total Correlations based on main study results.**

Cronbach's alpha for the whole scale was calculated also. This was excellent at 0.91. A summary of the reliability tests of the attitude scale, based on the 21 statements is provided in Table 25.

| ***Study Type*** | ***Cronbach's Alpha*** |
|---|---|
| Pilot | 0.88 (n= 43) * |
| Retest | 0.89 (n=39) * |
| Main | 0.91 (n=103) * |

* Only students who completed all 21 statements were included in the analysis

**Table 25. Summary of the reliability test results for the attitude to obtaining a degree scale.**

The mean attitude score for each participant was calculated by adding together the scores for the 21 statements, as described previously.

A histogram of the mean attitude scores with a normal curve superimposed is shown in Figure 3 overleaf.

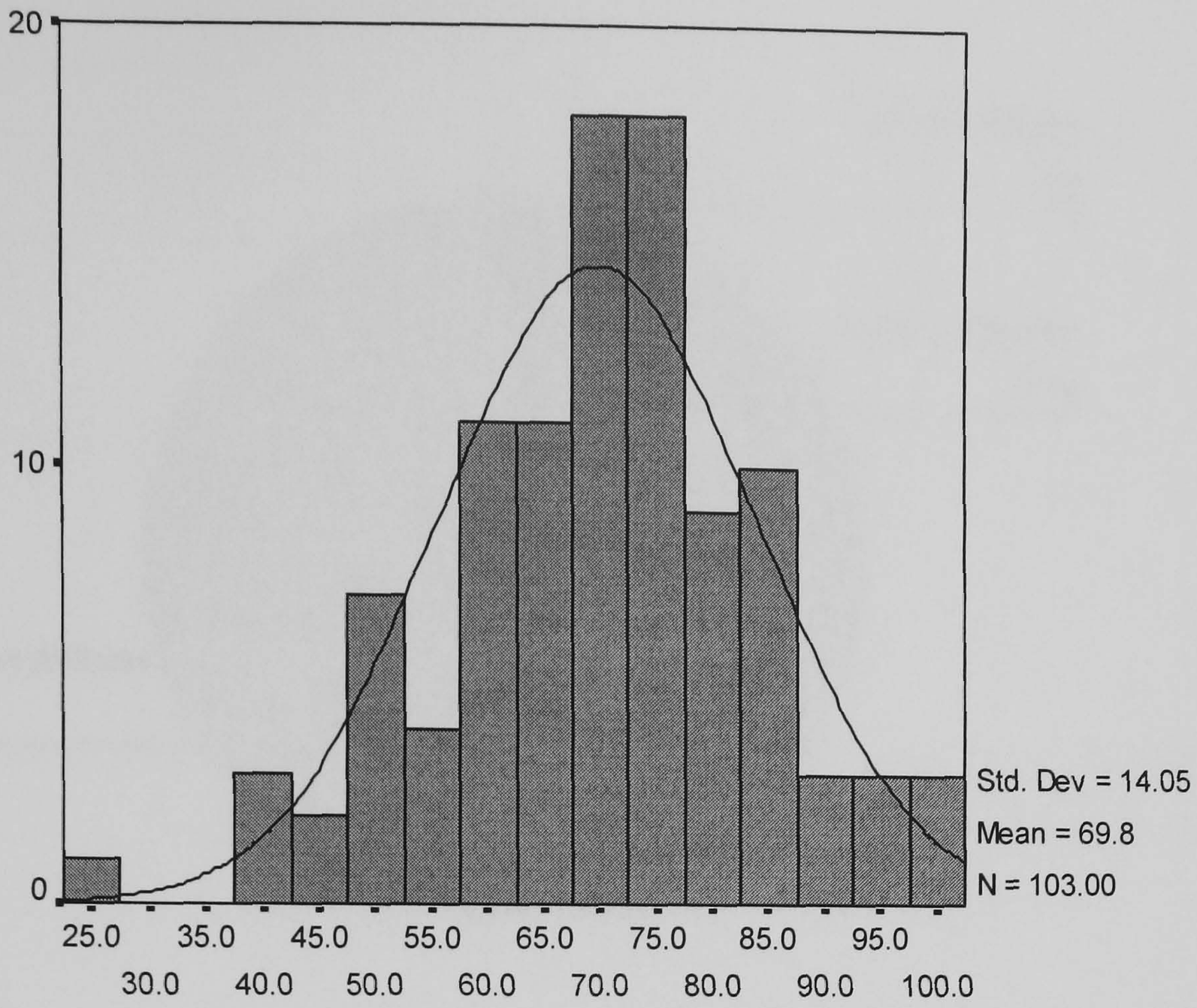


**Figure 3. Histogram of Attitude to obtaining a degree scores, with normal curve superimposed.**

The histogram (Figure 3) clearly demonstrates an approximate normal distribution. The mean attitude score for the sample was 69.8, s.d. 14.05 and range 27 to 101.

As previously discussed in the methods section, the mean score for the 21 attitude statements is 63 and is indicative of uncertain attitudes towards obtaining a degree. Twenty seven per cent of this sample recorded scores of less than the scale mean, 5% equal to, and 68%, that is, the majority scored above the scale mean. This suggests attitudes towards obtaining a degree were favourable amongst respondents (Figure 4 overleaf).

As this was a census, with an approximate normal distribution, it was possible to make inferences regarding a wider target population, that is, all third year student nurses within the school. The upper and lower 95% confidence intervals for the population attitude towards obtaining a degree mean score were 67.1 and 72.6.

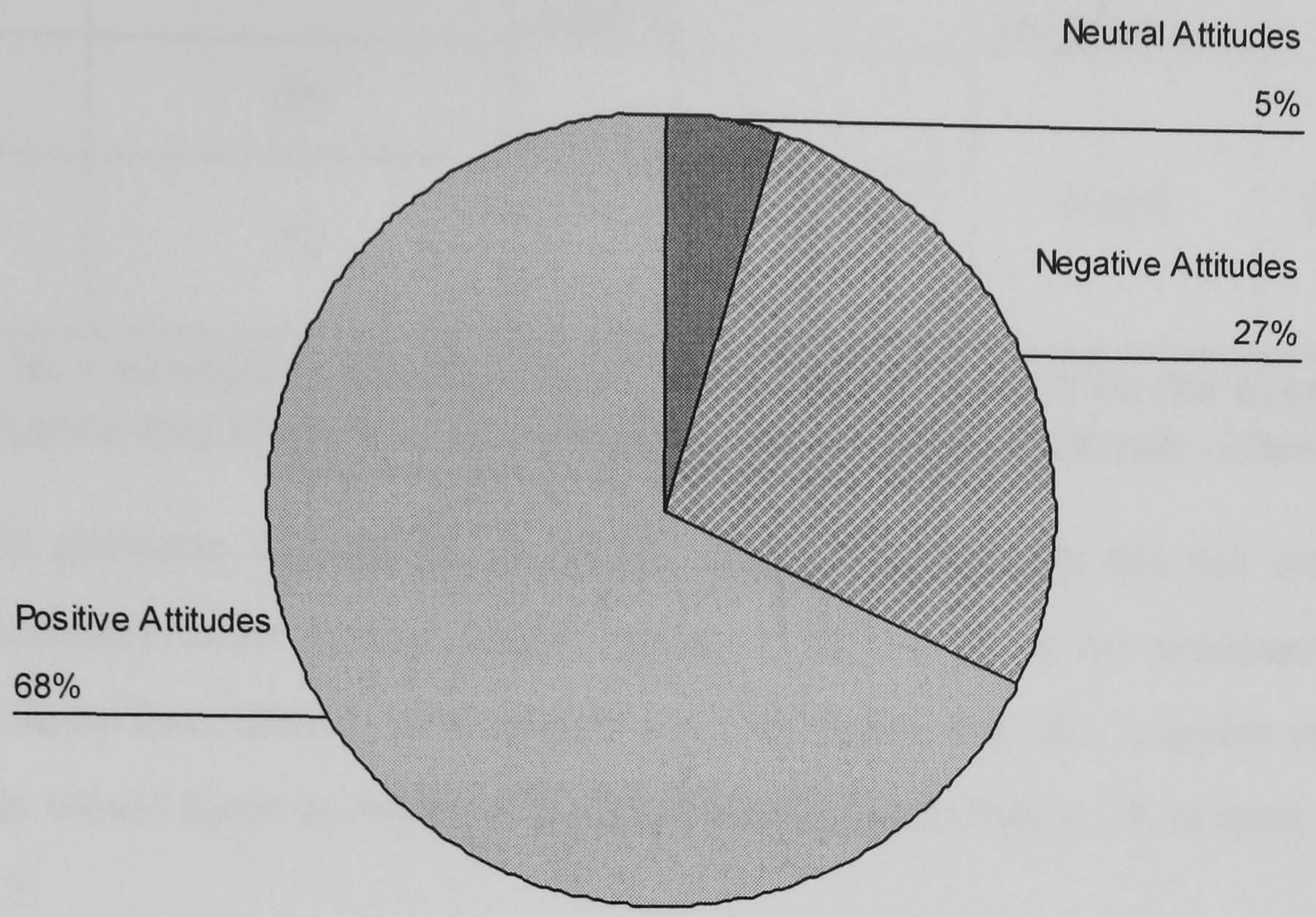


**Figure 4. Positive and negative attitudes towards obtaining a degree.**

### 5.4.1. Number of students to accept a place on the degree programme

The number of participants to accept a place on the degree programme was 76 (72%) and 29 (28%) did not. This was an indication of their intention to study for the degree, as they had not yet commenced study when the questionnaire was distributed.

In order to determine if students accepted transfer who previously would not have met the eligibility criteria, a code was created based on those who had completed four or more second year assignment grades in the questionnaire (n=77). Those who had met the previous criteria, that is four or more grades at B1 or above were compared to those who had not, using Pearson's correlation coefficient. Based on these criteria, nine participants would have previously been excluded from transfer. There was no significant relationship between meeting the previous eligibility criteria and accepting transfer or not. Please see Table 26 overleaf.

| | *Met previous academic criteria* | *Did not meet previous academic criteria* | *Pearson's correlation coefficient* | *p-value* |
|---|---|---|---|---|
| Accepted transfer | 56 | 7 | 0.038 | 0.742 |
| Did not accept transfer | 12 | 2 | | |

**Table 26. Correlation between those who accepted a place on the degree programme and those that did not based on previous academic criteria.**

However, in previous cohorts the academic clinical placements did not carry any academic currency, only the theoretical modules. Hence, again for comparison the results for these two clinical placements were excluded and the analysis repeated (n=74). This would have excluded a further 9 participants, that is 18 in total. Please see Table 27.

| | *Met previous academic criteria, excluding clinical placement grades* | *Did not meet previous academic criteria excluding clinical placement grades* | *Pearson's correlation coefficient* | *p-value* |
|---|---|---|---|---|
| Accepted transfer | 44 | 16 | -0.113 | 0.338 |
| Did not accept transfer | 12 | 2 | | |

**Table 27. Correlation between those who accepted a place on the degree programme and those that did not based on previous academic criteria and excluding grades for clinical assessments.**

Again, there was no significant relationship between meeting the eligibility criteria and accepting transfer or not.

The above demonstrates that a number of students accepted transfer who previously would not have been eligible.

### 5.4.2. Demographic differences between those who did or did not accept degree

The mean age for those who accepted a place on the degree programme was marginally lower 30 years s.d. 8.4 than those that did not 32 s.d. 8.2. This was not statistically significant p=0.770.

Using Pearson's correlation coefficient the differences between demographic variables and those to accept transfer or not were analysed. The only significant difference was based on the campus attended. Please see Table 28 overleaf. The complete statistical results for these tests are shown in Appendix 9.

In this analysis the highest qualification was used to allocate participants into three subgroups for comparison. This was based on the SCQF definitions. The three subgroups were:

- Group 1 - those who had an HE qualification or qualification defined as equivalent. This consisted of participants with degrees, HND, HNC and Advanced Highers (n=18).

- Group 2 - those who had a school based qualification at higher level or above, or qualification defined as equivalent. This consisted of participants with Highers and SVQ level 3 qualifications (n=28).

- Group 3 - This consisted of participants with all remaining qualifications (n=21).

| *Variable* | *No. of participants to accept* | *No. of participants to NOT accept* | *Total No. of participants* | *p-value* |
|---|---|---|---|---|
| **Age over 22** | 54 | 19 | 73 | 0.097 |
| **Age 22 and under** | 25 | 3 | 28 | |
| **Age over 26** | 43 | 30 | 73 | 0.413 |
| **Age 26 and under** | 19 | 9 | 28 | |
| **Male** | 4 | 2 | 6 | 0.719 |
| **Female** | 72 | 26 | 98 | |
| **Married** | 27 | 10 | 37 | 0.389 |
| **Single, divorced, widowed or other** | 49 | 18 | 67 | |
| **Have dependent children** | 28 | 17 | 45 | 0.386 |
| **Did not have dependent children** | 46 | 12 | 58 | |
| **Have dependent relatives** | 6 | 4 | 10 | 0.057 |
| **Did not have dependent relatives** | 68 | 25 | 93 | |
| **Have part-time job** | 41 | 14 | 55 | 0.676 |
| **Did not have part-time job** | 34 | 14 | 48 | |
| **Campus 1** | 43 | 7 | 50 | **0.003** |
| **Campus 2** | 33 | 22 | 55 | |
| **Previously worked as HCA** | 31 | 17 | 48 | 0.081 |
| **Did not previously work as HCA** | 44 | 11 | 55 | |
| **Highest Qualification** | | | | |
| **Group 1** | 15 | 3 | 18 | 0.250 |
| **Group 2** | 24 | 4 | 28 | |
| **Group 3** | 20 | 1 | 21 | |
| **Member of family previously studied for a degree** | 26 | 9 | 35 | 0.632 |
| **Member of family did not previously study for a degree** | 46 | 20 | 66 | |

**Table 28. Number of participants to accept or not based on demographic variables.**

In addition, correlations were also performed between those who did or did not accept transfer and the two year 2 clinical placement assessments and Core Skills exam results. This was to establish if there were any associations between accepting degree education and performance in clinical placements or skills exam. This was deemed important because the students appeared to perform better clinically than in

theory. Hence, did this make these students more or less likely to seek further theoretical knowledge. There were no significant associations. Please see Table 29.

| ***Correlation between assessments and accepting transfer to degree or not*** | ***Pearson's correlation coefficient*** | ***p-value*** |
|---|---|---|
| Year 2 clinical assessment – 1 | -0.026 | 0.822 |
| Year 2 clinical assessment – 2 | -0.023 | 0.838 |
| Core Skills exam | -0.096 | 0.391 |

**Table 29. Correlation between those who accepted a place on the degree programme and those that did not based on a selection of assignment results.**

### 5.4.3. Attitudes of students who did or did not accept a place on the degree programme

The mean attitude scores towards obtaining a degree were calculated based on those who did or did not accept transfer to the degree programme. There was a significant difference between the mean scores (74.1 s.d. 12.0) for those who accepted compared to those who did not (58.4 s.d. 12.8) $p = 0.000$.

The responses to the attitude statements based on those who accepted and those who did not are shown in Table 30. The associations between these responses were examined using Pearson's correlation coefficient. Sixteen out of the 22 responses were significantly different between the two groups. The Pearson's correlation coefficients are shown in Appendix 10.

| *STATEMENT* | *Strongly Agree* *Count/ Percent* | | *Somewhat Agree* *Count/ Percent* | | *Undecided* *Count/ Percent* | | *Somewhat Disagree* *Count/ Percent* | | *Strongly Disagree* *Count/ Percent* | | *p-value* |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Acc.** | **Not Acc.** | **Acc.** | **Not Acc.** | **Acc.** | **Not Acc.** | **Acc.** | **Not Acc.** | **Acc.** | **Not Acc.** | |
| 1. Will help nurses develop their career | 30 (40%) | 6 (21%) | 28 (37%) | 12 (41%) | 15 (20%) | 3 (10%) | 1 (1%) | 6 (21%) | 1 (1%) | 2 (7%) | **0.003** |
| 2. Will help nurses consider jobs outside nursing | 27 (36%) | 7 (24%) | 28 (37%) | 9 (31%) | 17 (23%) | 9 (31%) | 1 (1%) | 3 (10%) | 2 (3%) | 1 (3%) | 0.062 |
| 3. Will increase self confidence | 32 (43%) | 8 (28%) | 30 (40%) | 14 (48%) | 13 (17%) | 5 (17%) | 0 (0%) | 1 (3%) | 0 (0%) | 0 (0%) | 0.092 |
| 4. Will increase knowledge | 37 (49%) | 10 (35%) | 32 (43%) | 13 (45%) | 4 (5%) | 5 (17%) | 2 (3%) | 1 (3%) | 0 (0%) | 0 (0%) | 0.085 |
| 5. Will be more satisfying than obtaining a nursing diploma | 31 (41%) | 5 (17%) | 32 (43%) | 8 (28%) | 7 (9%) | 3 (10%) | 1 (3%) | 9 (31%) | 4 (5%) | 4 (14%) | **0.000** |
| 6. Ought to be essential for all student nurses | 9 (12%) | 2 (7%) | 14 (19%) | 1 (3%) | 22 (29%) | 8 (28%) | 16 (21%) | 8 (28%) | 14 (19%) | 9 (31%) | **0.035** |
| 7. Ought to be essential for all nurses | 9 (12%) | 1 (3%) | 14 (19%) | 2 (7%) | 22 (29%) | 8 (28%) | 17 (23%) | 9 (31%) | 13 (17%) | 9 (31%) | **0.017** |
| 8. Will make nurses better at their jobs | 3 (4%) | 0 (0%) | 13 (17%) | 0 (0%) | 18 (24%) | 4 (14%) | 24 (32%) | 12 (41%) | 17 (23%) | 13 (45%) | **0.001** |
| 9. Will increase professional status | 30 (40%) | 4 (14%) | 24 (32%) | 10 (35%) | 14 (19%) | 6 (21%) | 4 (5%) | 6 (21%) | 3 (4%) | 3 (10%) | **0.002** |
| 10. Will improve the patient care provided by nurses | 5 (5%) | 0 (0%) | 12 (16%) | 1 (3%) | 18 (24%) | 5 (17%) | 24 (32%) | 11 (38%) | 17 (23%) | 12 (41%) | **0.006** |
| 11. Is what employers of nurses want | 8 (11%) | 2 (7%) | 19 (25%) | 4 (14%) | 36 (48%) | 14 (48%) | 8 (11%) | 3 (10%) | 4 (5%) | 6 (21%) | **0.030** |
| 12. Is essential to be a good nurse | 2 (3%) | 1 (3%) | 4 (5%) | 0 (0%) | 5 (7%) | 0 (0%) | 26 (35%) | 11 (38%) | 38 (51%) | 17 (59%) | 0.270 |
| 13. Is easier as a student nurse because in studying mode | 19 (25%) | 2 (7%) | 31 (41%) | 0 (0%) | 15 (20%) | 9 (31%) | 5 (7%) | 11 (38%) | 5 (7%) | 7 (24%) | **0.000** |
| 14. Will make nursing a more attractive career option if becomes essential | 5 (7%) | 0 (0%) | 17 (23%) | 1 (3%) | 29 (39%) | 9 (31%) | 14 (19%) | 11 (38%) | 10 (13%) | 8 (28%) | **0.001** |
| 15. Will be easier as a student nurse than post registration | 17 (23%) | 3 (10%) | 24 (32%) | 1 (3%) | 22 (29%) | 13 (45%) | 7 (9%) | 7 (24%) | 5 (7%) | 5 (17%) | **0.001** |

cont'd overleaf

| *STATEMENT* | *Strongly Agree* *Count/ Percent* | | *Somewhat Agree* *Count/ Percent* | | *Undecided* *Count/ Percent* | | *Somewhat Disagree* *Count/ Percent* | | *Strongly Disagree* *Count/ Percent* | | *p-value* |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Acc.** | **Not Acc.** | **Acc.** | **Not Acc.** | **Acc.** | **Not Acc.** | **Acc.** | **Not Acc.** | **Acc.** | **Not Acc.** | |
| 16. Will increase choice of nursing jobs | 11 (15%) | 2 (7%) | 25 (33%) | 9 (31%) | 27 (36%) | 7 (24%) | 9 (12%) | 4 (14%) | 3 (4%) | 7 (24%) | **0.015** |
| 17. Is an excellent opportunity as a student nurse | 42 (56%) | 8 (28%) | 24 (32%) | 11 (38%) | 9 (12%) | 5 (17%) | 0 (0%) | 1 (3%) | 0 (0%) | 4 (14%) | **0.000** |
| 18. Should be recognised on the NMC Register | 35 (47%) | 4 (14%) | 22 (29%) | 4 (14%) | 16 (21%) | 12 (41%) | 1 (1%) | 5 (17%) | 1 (1%) | 4 (14%) | **0.000** |
| 19. Should mean higher pay than for nurses with a diploma | 29 (38%) | 1 (3%) | 20 (27%) | 5 (17%) | 14 (19%) | 7 (24%) | 10 (13%) | 4 (14%) | 2 (3%) | 12 (41%) | **0.000** |
| 20. Is necessary to further a career in nursing | 18 (24%) | 3 (10%) | 27 (36%) | 5 (17%) | 19 (25%) | 11 (38%) | 6 (8%) | 5 (17%) | 5 (7%) | 5 (17%) | **0.003** |
| 21. Will be difficult for many nurses because they lack confidence in their academic ability | 14 (19%) | 7 (24%) | 37 (49%) | 10 (35%) | 20 (27%) | 5 (17%) | 2 (3%) | 5 (17%) | 2 (3%) | 2 (7%) | 0.216 |
| 22. Should only be offered to student nurses who achieve good grades for their assignments in years 1 and 2 | 16 (21%) | 1 (3%) | 8 (11%) | 6 (21%) | 23 (31%) | 8 (28%) | 18 (24%) | 11 (38%) | 10 (13%) | 3 (10%) | 0.222 |

Acc.-Accept degree transfer and Not Acc.- Not accept degree transfer.

**Table 30. Attitude to obtaining a degree scale results based on those who did or did not accept transfer.**

Of the 76 who accepted, 43 out of 50 (86%) were from campus 1 and 33 out of 55 (60%) campus 2.

Of the 29, who did not accept (7 from campus 1 and 22 from campus 2):

- 21 (72%) planned to undertake a degree at a later date
- 4 (14%) did not
- 2 (7%) were undecided, and
- 2 (7%) did not complete this answer.

### 5.4.4. Subgroup comparisons of the mean scores for the attitude towards obtaining a degree scale based on demographic variables

The mean attitude scores based on subgroups are shown in Table 31 overleaf. Independent-samples t tests were used to test the significance of the results between each of the two sub-groups. A one-way analysis of variance was performed where three sub-groups existed.

Again the campus attended by students was the only significant difference found between subgroups. However, the mean attitude scores for each campus were both above the scale mean, indicating participants at both campuses had positive mean scores (Table 31 overleaf).

The demographics of the students at each campus were examined to try to explain the differences between the two sites. No significant differences were found using Pearson's correlation coefficient. Please see Appendix 11.

| *Variable* | *Number of participants* | *Total attitude scores Mean and s.d.* | *p-value* |
|---|---|---|---|
| **Age over 22** | 78 | 68.1 s.d. 14.1 | 0.083 |
| **Age 22 and under** | 21 | 74.0 s.d. 13.2 | |
| **Age over 26** | 61 | 68.3 s.d. 14.4 | 0.330 |
| **Age 26 and under** | 38 | 71.1s.d. 13.4 | |
| **Married** | 36 | 71.3 s.d. 15.1 | 0.445 |
| **Single, divorced, widowed or other** | 66 | 70.0 s.d. 13.6 | |
| **Have dependent children** | 44 | 68.32 s.d. 15.4 | 0.449 |
| **Did not have dependent children** | 57 | 70.5 s.d. 13.0 | |
| **Have part-time job** | 55 | 71.1 s.d. 14.2 | 0.264 |
| **Did not have part-time job** | 46 | 68.0 s.d. 14.1 | |
| **Campus 1** | 49 | 73.9 s.d. 12.3 | **0.004** |
| **Campus 2** | 54 | 66.1 s.d. 14.6 | |
| **Previously worked as HCA** | 47 | 69.8 s.d. 14.1 | 0.934 |
| **Did not previously work as HCA** | 54 | 69.6 s.d. 14.3 | |
| **Highest Qualification** | | | 0.864 |
| **Group 1** | 18 | 74.2 s.d. 13.7 | |
| **Group 2** | 27 | 73.0 s.d. 8.8 | |
| **Group 3** | 21 | 73.9 s.d. 12.6 | |
| **Member of family previously studied for a degree** | 35 | 72.4 s.d. 12.1 | 0.117 |
| **Member of family did not previously study for a degree** | 64 | 68.1 s.d. 14.7 | |

**Table 31. Attitude scale means based on demographic variables.**

## 5.5. The extent to which various factors influenced the decision to accept a place on the undergraduate degree programme.

The participants who accepted transfer to the degree programme were asked to tick how much 23 specific factors influenced their decision. The possible responses

ranged from: to a great, some or a little extent to not at all. The responses given by these 76 participants are shown in Table 32.

| ***Factors influencing decision to accept transfer to degree*** | ***To a great extent*** ***Percent*** | ***To some extent*** ***Percent*** | ***To a little extent*** ***Percent*** | ***Not at all*** ***Percent*** |
|---|---|---|---|---|
| To improve my clinical skills | 7% | 62% | 17% | 13% |
| For personal satisfaction | 74% | 24% | 1% | 1% |
| To improve patient care | 26% | 38% | 20% | 15% |
| Degree was funded | 75% | 17% | 4% | 4% |
| To increase my self confidence | 58% | 4% | 4% | 3% |
| In studying mode now | 61% | 34% | 4% | 1% |
| Feel motivated now | 45% | 41% | 9% | 5% |
| To increase my knowledge | 49% | 34% | 13% | 3% |
| No other commitments at present | 36% | 25% | 15% | 25% |
| Degree seen as gold standard | 22% | 38% | 30% | 8% |
| Excellent opportunity | 74% | 24% | 1% | 0% |
| To increase my professional competence | 37% | 47% | 8% | 7% |
| Confidence in my academic ability | 47% | 37% | 9% | 7% |
| To gain a higher academic award | 6% | 26% | 8% | 1% |
| Because employers want it | 17% | 42% | 18% | 22% |
| Can gain degree in 6 months rather than 2 years post registration | 76% | 20% | 4% | 0% |
| To enable me to consider jobs outside nursing | 20% | 12% | 28% | 40% |
| To enable me to consider a specific career pathway | 30% | 36% | 16% | 18% |
| Preferable to returning to study for a degree later in career | 70% | 15% | 12% | 4% |
| To enable me to consider a wider range of job opportunities in the future | 42% | 30% | 13% | 15% |
| To improve my job opportunities in the future | 47% | 36% | 11% | 7% |
| Modules offered were of particular interest* | 3% | 18% | 36% | 32% |
| Having a degree is the 'norm' | 4% | 29% | 24% | 43% |

* 9 (12%) participants missed this question out.

**Table 32. Factors influencing decision to accept transfer to degree.**

The majority of student nurses felt that the following factors influenced their decision to accept by a great extent, in descending order (Table 33).

| ***Factors influencing decision to accept transfer to degree*** | ***To a great extent Percent*** |
|---|---|
| Can gain degree in 6 months rather than 2 years post registration | 76% |
| Degree was funded | 75% |
| For personal satisfaction | 74% |
| Excellent opportunity | 74% |
| Preferable to returning to study for a degree later in career | 70% |
| To gain a higher academic award | 65% |
| To increase my self confidence | 58% |

**Table 33. Factors influencing decision to accept transfer to degree to a great extent in descending order.**

These appeared to relate to two main themes: personal and 'ease of obtaining a degree'.

Participants were also asked to choose three main factors which influenced their decision most to accept a place on the undergraduate degree programme from all 24 factors listed, including the 'other' option. These were not ranked. The three top factors were:

1. For personal satisfaction
2. Because the degree was funded, and
3. Because could gain degree in 6 months rather than 2 years post registration

These corresponded and further validated the findings presented in Table 33 above. Four respondents added four 'other' factors which influenced their decision to accept. These had similar themes to the above and related to: it was expected, because of mature age, to make it easier to look for jobs and higher pay.

## 5.6. The extent to which the possible factors influenced the decision to NOT accept a place on the degree programme

Respondents were asked to tick how much specific factors influenced their decision to NOT accept a place on the degree programme. Again the possible responses ranged from: to a great, some or a little extent to not at all. The 29 responses to each of the 23 statements are summarised in Table 34.

| *Factors influencing decision to NOT accept transfer to degree* | *To a great extent* *Percent* | *To some extent* *Percent* | *To a little extent* *Percent* | *Not at all* *Percent* |
|---|---|---|---|---|
| Lack of confidence in my academic ability | 3% | 38% | 14% | 45% |
| A degree will not enhance my clinical skills | 28% | 28% | 17% | 21% |
| Lack of motivation | 14% | 10% | 28% | 45% |
| Some modules taught some distance away | 10% | 17% | 14% | 59% |
| Lack of clinical experience | 21% | 21% | 24% | 35% |
| Lack of knowledge to complete degree | 3% | 21% | 10% | 62% |
| Financial commitments | 24% | 21% | 21% | 35% |
| Employment commitments | 10% | 14% | 10% | 62% |
| Combined pressures of academic workload, family & work commitments | 79% | 14% | 3% | 3% |
| Found previous assignments difficult | 7% | 35% | 24% | 35% |
| Choice of modules did not interest me | 10% | 35% | 17% | 38% |

cont'd overleaf

| *Factors influencing decision to NOT accept transfer to degree* | *To a great extent*<br><br>*Percent* | *To some extent*<br><br>*Percent* | *To a little extent*<br><br>*Percent* | *Not at all*<br><br>*Percent* |
|---|---|---|---|---|
| Too stressful | 62% | 24% | 10% | 3% |
| Did not like type of assessments for degree modules | 28% | 24% | 28% | 21% |
| Want to gain more post registration clinical experience first | 62% | 21% | 3% | 10% |
| Want to concentrate on clinical experience before registration | 59% | 24% | 3%) | 14% |
| Too much extra academic study in final 6 months | 69% | 14% | 10% | 7% |
| Want time to gain confidence in final clinical placements | 69% | 17% | 3% | 10% |
| Want to undertake further study for a degree at a later date | 69% | 17% | 3% | 10% |
| No specific career plan for which a degree will be useful | 17% | 17% | 24% | 35% |
| Want to concentrate on improving theoretical knowledge in final placements | 62% | 28% | 0% | 10% |
| Want to concentrate on improving clinical skills in final placements | 72% | 17% | 0% | 10% |
| Want to study for a degree relevant to specialist area after registration | 55% | 24% | 7% | 10% |
| Did not wish to change to a new personal tutor for degree modules | 3% | 10% | 10% | 72% |

**Table 34. Factors influencing the decision to NOT accept transfer to degree.**

The majority of student nurses felt that the following factors influenced their decision to NOT accept by a great extent, in descending order (Table 35 overleaf).

| *Factors influencing decision to NOT accept transfer to degree* | *To a great extent*<br><br>*Percent* |
|---|---|
| Combined pressures of academic workload, family & work commitments | 79% |
| Want to concentrate on improving clinical skills in final placements | 72% |
| Too much extra academic study in final 6 months | 69% |
| Want time to gain confidence in final clinical placements | 69% |
| Want to concentrate on improving theoretical knowledge in final placements | 62% |
| Too stressful | 62% |
| Want to gain more post registration clinical experience first | 62% |
| Want to concentrate on clinical experience before registration | 59% |
| Want to study for a degree relevant to specialist area after registration | 55% |

**Table 35. Factors influencing the decision to NOT accept transfer to degree to a great extent in descending order.**

These appeared to relate to two main themes: stress and 'maximising final clinical placement'.

Participants were asked to choose the three main factors which influenced their decision most to NOT accept a place on the undergraduate degree programme from all 24 factors listed. These were not ranked. The three top factors were:

1. Combined pressures of academic workload, family & work commitments
2. Too much extra academic study in final 6 months
3. Too stressful

These again corresponded fairly closely with the findings presented in Table 35 above.

Twenty three respondents suggested a number of further factors, which also influenced their decision. These had similar themes to the above and related to: lack of motivation, wishing to do degree in specialist area once settled in job, wished to gain confidence first, personal commitments, to enjoy last year with no exams, felt crammed into six months and finally, if younger.

Participants who did not accept were also asked if there were any factors, which might have changed their mind to accept a place on the degree programme. Thirteen participants responded to this question. The responses ranged from choosing after year 3 diploma assignments were marked, did not like assignments for degree, if could give up part time job, if it was a four year course and mandatory, too much work when it can be done later, more relevant assignments for a newly qualified staff nurse and finally if there were not extenuating personal circumstances.

## 5.7. Outcomes of participants involved in this research

When this research began only students who met specific academic criteria were offered transfer onto the degree programme. This resulted in 37% of the student nurses involved in the study graduating with a degree. Please see Table 36 overleaf based on the published graduation ceremony results (University of Paisley, 2004). This did not reach the 80% target set by the university.

By the time the pilot and main study took place, all students were offered transfer. This resulted in a larger percentage initially indicating they wished to transfer. However, from the cohort who participated in the pilot, only a similar percentage to when the restricted policy was in place actually graduated with a degree, the remainder withdrawing from the degree programme either before or during the programme.

The numbers to graduate with a degree for the cohort who participated in the main study are based on the figures available in late August 2005. However, these figures

are slightly misleading because 9 students appear to have not been present on the day the research was carried out and therefore missing from the original denominator. The official number to originally accept transfer was 84 out of 122. Thus 38 students remained on the diploma programme. However, the denominator has subsequently reduced and 117 now remain on target to complete their pre-registration nurse education. Please see Table 36 below.

The trend again is that a number of students have withdrawn from the degree programme. Anecdotal evidence has suggested that these withdrawals were for academic reasons. This is an area requiring more detailed study at a later date and is discussed further in the next chapter. Nevertheless, this demonstrates that the attitudes of a number of the participants matched their initial intentions but ultimately did not determine their behaviour to achieve a degree. It would seem other factors subsequently intervened.

| ***Study populations*** | | | | | ***Cohort populations*** | | |
|---|---|---|---|---|---|---|---|
| ***Study*** | ***Sample Total*** ***Count*** | ***Not eligible*** ***Count/ Percent*** | ***Accepted transfer*** ***Count/ Percent*** | ***Not accepted transfer*** ***Count/ Percent*** | ***Number of students receiving academic awards*** ***Count*** | ***Outcomes of training: Diploma*** ***Count/ Percent*** | ***Outcomes of training: Degree*** ***Count/ Percent*** |
| **Instrument Development** (1 campus only) | 44 | 17 (39%) | 18 (41%) | 9 (21%) | 52 | 33 (64%) | 19 (37%) |
| **Pilot** (1 campus only) | 45 | N/A | 38 (84%) | 7 (16%) | 41 | 24 (58%) | 17 (41%) |
| **Main** (2 campuses) | 105 | N/A | 76 (72%) | 29 (28%) | 117 Based on figures available in late August 2005 | 57 (49%) on target for Nov 2005 | 60 (51%) on target for Nov 2005 |

**Table 36. Outcomes of cohorts involved in this research.**

# CHAPTER SIX: DISCUSSION

## 6.1. Introduction

This final chapter discusses the key findings of the main study and where appropriate the pilot and retest data are referred to also. Finally, the studies limitations, lessons learned, recommendations and implications for future research are discussed.

In doing so this research provides the first comprehensive analysis of student nurses' attitudes towards obtaining a degree. This in turn adds the student nurses' voice to the current debate on a move to an all graduate profession. In addition, this research proposes a comprehensive SNEDS to make such research easier to perform in the future.

The student nurse population involved in this study were typical of student nurses, particularly in the new universities i.e. the majority were female, mature and worked part-time. This suggests the findings of this study may also be generalisable to a wider student nurse population. This is important as many more universities in the future may be offering similar degree transfer systems to their student nurses.

It is hoped therefore that the results of this study will help other institutions understand the attitudes of students to obtaining a degree and the factors promoting or impeding this. In addition, it is hoped this study will provide useful information for educators to develop more effective promotional campaigns for degree transfer programmes. However, as was noted in previous chapters, the entrance gates into nursing vary widely and the courses provided vary widely and hence any generalisations must be interpreted with caution.

## 6.2. Discussion of main findings

The study aim was to identify the factors promoting or impeding pre-registration nursing education at degree level at a large School of Nursing offering both diploma and degree programmes. This was met by three objectives. Each objective is discussed in turn to determine how well each was met by this study.

## 6.3. Objective 1: to carry out a questionnaire survey which would collect data on why students accepted or declined transfer from diploma to degree programmes.

This study involved the development and testing of a questionnaire to collect data on why student nurses accepted or declined transfer from diploma to degree programmes. This included the development of an attitude towards obtaining a degree scale. The development of the questionnaire, particularly the attitude scale was extensive, as detailed in previous chapters. This helped to maximise the reliability and validity of the questionnaire and in particular the attitude scale. The pilot work highlighted where a number of changes were required. These were subsequently made, thus refining and improving the questionnaire further.

The response rates for each step of the study, that is, the instrument development, pilot, retest and main study were all excellent.

The attitude scale, once developed and tested, was quick and easy to administer and complete. The attitude scale was administered to third year student nurses on three separate occasions and on each was shown to have good internal reliability, measured using Cronbach's Alpha.

Stability or external reliability, measured using Pearson's correlation co-efficient was moderately satisfactory. As discussed in chapter three, it has been suggested that attitudes are an enduring response to an object and that if after a repeated measure of the attitude, the responses change, as happened in the re-test, then perhaps what was

being measured was not attitudes but transient opinion (Coolican, 2004). However, the differences between the two sets of results, in the pilot and re-test, were not so dissimilar to suggest this was the case. The main study results were also on the whole consistent with the pilot and retest results so re-confirming the findings.

Nevertheless, this suggests that at the time when student nurses are making the decision to exit with a degree or a diploma that there may be some scope for influencing their attitudes towards transferring to the degree programme. This may be useful if it was thought appropriate to encourage more positive attitudes as a means to increase the number of students accepting transfer.

It must also be remembered that many of the students who participated in the pilot initially accepted transfer but then did not complete the degree. Hence, for many it is possible that both their attitudes and behaviours changed. However, this could not be confirmed in this research.

## 6.4. Objective 2: to identify factors promoting or impeding pre-registration education at degree level.

The second objective of the study was to identify factors promoting or impeding pre-registration education at degree level. The questionnaire considered a wide range of factors including: attitudes towards obtaining a degree, age, gender, marital status, having a part-time job, having dependent children and/or relatives living with the participant, previously working as a HCA, entrance qualifications, academic achievements and previous member of the family studying at degree level in any subject. In addition, those who did or did not accept a place on the degree programme were asked the extent to which specific factors influenced their decision.

The key findings for each of the above are discussed separately.

### 6.4.1. Attitudes towards obtaining a degree

Attitudes towards obtaining a degree, measured using the attitude scale developed in this study, were generally positive. There was no one statement that the majority of participants strongly agreed with. However, on combining strongly and somewhat agree the majority of students agreed with 11 statements in the attitude scale. These included that obtaining a degree would increase knowledge, self-confidence and professional status. This was similar to the results from previous research on registered nurses attitudes towards degree level education (Ehrenfeld et al, 1993; Davey and Robinson, 2002 and Leonard, 2003).

The majority of student nurses also believed obtaining a degree would help nurses develop their career, also similar to previous research on registered nurses (Dowswell et al, 1998; Pelletier, 1998 and Leonard, 2003). This suggests these students wished to develop their career. Indeed, previous research by Robinson et al, (2003) found graduates were more ambitious but feared that the NHS could not fulfil their career aspirations. However, many previous documents cited in the literature review have recognised the need for substantial changes in the future roles of nurses. This evidence consistently points to the need for nurses to have a broader, more critically analytical education which will prepare nurses for specialist and advanced roles, and also for the generalist nursing roles of the future. Therefore, these future roles may better meet the career aspirations of nurses and perhaps graduate nurses in particular.

Nevertheless, these role changes require the careful consideration of the appropriate skills required, or perhaps more importantly that the people carrying out these skills are the most appropriate and skills are not being transferred for financial reasons.

Perhaps worryingly, 67% of student nurses believed obtaining a degree would help nurses consider jobs outside nursing. However, these nurses may have less reason to consider leaving if more well-paid career jobs were created in nursing. Hence, this is another reason for the definitions of these roles to be agreed as soon as possible.

The majority of students were also looking for recognition of their degree status on the NMC register and in their pay packet! However, if diploma and degree nurses do the same job then is more pay justified? Or does this suggest that students think the two groups will eventually, or ought to, do different jobs, that is, that graduate nurses will move into the advanced and specialist roles. Indeed, it would seem necessary that a degree be the minimum qualification required for these advanced and specialist roles. Without a degree nurses could not pursue further study, for example, Masters and Doctorates as may become the norm for such roles.

Hence, in recognition of the expected new roles of the future, not only are increased knowledge and skills required, but financial recognition for the increased professional accountability. Interestingly, there has been little or no discussion of expected wage increases! However, Agenda For Change (RCN, 2005) acknowledges that the new pay structure currently being introduced into the NHS should recognise skills and expertise.

Hence, the argument against an all degree profession put forward by Robinson et al (2003), may not transpire if the NHS changes in accordance with the proposed changes in the Wanless (2002) Report, RCN (2004a,b,e and f) and the RCN Labour Market Review (2002).

In relation to disagreeing with the attitude statements, the majority of students strongly disagreed with one statement: obtaining a degree is essential to be a good nurse. In combining strongly and somewhat disagree the majority disagreed with three statements. They disagreed that obtaining a degree is essential to be a good nurse, will make nurses better at their jobs and will improve the patient care provided by nurses. These are three key statements.

Eighty nine per cent disagreed that obtaining a degree was essential to be a good nurse. Only 7% agreed with this statement. Yet the majority accepted the degree option.

As stated previously it is 'critical thinking' that distinguishes graduates from diplomates. The four extra modules for the degree programme aim to develop critical thinking skills. The four extra modules were the only difference between the degree and diploma programmes, in the study site. Therefore, is it the content of these four modules that the participants did not see as essential to be a good nurse, that is, the predominately research orientated modules? This is partly reflected in the participants' responses to the question, to what extent the choice of modules influenced their decision to accept transfer or not? Of those who accepted only 3% ticked that the module choice influenced their decision to accept by a great extent. On the other hand, only 10% of those who did not accept indicated that the choice of modules influenced their decision to not accept by a great extent.

However, previous research has demonstrated that deficiencies in nurses' basic research appreciation skills exist (DOH, 1993). Nurses need research skills to be able to make clinical practice increasingly evidence based. The above responses suggest the participants did not make the link between research appreciation skills and providing and improving evidence based care, that is, improving patient care.

Indeed, sixty two percent disagreed that obtaining a degree will improve patient care provided by nurses. Only 16% agreed with this statement. However, if the additional study is meant to develop more critical thinkers and student nurses do not think this will improve patient care, is this because student nurses do not link critical thinking with patient care? However, previous research by Girot (2000b) found no significant differences between the critical thinking skills of graduate and non-graduate nurses, although they were better decision makers. Could it be that diplomates already have sufficient critical thinking skills and that these particular skills do not need to be increased? Or is it that some degree students fail to acknowledge or accept that they can influence clinical practice in the way expected of a graduate? This may also be because both diplomates and graduates have the same professional registration and are expected to do the same job. Hence, is there scope for newly qualified nurses to use these additional skills?

Sixty three percent disagreed that obtaining a degree would make nurses better at their jobs, with only 15% of students agreeing with this statement. Hence, again this questions why so many are intending to obtain a degree and why they do not agree that the increased knowledge will make them better at their jobs.

The above responses all also suggest that what is taught in class may not correlate with what the student expects as a newly qualified staff nurse in the clinical areas. Otherwise known as the theory-practice gap (Landers, 2000). Student nurses may rightly or wrongly perceive the four extra theory modules obtained for the degree qualification as not directly impacting on the patient care provided by them as newly qualified nurses.

A further theory, which may also help shed light on the meaning of the findings, is based on Allmark's (1995) classical view based on Greek origins. This suggests that much of the theory-practice gap exists because much of nursing practice cannot be taught through theory. Allmark uses the examples of learning to play the piano or ride a bike. However, this is not a debate which will be discussed further in this study. Nevertheless, this sounds familiar to Florence Nightingale's era, when it was believed nurses learnt simply by doing. Furthermore, this is not to suggest that research knowledge is not based on theoretical knowledge, but to further emphasise that the students may not associate these research modules with practicing as a nurse.

These three statements are all potential areas where lecturers can influence the student nurses' attitudes towards degree level education and perhaps more specifically focus on ways to bridge student nurses' perceptions of a theory-practice divide. On the other hand, perhaps students should also have an increased choice of modules, as do post-registration nurses. Previous research on registered nurses did find that some registered nurses 'topping up' reported that obtaining a degree did enhance their clinical practice (Davey and Robinson, 2002 and Ehrenfeld et al, 1993) However, registered nurses have a wider choice of modules to choose from and hence the choice of module may more directly impact on their specific place of work.

Almost half the student nurses (48%) were undecided if obtaining a degree was what employers of nurses wanted. This is perhaps not surprising as until very recently most newly qualified nurses in the local area were not graduating with a degree. Hence, there has been no competition between diplomates and graduates. This may change in the near future. Indeed, Burke and Harris's (2000) previous research suggested some employers preferred graduates and with the increasing number of students obtaining a degree, this is only likely to increase. In the U.S., as reported previously, some employers had a degree preferred policy for newly hired nurses (AACN – American Association of Colleges of Nursing, 2000, as cited by Spear, 2003, p.244). This may also become the norm here. Perhaps now is an opportunity to encourage employers to voice their opinion, which in turn may influence student nurses' decisions to accept transfer or not.

However, it is interesting to note, that only 25% of the participants believed obtaining a degree ought to be essential for all student nurses and of those only 11% strongly believed this. The same percentage (25%) believed it ought to be essential for all nurses, with only 10% strongly believing this. Again, this questions their motives for obtaining a degree.

In conclusion, the 11 statements the majority agreed with all related to career and professional development. There were no statements relating to patient care. However, the scale contained only a small number of statements directly related to patient care. A number had been removed following the psychometric testing carried out during the pilot, as described in the methods section, because of their low discriminatory power. However, looking back at a statement that was in the pilot, but not the main study on direct patient care, 0% strongly agreed that obtaining a degree would increase nurses' clinical skills, 22% agreed somewhat, and the majority (62%) disagreed.

### 6.4.2. Relationships between attitudes and behaviours

Attitudes towards obtaining a degree were one of the main factors examined to determine if these influenced a student's decision to accept transfer or not to the degree programme. As indicated in chapter three, the relationship between attitudes and behaviours is complex, but where specific attitudes are measured these have been found to relate to a specific behaviour (Ajzen and Fishbein, 1977, as cited by Gross, 2001). The findings of this study provide further evidence to support this.

After calculating the total scores for attitudes towards obtaining a degree the results of this study found that student nurses' attitudes towards obtaining a degree were generally positive. Indeed, the majority (68%) of students had positive attitudes and the majority (72%) accepted transfer onto the degree programme. Of those who did not accept transfer (n=29), the majority (n=21) intended to study for a degree at a later date.

Those who accepted transfer pre-registration had more positive attitudes, than those who did not. This was statistically significant. This would seem to reconfirm the theories linking attitudes and behaviours. However, this behaviour was a measure of intention to obtain a degree. This research did not follow up individual participants to determine if the intention to obtain a degree was successful.

Nevertheless, the majority of those who did not accept transfer also intended studying for a degree at a later date. This would suggest that their attitudes should also be positive. Their attitudes were significantly less positive and indeed the mean score was below the scale mean. The low mean score for those who did not accept may be an indication that their intentions to obtain a degree later were low. However, it also suggests as discussed previously, that our behaviours affect our attitudes (Myers, 1995). Those who accepted may have justified this decision by reporting more positive attitudes, whereas the students who did not, had no need to justify their actions because they had not yet committed to obtaining a degree and the hard work this entailed. However, if the profession wishes to move to an all degree profession

at the point of registration, then it is the attitudes of pre-registration students, when the decision to transfer or not is made, that are more important.

Nevertheless, as discussed previously, giving an attitude a numerical score is debatable (Gross, 2001). In addition, the scores calculated could have been reached by a number of combinations of answers (Burns, 2000). As a result, the total scores have to be interpreted with some caution, despite extensive piloting to ensure that the final scale produced as meaningful results as possible. The following section therefore considers participants' responses to individual statements in the attitude scale based on those who did or did not accept transfer.

### 6.4.3. Differences in students' specific attitudes between those who accepted transfer to the degree programme and those who did not

There were 16 significant differences between the responses to the attitude statements for those who accepted transfer and those who did not. Some of these are considered below.

Only 3% of those to NOT accept agreed that it would improve patient care, compared to 21% of those who did.

Sixty six per cent of student nurses who accepted agreed that obtaining a degree was easier as a student nurse because in studying mode, whereas 62% of those not to, disagreed with this statement. Fifty five per cent of those to accept agreed it was easier than studying post registration, whereas 45% of those not to were undecided.

Seventy six per cent of those who accepted also believed that their higher qualification should be recognised on the NMC register, whereas only 28% of those not to, agreed with this statement. Sixty five per cent of those accepting thought it should mean higher pay, whereas only 20% of those not to, agreed with this statement.

Sixty per cent of those to accept also believed that a degree was necessary to further a career in nursing whereas only 27% of those not to, agreed with this statement. This suggests perhaps that those accepting were more ambitious and expected to need the degree to pursue their career further, whereas those who did not may not have been.

Of the students to not accept **none** believed that obtaining a degree would make nurses better at their jobs. Of those to accept, still only 21% agreed with this statement. On the other hand of the students to accept, none disagreed that obtaining a degree as a student was an excellent opportunity, whereas 17% of those not to, disagreed with this statement.

The above all highlights some marked differences between those to accept transfer and those not to. These highlight potential areas for lecturers to promote more positive attitudes towards obtaining a degree as a means to encourage more students to accept transfer, if this is desirable.

Hence, to enhance the attitudes of those who did not accept transfer may again require increasing their belief in the potential benefits to patient care and career prospects. The latter may lead to higher pay, once clearer career structures are in place. The attractiveness of the degree option may be improved if the two were clearly linked.

However, not only are the attitudes important, but the factors promoting or inhibiting degree level education pre-registration. These are discussed in subsequent sections.

### 6.4.4. Age

The majority of students participating in this study were mature. This was regardless of what definition of mature student was used, that is, aged over 22 or over 26. Younger students scored higher on the attitude towards obtaining a degree scale; however this was not statistically significant. The average age of students to accept

transfer was marginally lower 31 s.d. 8.4 compared to those that did not 32 s.d. 8.2. This was not statistically significantly.

In previous studies, age has been shown to be a good predictor of academic achievement/outcome. However, in this study it was not shown to be a good predictor of intention to study for a degree.

### 6.4.5. Gender

Inferential statistical analysis using the subgroup gender was not performed because of the small number of male student nurses and hence the small number of males participating in the study (n=6). This was disappointing. However, the low numbers are representative of the low numbers of males in nursing and therefore in the study population.

### 6.4.6. Marital status

A minor difference between those who were married and those who were single, divorced, widowed or other was found on the attitude towards obtaining a degree scale; however this was not statistically significant. In addition there was no significant difference between those who accepted transfer and those who did not based on whether married or not.

### 6.4.7. Campus attended

Statistical relationships were found between campus attended and attitudes towards obtaining a degree and in the number who accepted transfer to the degree. There were no significant demographic differences found between the student populations at each campus to help explain these findings. Possible explanations therefore may relate to differences in social norms between the two groups, as the students exist as two separate peer groups. In addition, different lecturers on the whole, teach on either campus, although there is only one BSc and one Diploma Programme Leader.

This perhaps adds support to the links between attitudes, social norms, in particular peer group pressure, and behaviours, as discussed in chapter 3. The answer may be to actively seek to shift social norms through education to increase the number of students accepting transfer.

However, because the instrument development and pilot questionnaires were distributed on one campus only then this raises methodological concerns, relating to possible bias. This is discussed further in subsequent sections.

### 6.4.8. Working part-time

With more mature students in nursing, it was not surprising to find the majority of participants in the study had part-time jobs as they had families to support. Interestingly, students who worked part-time scored higher on the attitude towards obtaining a degree scale; however this was not statistically significant. There was no significant difference between those who accepted transfer and those who did not based on whether working part-time or not.

### 6.4.9. Dependant children and/or relatives

Students who did not have dependent children living with them scored slightly higher on the attitude towards obtaining a degree scale; however this was not statistically significant. There was no significant difference between those who accepted transfer and those who did not based on whether participants had dependant children or relatives living at home or not.

A t-test using the subgroup 'having dependant relatives living at home with the participant' and attitude score was not performed because of the small number of student nurses in this category (n=10).

### 6.4.10. Previously working as a Health Care Assistant

Just under half of the participants had previously worked as a HCA. There was no significant difference between the scores towards obtaining a degree for those who had previously worked as a HCA and those that had not. In addition, there was no significant difference between those who accepted transfer and those who did not based on whether they had previously worked as a HCA or not.

### 6.4.11. Entrance qualifications

The students participating in this study had a wide variety of entrance qualifications, varying form a degree to the DC test. This served to re-emphasise the diverse backgrounds of today's nursing students. Many had qualifications far exceeding the minimum entrance requirements for a diploma programme, whilst only a small number reported having the minimum. Many had the necessary qualifications to enter a degree programme had they originally chosen a different institution. Again, as identified previously by Soothill, Bradby and Williams (1994) this suggests these student nurses choose this institution because of its location.

The large number of missing data in this section limited the inferential analysis possible. This also imposed constraints on the inferences from those who did complete this section because of possible response bias.

This study had hoped to more fully understand if entrance qualifications influenced the decision to transfer to the degree programme. This proved difficult because the design of the study relied on participants remembering their entrance qualifications. However, Longden (2000) has suggested that there is perhaps too much of a fixation on entry qualifications into HE. Indeed, the previous evidence cited in the literature review did not consistently find nurses entrance qualifications to be good indicators of future performance. Furthermore, mature students, being the students with the most variety of entrance qualifications, bring benefits to the profession as detailed in previous chapters, simply because of their maturity.

The students within this study who had entered with a wide variety of entrance qualifications did not seem to be hindered from accepting transfer.

Using ANOVA there were no significant differences between entrance qualifications, based on the three groups as described previously, and the decision to accept a place or not on the degree programme or the total attitude towards obtaining a degree scores.

### 6.4.12. Academic achievements

Again, the large number of missing data in this section limited the inferential analysis possible.

The majority of the students participating in this study achieved 'A' grades for their clinical assessments in year 2. (The year 1 clinical assessments were not graded for this cohort). These were the only assessments where the majority achieved 'A' grades. This would suggest that either these students were performing at a high level in the clinical areas contrary to their theoretical performance, or the discriminatory power of the grading scale for clinical assessments is questionable. This new scale has only recently been introduced and is currently undergoing evaluative research. This may also mean that the clinical mentors are not yet fully accustomed to the grading system used to give academic credit for clinical assessment.

However, previous research has found that very few student nurses fail clinical assessments (Anon. PhD thesis, no date). This is for many reasons, both positive and negative, which this research does not intend to discuss. However, given that the programme is 50% theory and 50% placement, getting the academic accreditation accurate is essential. No participants in this study reported failing their clinical assessments. In addition, in contrast to the theoretical assignment results, the majority received 'A' grades.

However, these students also performed well in their Core Skills exam, thus reconfirming a greater ability/interest towards clinical skills. This perhaps ties in with previous responses in which the students did not believe obtaining a degree would make them better nurses and improve patient care. Instead, these student nurses appeared to perform better clinically and did not associate more knowledge as improving this.

However, is it not more knowledgeable and highly clinically skilled nurses the NHS of the future needs? Perhaps a compromise needs to be met, whereby degree educated nurses increase both their knowledge and clinical skills during their additional degree level study. This may be more appealing to student nurses and better meet future health needs as well as the needs of nurses in the future. Indeed, previous evidence cited in the literature review suggested the difference between graduates and diplomates in terms of clinical performance was dubious. Perhaps the debate between graduates and diplomates should focus less on the outcomes of the two different programmes and more on the content of a degree and its relevance to future practice.

On the other hand, the students may be aware of their own strengths and weaknesses and acknowledge theory as not being their strong point and therefore not attempt the degree. If students expect or fear failure then this may have influenced their decision to not accept, that is, if students expected the outcome of their further studies to be a 'bad' outcome, then they may not have accepted transfer. Interestingly, of those who accepted transfer, 21% strongly believed the degree option should only be offered to those who previously achieved good grades, compared to only 3% of those who did not. However, only 3% gave lack of confidence in their academic ability as a factor influencing their decision to not accept to a great extent.

It has to be remembered however, that in the instrument development stage of this study, only students who met the academic criteria were offered transfer. Out of this cohort of students at one campus, 19 graduated with a degree out of a total of 52. This was 37% of the total graduating that day; the remainder received a diploma. In

the pilot cohort, at the same campus, all students were offered the degree transfer. As a result 17 graduated with a degree, out of a total of 41. This was 42% of the total graduating on that day. This was only slightly higher than the percentage when the degree transfer was based on a restricted policy.

The outcomes for the main study cohort are based on the figures available in late August 2005. Sixty (51%) were on target to graduate with a degree out of a total of 117. Again, this is less than the number initially accepting transfer to the degree programme. It was demonstrated in the results section that a number of students did accept who would not have previously been offered transfer. However, there is no way of knowing, in this research, whether it was these students who dropped out or not.

In terms of the psychological theories discussed previously, individuals do not always behave consistently with their intentions. It seems other factors subsequently intervened to prevent these initially enthusiastic students achieving a degree, including academic difficulties. It therefore seems prudent to recommend that students seek more advice from personal tutors, in relation to overcoming potential or actual obstacles to achieving a degree, for example, workload, time implications and their academic ability. In other words, in relation to the previous psychological theories discussed in chapter three, if an individual or significant others, that is, lecturers, believed that they were unlikely to achieve a degree because of such obstacles, then this may be a better predictor of the outcome than their initial intentions. On the other hand, more time and/or resources may be required to help students achieve degree level study.

In conclusion, the limited evidence from this study suggests that when the degree was offered to those who met academic criteria, the percentage to graduate almost matched the numbers to accept. However, when the degree was offered to all students, a large percentage expressed interest and initially accepted, but subsequently half withdrew at various stages before and during commencement of the degree programme. This therefore suggests that previous proven academic ability

appeared to be a better predictor of the numbers to complete the degree. The number of students to initially accept and then subsequently graduate requires monitoring to assess what the typical trends are likely to be. In addition, further research may then be required to understand why students subsequently change their mind and withdraw from degree programmes.

Nevertheless, remembering that the percentage of nurses graduating with a degree at the point of registration prior to the policy to offer transfer from diploma to degree programmes was zero, there has been a large increase in the number of graduate nurses at the point of registration. The implications of the findings of this research on achieving an all graduate profession are discussed in subsequent sections.

### 6.4.13. Previous member of the family studying at degree level

Students who had a family member who had previously studied for a degree in any subject scored higher on the attitude towards obtaining a degree scale, however this was not statistically significant. In addition, there was no significant difference between those who accepted transfer and those who did not based on whether the participant was a first generation graduate student or not.

### 6.4.14. The extent to which specific factors influenced student nurses' decision to accept a place

Seventy six students out of the 105 students participating in the study accepted transfer. The decision to accept has to be seen in the context of the factors which influenced this choice. The majority of these students identified a total of seven factors which influenced their decision to a great extent. These factors were categorised under two main headings: personal and 'ease of obtaining a degree'.

The top three factors were to obtain a degree in 6 months rather than 2 years post-registration, because the degree was funded and for personal satisfaction. Indeed, all 76 participants who accepted indicated that obtaining a degree in 6 months influenced their decision to a great, some or a little extent. These first two factors,

suggest an inevitability that these participants intended to obtain a degree at some point and obtaining it pre-registration offered the added benefits of it being in a shorter time frame and free! This would appear to be in contrast to those who did not accept transfer, in which these benefits did not outweigh the barriers caused by the additional workload and perceived stress during their final clinical placements.

Perhaps worryingly, 60% of participants accepted a place to enable them to consider jobs outside nursing to either a great, some or a little extent. This again reconfirms the findings for the attitude statement in which 65% believed it would help nurses consider jobs outside nursing.

Contrary to the responses to the attitude statements relating to patient care, 69% of participants did indicate that they accepted the degree option to improve their clinical skills to a great or some extent. However, of these only 7% indicated this was to a great extent.

### 6.4.15. The extent to which specific factors influenced student nurses' decision to NOT accept a place

Twenty nine students out of the 105 participating in the study did not accept transfer to the degree. However the majority were planning to undertake a degree at a later date, with a small number yet undecided. Only four said they did not plan to. This demonstrates yet again enthusiasm towards obtaining a degree.

A number of factors were identified as inhibiting pre-registration education at degree level. These factors were categorised under two main headings: stress-related and 'maximising final clinical placement'.

The greatest barrier was the combined pressures of academic workload, family and work commitments. This is similar to the findings of Davey and Robinson (2002) in which the main reason given by RGNs who did not plan to undertake a degree was because of the difficulties of combing paid work with studying. Likewise, Pelletier

(1998) also reported family and work commitments as factors hindering graduate study. These students now combine studying, managing on a bursary and possibly working in paid employment over and above a 40 hour week as a student nurse.

Interestingly, 62% of those who did not accept reported that employment commitments on their own did not, at all, influence their decision. A smaller percentage (35%) reported that financial commitments alone did not, at all, influence their decision. It was the combined pressures which caused problems. This is not an easy barrier for the university to overcome because many of the factors are outwith its control.

It is often females who undertake a greater amount of family commitments. The correlation between accepting transfer and gender was not statistically significant. However, this was based on a small number of males in this study.

The students who did not accept seemed to feel their final 6 months clinical experience prior to registration would be compromised because of the additional stress of study. This highlights the high value students placed on their final clinical experience prior to registration. This would appear to be more highly valued than the opportunity to achieve further theoretical knowledge. This perhaps further explains these students commitment to achieving high standards for clinical skills, as was previously demonstrated in their good grades in the core skills exam and clinical assessment placements. This also adds further evidence to previous arguments that these student nurses did not believe that the additional theory would make them better nurses. Indeed, 55% wanted to study for a degree relevant to a specialist area after registration.

However, coping with stress as a student nurse is not a new problem as previous research has demonstrated (Timmons and Kaliszer, 2002). The answer may be to aim to make the student environment less pressured, rather than more. Educational institutions can address this in a number of different ways. For example, as cited previously, some institutions have chosen a four or a five year ordinary degree. The

four year option chosen by the Irish National Board (NIC, 2001) has a final one year of paid employment, thus facilitating consolidation of clinical skills without other pressures. On the other hand, the attraction to those who did accept was to be able to achieve the degree in three years. So for the majority, this was a major factor influencing their decision to accept. Other solutions may be to lessen the theoretical content of the degree by giving academic credit to all clinical placements.

The above also relates to a key point discussed in the literature review: that of the difference between training and education. Is it possible that the student nurses who did not accept, perhaps believed nursing is more of a 'practical occupation' rather than a profession, and therefore put less importance on 'education'?

Previous evidence pointed to low self confidence and negative attitudes towards the value of education as stemming from socio-economic barriers (Lifelong Learning Research Group, 2002). Socio-economic data were not collected in this study and therefore cannot be commented on. However, only 3% gave lack of confidence in academic ability as a factor influencing their decision to not accept to a great extent, although 55% in total gave this as a reason.

One of the factors which least influenced students was lack of knowledge to complete the degree. However, anecdotal evidence from lecturers suggests some degree students have required high levels of support to achieve the required standard for degree level study. This is perhaps amongst one of the easier barriers for the university to overcome, for example, by offering encouragement and education, but appeared to be of less importance to the student or not recognised by the student before they commenced! Indeed, these students have already demonstrated that they can achieve at SCQF Level 9 by completing four modules during year three whilst in university. However, these final degree modules do require more independent study whilst on clinical placement.

The barriers of greatest importance to the students to obtaining a degree principally related to the combined pressures of work, study and family, stress, academic

workload and wishing to concentrate on or to gain more clinical experience first. These were more important than the individual factors, such as, lack of knowledge or lack of confidence. Again, this reconfirms previous research in which academic related concerns were amongst the most stressful areas for third year student nurses (Timmins and Kaliszer, 2002).

The above would seem to reconfirm Ajzen and Madden's Theories, in that the participants firstly may have believed that because of external factors, that is, the combined pressures of work, study and family that they were less likely to achieve a 'good' outcome if they commenced on the pre-registration degree programme. Secondly, they also perceived this would be detrimental to their final clinical placements. Thirdly, some of the participants' responses suggested that their perceptions of their control over internal factors, that is, lack of knowledge, played a further part. Hence, these barriers in combination with a mean attitude score towards obtaining a degree below the scale mean, would appear to have all influenced their behaviour to not accept transfer.

These factors have implications for the achievement of an all graduate profession at the point of registration. Previous research found that men were more likely to be degree minded (Davey and Robinson, 2002). However, this could not be tested in this research because of the small numbers of males in the study. Nevertheless, if males are less likely to experience such combined pressures, then perhaps this is another argument for increasing the number of males in nursing. This is an area again where further research is required.

## 6.5. Objective 3: to define a student nurse educational data set (SNEDS) for adult student nurses which could be used for audit purposes, to generate research hypothesis and explore research questions.

The third objective was to consider ways of improving the accessibility of routine collected data to make research, such as this study, and routine audit easier to perform in the future. In the study site, pre-registration nurse data is currently stored in many systems including: the University Registry Database, Assessment Office and Student Files. The data held can be summarised thus:

1. Recruitment and Selection Outcomes including Numeracy, Literacy and Group Discussion Tests at interview.*

2. Study Skills Outcomes based on a Pathways Programme aimed to develop a range of study skills (Pathways, no date).

3. Demographic, entrance qualifications and attrition/status held on the University Registry Database.

4. Academic Achievements collated and stored in the Assessment Office.

5. Clinical Placement Assessments collated manually by Personal Tutors and transferred to the Assessment Office.

6. Special Educational Needs collated and stored in Registry and by a designated lecturer.

7. Reasons for leaving held in student files.

8. Transfer to degree programme: data held by BSc Programme Leader.

*In the study site, prospective students undergo a numeracy, literacy and group discussion test to augment the interview process. Candidates are required to pass all four aspects of the recruitment and selection procedure to be accepted into pre-registration nurse education.

The above data could be routinely collected at appropriate times e.g. Exit Year Interviews using computerised standardised audit tools. Hence, a comprehensive

system to store all such data when students successfully progress or discontinue needs to be considered. Glossop (2002) has previously recommended this for students who have discontinued only.

Storing all data generated during the journey of a student through a pre-registration nurse programme in a computerised system will create an improved data retrieval system. It is envisaged that such a system will track the students throughout their academic life cycle and therefore, not only improve the ability to carry out audit and research as above, but also improve the effective management and administration within a school. Some of the uses are found in Appendix 12.

In education the central source for higher education statistics is the Higher Education Statistics Agency (HESA, 1993). HESA was set up in 1993. Data is routinely collected for HESA on an annual basis. Hence, within educational establishments a considerable amount of data about education exists that could be used as the basis of a minimum dataset. It is essential that these data are as complete as possible, have high reliability and validity, and are appropriate for purpose.

Hence, as a by-product of this research the author recommends an expansion of such routinely collected data, that is, a student nurse educational dataset which could meet the needs of multiple data users similar to the concept of the 'nursing minimum data set (NMDS) (Werley et al, 1991). For some users the data needs to be highly aggregated and therefore anonymous. For other users, for example personal tutors, it will be important that the data is at an individual level. Access to the data therefore must be strictly controlled to that appropriate for the user.

As with any dataset, the data must be accurate (Joint Information Systems Committee, 1998) and have all data variables including field names, descriptions, parameters, ranges and constraints appropriately defined (Scottish Intercollegiate Guidelines Network (SIGN), 1998). This has not been carried out as part of this research, but would need to be agreed if the system was adopted.

Previous chapters consistently pointed to problems of retrieving routine data from files, and other sources, in a number of institutions. This study itself did not attempt to retrieve data from secondary sources but collected it from the students themselves. The secondary source method was deemed to be too time consuming and would have required the participants and data controllers consent to collect this data from the various primary sources. However, the design chosen for this study resulted in two sections of the questionnaire being poorly completed: entrance qualifications and academic achievement data.

This study therefore only reconfirms the need for a SNEDS. This could have made the data collection for a section of this study part of a routine audit, for example, by analysing the relationships between those who accepted transfer, entrance qualifications, academic achievement and other demographic variables. This would have resulted in more robust data analysis based on complete data in all sections. In addition, the analysis could be repeated for several cohorts to monitor trends.

A shorter questionnaire on the attitudes to obtaining a degree and factors influencing this decision could then have been used which would have been required to be linked only once, with the participants consent, to the anonymous data taken from a SNEDS. The SNEDS data could also include more data than was included in this study for analysis, for example, numeracy and literacy interview results, study skills referrals and special educational needs. This research has only just begun to demonstrate the possible uses of a comprehensive computerised SNEDS. The proposed basic variables for a SNEDS can be found in Appendix 13.

## 6.6. Summary

The historical and futuristic approach, the arguments for and against degrees and an all graduate profession and finally the relationship between attitudes and behaviours all helped to place students' attitudes towards obtaining a degree in context. Without this the interpretation of the findings of this study would have lacked supportive evidence. Nevertheless, to try to more fully explain some of the findings of this study, further research is yet required.

The literature review highlighted the desire to increase the professional status of nursing. This is being done in a number of ways including to date increasing the number of nurses with degrees. However, if the future of nursing changes as proposed in many of the documents previously cited, then a substantial increase in the number of nurses is required, with ever increasing evidence that these nurses need to be highly educated and highly skilled.

The RCN fully supports the need for more nurses and is providing much of the 'vision' for the future role of nurses, but the RCN also wants an all-graduate profession at the point of registration.

The Council of Deans (2002) supports an all graduate profession, but questions where the increased number of nurses are to come from, particularly in areas where shortages of recruitments already exist. At the same time it wishes to maintain the 'widest' entrance gates into nursing.

The three strategic options put forward to reconcile demand with supply are (RCN, 2004, p.6):

- To increase the number of registered nurses
- To change what nurses do using skill mix solutions or new roles in health care, and

- To reduce the demand of health care by focusing on preventing disease and managing the early stages of disease more effectively.

This research has discussed the first of these two strategies, but not the third. This is perhaps the most difficult strategy as it involves the public taking a greater responsibility for their health, rather than the NHS. However, the Wanless Report (2004) acknowledges the importance of this option as a realistic cost effective approach to improve the health of the whole population. Though not explicit in this report, it would again appear that nurses in Primary Care would provide much of the additional health promotion required.

Hence, no matter the strategy, more, better skilled nurses are required for the future. However, until this research, no one had considered, in depth, what the future nurses of tomorrow think, that is, the students of today in relation to obtaining a degree.

Increased resources will be required to achieve an all graduate profession. These resources must be used wisely to most appropriately meet the future health care needs of society but also the future needs of nurses to carry out the future roles to meet those needs. The limited findings from this research suggest that perhaps the additional degree level education offered to student nurses could be more attractive to students if more clinically focused.

This research has considered student nurses' attitudes and indeed found that there are many similarities and also some differences between students and registered nurses attitudes towards obtaining a degree. This has been important in itself, as it could not be assumed they were the same.

Much has been written on the context of pre-registration nurse education that currently exists. This in itself seems not always conducive to achieving an all-graduate profession. To summarise, student nurses do not yet appear to have full student status, because they are expected to work full-time as part of their 'education'. Hence they already have a high workload before increasing it further.

Secondly, even though nurse education has moved into HE, with all the benefits this was to bring student nurses, Longden (2000) maintains that pre-1992 universities still enjoy benefits, which post-1992 do not, for example smaller student to tutor ratios, smaller class sizes and insistence on the 'gold standard' entry qualifications. Hence, he believes that instead of a move from an elite to a mass system of education, they both currently co-exist in the UK. Subsequently he wonders that without redistribution of funding to the masses is it any surprise that the quality of the teaching and learning environment (and the student) may have an impact on the student outcome. Hence, new debates on the differences between graduates from one institution and another, as well as differences in the content of one degree to the next, may surface to replace the old debate of differences between diplomates and graduates.

Kenny (2004, p.97) also believes that the educational and apprenticeship models are poles apart. He believes the ideal, that is, an in-between, which integrates the better of the two, has not been achieved. Indeed, the emphasis seems to have swung towards ensuring nurses are educated to the highest level and perhaps, not enough on what they are educated in nor how this is best achieved. Certainly, the majority of participants in this study did not agree that obtaining a degree was essential to be a good nurse, would make nurses better at their jobs nor would improve the patient care provided by nurses.

He suggests what is needed is better partnerships between providers of care and educational institutions, whereby nurse education is more employment focused to meet the demands of the future. The RCN (2004a) also recognises the need for the culture of the NHS to shift from a service delivery to a learning environment. This is already being addressed by the recent implementation of Practice Education Facilitators in 2004 (NES, no date). Likewise, the NHS needs to be able to continually transform itself to meet the needs of the ever expanding roles and needs of its individual workers (Timpson, 1998). This is centred on preparing nurses who are fit to register, but ultimately fit for purpose also, hence returning to issues of employability. The difficulty is the scope of nursing is arguably expanding at a faster

rate than ever before and perhaps the education system is not quite up to pace, in that, more degree level nurses are required, because of the increase in the number of nurse led services and transfer over of medical duties. However, some students may prefer a more clinically focused degree and this may attract more students to achieve a degree pre-registration.

Previous arguments focused on nurses with degrees having less clinical skills. This is not a relevant argument for the Scottish degree transfer scheme because students studying for a diploma or a degree have the same amount and type of clinical experience. However, perhaps the debate should refocus on increasing both the theoretical knowledge and clinical skills of all student nurses, as they achieve a pre-registration degree. Indeed, perhaps a move to an all graduate profession should be used as an opportunity to better prepare nurses for the proposed new roles of the future.

Nevertheless, increasing the number of nurses with a degree is indeed currently being achieved. This is because of innovative ways of providing nurse education, such as the Scottish transfer scheme. This has increased choice for student nurses. Such diversity is essential for innovation (Glen 2002). In addition, this diversity is providing a nurse education system more responsive to the demands of society, political ideologies and developments in medical technology, to return to the words of Crotty (1993). However, perhaps more yet needs to be done to ensure the nurses of the future can meet the skills required for the proposed transfer of work from GPs and junior doctors in the future.

This research suggests that in a university with wide entrance gates the ability to increase the number of nurses with a degree at the point of registration is indeed possible and flourishing. However, offering the degree transfer to all students may be of limited value as the numbers actually graduating were similar when restrictions were applied to the transfer. This suggests that students need more guidance from personal tutors on their likely performance at degree level.

The majority of student nurses' attitudes towards obtaining a degree were positive. However, based on the evidence from this study, the ability to achieve an all graduate profession would appear to be difficult because of students' limited abilities, aspirations and continued motivation to obtain a degree. This also reconfirms previous fears that achieving an all graduate profession at the point of registration may only be achieved by narrowing the entrance gates and making it compulsory.

However, the findings from this study also suggest that student nurses' attitudes may be influenced by peer pressure. Hence, attitudes and hence behaviours may potentially be influenced by and may also require a shift in social norms. This may be achieved by more discussion on the benefits of degree level education.

Then again, a more radical shift in social norms may be 'imposed' by a policy move to an all graduate profession at the point of registration! However, is this possible in institutions such as the study site with wide entrance gates? The limited evidence of this study would suggest not.

Diversity is important in higher education and has indeed been described as a cornerstone of higher education policy since 1992 (HEFCE, 2000, cited in Glen 2002, p358). However, has nursing perhaps taken this a step too far and is preventing the profession reaching its target of an all graduate profession at the point of registration?

If universal education is proposed, the knock on effect on nursing may be to further widen the entrance gates. It has already been suggested that widening access is simply *'a euphemism for lowering educational standards'* (Watson, 2002). Hence, achieving an all graduate profession may prove even more difficult.

An argument against an all graduate profession was that there would not be enough nurses with the academic ability based on current recruitment strategies. However, increasing numbers only, has been recognised as not enough to solve the NHS

staffing shortages (RCN Labour Market Review, 2002). Instead, the NHS needs both the right numbers, including, more nurses, and the right mix of staff, including, nurses who will be able to take on the generalist, specialist and advanced roles of the future. This report also recognises the need to achieve this by increasing the intake of student nurses, but also reducing the attrition rate. Previous research has shown many students leave because of academic failure (Glossop, 2002). To move to an all graduate profession can only worsen attrition due to academic failure if the current wide entrance gates remain the same. Hence, entrance requirements for the highly skilled nurses of the future perhaps should be narrowed rather than widened, to ensure nurses who can meet the requirements of an all degree profession and the more highly skilled roles expected of them in the future.

Instead, potential candidates with minimum entrance qualifications could be encouraged into what is set to become a more highly qualified HCA role. This might also be the time to consider title changes for HCAs to acknowledge the proposed new advanced HCA roles. Indeed, recent initiatives to implement new health care workers with a shorter preparation have been proposed and have been introduced in some areas (RCN, 2004f and Hayes, 2005).

In conclusion, there appears to be two possible options for the future of nurse education. Firstly, by narrowing the entrance gates an all graduate profession at the point of registration could be achieved. The shortfall in nurses could be met by HCA/ Practitioner type roles. Indeed, the RCN (2004b) have recognised that without the three year education required for registered nurses, recruitment would be quicker. Could this be similar to the two year Enrolled Nurse course introduced in the 1960s to meet staffing shortages? Indeed it sounds as if the HCAs of the future are becoming more similar to this role as they achieve higher qualifications and skills.

A second possible option would not achieve an all graduate profession at the point of registration, but would still aim to achieve an all graduate profession. This could be based on a short term learning contract post-registration. This would be more achievable if universities were to consistently recognise academic points for all

clinical assessments. In the study site, this would immediately add 30 level 9 points towards the degree. This would leave a deficit of only 30 further level 9 points. These points therefore could either be counted towards a pre-registration degree or carried forward if a student did not transfer to the degree option pre-registration. The points carried forward could be added towards a learning agreement similar to the 'lifelong learning contract' put forward by the Council of Deans and Heads (2002) but instead focus on a short term learning contract to achieve a degree within a set period of time. Please see Table 37 below.

At a time when nurse recruitment, retention and retiral are of great concern to nurse leaders, hospital managers and politicians alike, it would seem that the system of offering student nurses transfer to degree programmes is not likely to worsen these problems if it remains a pre-registration option. Research to establish if a short term learning contract system would achieve an all graduate profession within a defined period of time is then required.

| | ***Degree*** | | |
|---|---|---|---|
| | **Theory Modules** **Count** | **Practice Placement/Oral Assessments** **Count** | **Total Degree** **Count** |
| **Level 1 Modules in Year 1** | 4 | 4 | 8 |
| **Level 2 Modules in Year 2** | 4 | 4 | 8 |
| **Level 3 Modules in Year 3** | 4 | * 2 plus 2 degree modules whilst on placement | 8 |
| **Total Modules** | 12 | 12 | 24 |
| **Total Points** | 180 | 180 | 360 |

* Thirty points carried forward towards short term learning agreement

**Table 37. Proposed number of modules and corresponding academic points for degree.**

In giving academic credit for year 3 clinical assessments it has to be emphasised, as discussed previously, that very few students fail clinical assessments. Giving

academic accreditation to the year 3 clinical placements, or any year, therefore must not compromise the academic award given. Perhaps, now more than ever addressing issues of why so few students fail clinical assessments needs to be addressed before any such proposed changes could even be considered.

The fear was that moving to an all graduate profession would reduce diversity; however the above option would not change student nurse recruitment. It would continue to address nurse shortages as well as ensure the demographic mix of nurses was similar to the communities they served.

Another fear was that obtaining a degree would help nurses consider jobs outside nursing. The majority of participants in this study agreed with this. However, the proposed new career roles for future nurses may help retain more nurses in the NHS.

The need to improve the gender balance and ways to improve the profile of nursing amongst males has been recognised (National Implementation Committee, 2001). Medicine has reversed the trend of being male dominated (BMA, 2004). However, nursing needs to give more consideration to the arguments for and against more males in nursing and ways to address the balance. Indeed, attracting better educated males may reduce the need to progressively widen the entrance gates into nursing, which has come about because of the reduced pool of young females. The opportunities for role development in the NHS are great (NHS Scotland, 2005). Indeed, in recent years nurses have become more involved in clinical decision-making (Krogstad, Hofoss and Hjortdahl, 2004). These are perhaps positive strengths not yet exploited strongly enough to attract more males into nursing. In addition, participants in this study agreed obtaining a degree increased professional status. Hence, achieving an all graduate profession may also be influential.

However, rather than only focusing on diversity, perhaps nursing needs to also focus on consistency and standardisation. The historical perspective taken at the start of this research recognized lack of consistent standards in nurse education as an issue. This appears to still be an issue requiring further attention. Firstly, consistency of

clinical assessment accreditation is required. Secondly, standardisation of the pre and/or post registration award at degree level needs to be addressed as many other Western nations have done already.

In conclusion, the literature review considered the development of nursing and had it developed to meet health care needs. It seems clear that since Florence Nightingale first introduced formal education, the role of the nurse has developed at a phenomenal rate from cleaning lavatories to prescribing drugs, administering epidurals to possibly nurse surgeons in the future. Indeed, there seems to be no question that the nursing profession continues to evolve to meet new health care needs (RCN, 2004b). However, perhaps nursing is too accommodating, after all 'caring is what nurses do best!' Perhaps, this has been to the profession's detriment, as nursing constantly bends and changes to meet everyone else's needs. It may be that what is required is not only a shift in some students' social norms but also a shift in the profession's social norms! Perhaps some nurses' attitudes are still tied to the past and therefore resistant to change. If nursing wishes to establish itself, once and for all, as a profession, then a first step should be in establishing an all graduate profession. Maximising recruitment and minimising attrition is not easy. Moving to an all graduate profession may require altering recruitment and selection criteria depending on how and when this is achieved, that is, to achieve it at the point of registration may be more difficult than to achieve it as part of a short term learning contract post registration.

## 6.7. Limitations

There were several limitations of this study as already discussed in the methods section. These related to the limited answers possible from a self-completed questionnaire. This study has provided much new knowledge on students' attitudes towards obtaining a degree and therefore the impact on achieving an all graduate profession however; there are also some responses which require more in depth enquiry to understand their full meaning. Hence, further research has been recommended as a result of the findings of this research.

However, as a result of completing this research four further key limitations have been recognized by the author. These are each discussed in turn.

### 6.7.1. Campus differences

The instrument development and pilot questionnaires were both carried out on one campus only. This was mainly for convenience. No differences were expected between the two campuses. However, the results of the main study subsequently found there were significant differences between the campuses in relation to the number of students to accept transfer and the mean attitude scores towards obtaining a degree.

This may have biased the results of the study, because the development of the attitude scale was based on the results from one campus only. The students in this campus had more positive attitudes towards obtaining a degree. However, the mean attitude scores for both campuses were positive, that is, both were above the scale mean. As with the development of any new scale, further testing would be beneficial.

### 6.7.2. Poor stability of attitude scale

The Pearson correlation co-efficient used to test the scales stability following test-reset was 0.64. This moderately satisfactory result was disappointing. However, the

students themselves did report to the researcher that some of their attitudes had changed as a result of changes in their perceived difficulties of obtaining a degree. Indeed, this was perhaps made more explicit in that from an initial 84% of the study population accepting transfer, only 42% actually exited with a degree. Hence, not only did their attitudes change, but also their behaviours changed to match. Again, perhaps this adds evidence to the theory that behaviours are influenced by our attitudes, that is, their attitudes changed consistently with their changed behaviour. However, because this was unexpected prior to the re-test, the author did not ask the participants to confirm whether they had changed their mind and withdrawn from the degree programme. With hindsight, this question would have been beneficial on the retest questionnaire.

### 6.7.3. Missing data

The amount of missing data was particularly poor in the entrance qualifications and academic achievement sections of the questionnaire. This was because the questionnaire relied on participants' memory. The year 2 academic achievement data was slightly better, probably because it was more recent and because the year 2 results were available for students to refer to.

This limited the analysis possible and therefore the findings from the study.

### 6.7.4. Small sample size to NOT accept transfer

The number of student nurses who did not accept transfer to the degree programme was small. This was good because it demonstrated enthusiasm towards the degree option; however this limited the statistical tests performed.

The author therefore needs to emphasise that the results need to be interpreted with caution because of the small sample size not to accept transfer. In addition this limits the generalisability of the findings. However, the small sample was representative of the small number of students initially not accepting transfer.

As discussed previously, this study was predominately interested in students' decisions at the time the offer to transfer to the degree programme was made, in order to understand students' attitudes towards accepting a place or not. This was considered particularly relevant in relation to moving towards an all degree profession at the point of registration. However, a study, or an audit which followed up students at the end of their three year programme when the actual numbers to subsequently complete the degree were confirmed would more accurately reflect the number of students who not only did not accept, but did not complete the degree programme. In addition, auditing of cohorts to assess typical trends needs to be performed.

When the study first commenced, the number of students to subsequently drop out of the degree appeared small. Indeed, in the cohort used in the instrument development questionnaire, 41% accepted transfer and 37% graduated with a degree. Hence this was not an expected problem.

## 6.8. Lessons Learned

Three key lessons were learnt from carrying out this research. These are each discussed in turn.

### 6.8.1. Relying on memory to complete questionnaire data

The questionnaire was the least time consuming method to collect and analyse data and achieved comprehensive coverage of the third year student population. However, relying on memory to collect entrance qualifications and academic achievements during the pre-registration degree programme proved to be difficult for participants.

If required to collect entrance qualification data again this will be from files where possible or the questionnaire will ask the participants to complete the number of passes, rather than the name and grade achieved. This may encourage more complete data to be collected, though less specific.

Academic achievement data will also be collected from files. However, these difficulties only once again highlight the benefits of a SNEDS.

### 6.8.2. Problems in the development of the attitude scale

The literature review on the development of attitude scales acknowledged the importance of ensuring all aspects of the attitude were included in the scale. On hindsight the scale contained very few items on the impact of obtaining a degree on direct patient care. These were reduced further following psychometric testing during the pilot. This may need reconsideration prior to further testing of the scale.

Secondly, the process of ensuring the attitude scale was valid and reliable which resulted in it being reduced from a 33 to a 21 item scale was on hindsight perhaps a little over zealous. A number of statements were removed from the initial scale to improve the Cronbach's Alpha score by a minor amount. Some of these statements

were similar to each other and may not have added to the overall study outcome, however a small number which were excluded, could have been of value to the study.

Thirdly, the Theories of Reasoned Action and Planned Behaviour were used to a limited extent as a conceptual model for the study design. These could have been used more explicitly as models to develop the attitude scale and other aspects of the questionnaire also.

### 6.8.3. Reverse data coding

The study generated large amounts of data, some of which required reverse scoring and calculating of total scores. Initially, errors were made in the naming and renaming of variables and databases as they were manipulated and data altered. This could have been carried out in a more methodical way, which would have prevented analysis being performed, checked, rechecked and corrected, as happened on occasions.

## 6.9. Recommendations

The key study findings have been summarised in terms of 12 recommendations:

1. More explicit discussion between lecturers and students on the benefits of degree level education, with particular focus on the links between theory and practice.

2. To recommend that all students seek advice from personal tutors prior to accepting transfer onto the degree programme.

3. Following further evaluative research on accrediting clinical practice: to give academic credit for all clinical assessments.

4. To offer a wider choice of degree level modules to pre-registration students including clinically focused modules.

5. To encourage employers to voice their opinion on pre-registration degree level education.

6. To determine the appropriate support required for transfer students.

7. To achieve an all graduate profession:

    a. To maintain current entrance gates into pre-registration nursing,
    b. To continue to offer transfer to all students,
    c. To ensure the appropriate support is available for transfer students, taking into consideration lecturer to student ratios and
    d. To consider implementing short-term learning contracts for those who do not complete a pre-registration degree

or

8. To achieve an all graduate profession at the point of registration:

    a. To consider narrowing the entrance gates into nursing and
    b. To establish a shorter course for an advanced HCA/Practitioner type role to continue to maximise recruitment.

9. To use a move to an all graduate profession as an opportunity to better prepare nurses for the proposed new nursing roles of the future.

10. To carry out research into why students accept and then withdraw from degree programmes.

11. To carry out research to determine if gender may influence the achievement of an all graduate profession.

12. To implement a SNEDS for audit purposes, to generate research hypothesis, to explore research questions and to monitor trends.

## 6.10. Future Research

This was the first research into this particular topic. As a result many more questions have been raised which require further research to more fully understand the answers to these questions.

There are many possible areas which could be investigated, two of which were highlighted in the recommendations section:

- to carry out further research into why students accept and then withdraw from degree programmes, and
- to determine if gender issues may influence the achievement of an all graduate profession.

The first in particular is an area requiring immediate research if the aim of achieving an all graduate profession is to become a reality.

Many interesting findings could be further explored using a qualitative approach to more fully understand the associations between phenomena (Wilson and Butterworth, 2000). In particular, the responses to individual attitude statements, such as, the relationship between obtaining a degree and patient care need further research to more fully understand their meaning. Further questioning using, for example, focus groups will allow greater depth of understanding of these findings.

This research could also be part of a larger case study approach to study the impact of the degree programme on an entire school. This could include: levels of support for degree students, impact on lecturers' workload and future resource implications as more students, if not all, study at degree level. Practice Education Facilitators and mentors may also be included and hence bring the impact on the clinical environment and patient care more explicitly into the study. In addition, the views of employers could be sought.

In addition, the development of a SNEDS would create an improved data retrieval system. The ability to carry out further research on a larger dataset would then be possible.

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# APPENDICES

# THE PATH TO NURSE REGISTRATION-

## Information Sheet

Principal Investigator:
**Louisa Sheward**
**Nurse Lecturer,**
**University Campus Ayr,**
**University of Paisley.**

## Background to study

In 1989, Project 2000 was introduced. This changed student nurse training from an 'apprenticeship' model to a diploma. As a result almost all student nurse education moved into the Higher Education sector. To date the majority of student nurses still exit with a diploma. However, for many years many have argued that nursing should be an all degree profession.

In 2003, a major change in Scottish undergraduate nurse education occurred. Universities that had previously offered only diploma courses began to offer degree programmes also. Student nurses therefore can now transfer from diploma to degree programmes. This means that many more nurses than ever before will have a degree as the minimum academic standard of pre-registration nursing.

However, not all nurses will be able nor wish to transfer onto an undergraduate degree programme. Hence issues of ability and desire are important to consider for several reasons. First, universities need to plan for the additional resources required. Second, local and national targets set for the number of students studying at degree level will need to be met. In addition if the ultimate aim for the profession is that the degree programme becomes the only way to register as a nurse, then this will require detailed information on the possible impact on the recruitment and selection of student nurses.

To fully understand these issues will require knowing the types of student nurses that are eligible, accept or decline transfer onto a degree programme. This can only be done by having accurate, accessible and appropriate data to analyse. Large amounts of data are generated during student nurse training programmes which are accurate and appropriate to use, however they are often very fragmented and therefore not easily accessible for analysis. These data could be much more easily managed through the better use of Information Technology.

Hence it is hoped that this research will collect information that will help the university and potentially other institutions

I am very grateful for your help with this research. If you have any queries please contact Louisa Sheward, Nurse Lecturer at Ayr Campus, University of Paisley on 01292 886249 or email : shew-nm0@wpmail.paisley.ac.uk

understand more about student nurses desires and abilities to study at degree level.

**Study aims**

1. To identify and analyse factors promoting or impeding undergraduate nursing education at degree level at a large School of Nursing offering both diploma and degree courses.

2. To develop a comprehensive student nurse educational data set.

**Methods**

This study will use a quantitative approach to collect **anonymous** data using a student nurse questionnaire survey. The questionnaire should take approximately 10 minutes to complete. This data will be used to demonstrate some of the uses of a student nurse educational data set e.g. for audit purposes, for examining trends, research hypothesis generation and the exploration of research questions.

**The survey**

**Participation in this questionnaire survey is entirely voluntary**.

All answers will be anonymous and confidential. If you do or do not decide to complete the questionnaire then this will not alter the outcome of your nursing course in any way. You can also decline to answer any specific questions.

**About the data to be collected in the survey**

This will include age, gender, date of birth, university entrance qualifications, and academic achievements whilst on your current undergraduate nursing course, eligibility and reasons for accepting or declining transfer onto degree programmes. If you were not eligible for transfer onto the degree programme you will be asked about your desire, or not, to study for a degree at a later date and your reasons for this.

**Ethical considerations**

An application form for ethical approval was submitted to the University Research Ethics Committee. Permission to carry out this study was granted.

I am very grateful for your help with this research. If you have any queries please contact Louisa Sheward, Nurse Lecturer at Ayr Campus, University of Paisley on 01292 886249 or email : shew-nm0@wpmail.paisley.ac.uk

# THE PATH TO NURSE REGISTRATION-

## Information Sheet

Principal Investigator:

**Louisa Sheward**

**Nurse Lecturer,**

**University Campus Ayr,**

**University of Paisley.**

## Background to study

In 1989, Project 2000 was introduced. This changed student nurse training from an 'apprenticeship' model to a diploma. As a result almost all student nurse education moved into the Higher Education sector. To date the majority of student nurses still exit with a diploma. However, for many years many have argued that nursing should be an all degree profession.

In 2003, a major change in Scottish undergraduate nurse education occurred. Universities that had previously offered only diploma courses began to offer degree programmes also. Student nurses therefore can now transfer from diploma to degree programmes. This means that many more nurses than ever before will have a degree as the minimum academic standard of pre-registration nursing.

However, not all nurses will be able nor wish to transfer onto an undergraduate degree programme. Hence issues of ability and desire are important to consider for several reasons. First, universities need to plan for the additional resources required. Second, local and national targets set for the number of students studying at degree level will need to be met. In addition if the ultimate aim for the profession is that the degree programme becomes the only way to register as a nurse, then this will require detailed information on the possible impact on the recruitment and selection of student nurses.

To fully understand these issues will require knowing the types of student nurses that accept or decline transfer onto a degree programme. This can only be done by having accurate, accessible and appropriate data to analyse. Large amounts of data are generated during student nurse training programmes which are accurate and appropriate to use, however they are often very fragmented and therefore not easily accessible for analysis. These data could be much more easily managed through the better use of Information Technology.

Hence it is hoped that this research will collect information that will help the university and potentially other institutions understand more about student

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nurses desires and abilities to study at degree level.

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2. To develop a comprehensive student nurse educational data set.

**Methods**

This study will use a quantitative approach to collect **anonymous** data using a student nurse questionnaire survey. The questionnaire should take approximately 10 minutes to complete. This data will be used to demonstrate some of the uses of a student nurse educational data set e.g. for audit purposes, for examining trends, research hypothesis generation and the exploration of research questions.

**The survey**

**Participation in this questionnaire survey is entirely voluntary**.

All answers will be anonymous and confidential. If you do or do not decide to complete the questionnaire then this will not alter the outcome of your nursing course in any way. You can also decline to answer any specific questions.

**About the data to be collected in the survey**

This will include age, gender, date of birth, university entrance qualifications, academic achievements whilst on your current undergraduate nursing course and reasons for accepting or declining transfer onto degree programmes. If you accept transfer onto the degree programme you will be asked about your desire, or not, to study for a degree at a later date and your reasons for this.

**Ethical considerations**

An application form for ethical approval was submitted to the University Research Ethics Committee. Permission to carry out this study was granted.

I am very grateful for your help with this research. If you have any queries please contact Louisa Sheward, Nurse Lecturer at Ayr Campus, University of Paisley on 01292 886249 or email : shew-nm0@wpmail.paisley.ac.uk

# THE PATH TO NURSE REGISTRATION-

## Information Sheet

Principal Researcher
**Louisa Sheward**
**Nurse Lecturer,**
**University Campus Ayr,**
**University of Paisley.**

## Background to study

In 1989, Project 2000 was introduced. This changed student nurse training from an 'apprenticeship' model to a diploma. As a result almost all student nurse education moved into the Higher Education sector. To date the majority of student nurses still exit with a diploma. However, for many years many have argued that nursing should be an all degree profession.

In 2003, a major change in Scottish undergraduate nurse education occurred. Universities that had previously offered only diploma courses began to offer degree programmes also. Student nurses therefore can now transfer from diploma to degree programmes. This means that many more nurses than ever before will have a degree as the minimum academic standard of pre-registration nursing.

However, not all nurses will be able nor wish to transfer onto an undergraduate degree programme. Hence issues of ability and desire are important to consider for several reasons. First, universities need to plan for the additional resources required. Second, local and national targets set for the number of students studying at degree level will need to be met. In addition if the ultimate aim for the profession is that the degree programme becomes the only way to register as a nurse, then this will require detailed information on the possible impact on the recruitment and selection of student nurses.

To fully understand these issues will require knowing the types of student nurses that accept or decline transfer onto a degree programme. This can only be done by having accurate, accessible and appropriate data to analyse.

Large amounts of data are generated during student nurse training programmes which are accurate and appropriate to use, however they are often very fragmented and therefore not easily accessible for analysis. Therefore this research will collect data from students themselves.

It is hoped that this research will collect information that will help the university and potentially other institutions understand more about

I am very grateful for your help with this research. If you have any queries please contact Louisa Sheward, Nurse Lecturer at Ayr Campus, University of Paisley on 01292 886249 or email : shew-nm0@wpmail.paisley.ac.uk

student nurses desires and abilities to study at degree level.

**Study aim**

1. To identify and analyse factors promoting or impeding pre-registration nursing education at degree level at a large School of Nursing offering both diploma and degree courses.

**Methods**

This study will use a quantitative approach to collect **anonymous** data using a student nurse questionnaire survey. The questionnaire will take approximately 10 minutes to complete.

**The survey**

**Participation in this questionnaire survey is entirely voluntary**.

If you do or do not decide to complete the questionnaire then this will not alter the outcome of your nursing course in any way. You can also decline to answer any specific questions.

**About the data to be collected in the survey**

This will include age, gender, date of birth, university entrance qualifications, academic achievements whilst on your current pre-registration nursing course and reasons for accepting or declining transfer onto a degree programme.

If you do not accept transfer onto the degree programme you will be asked about your desire, or not, to study for a degree at a later date and your reasons for this.

**Ethical considerations**

An application form for ethical approval was submitted to the University Research Ethics Committee. Permission to carry out this study was granted.

I am very grateful for your help with this research. If you have any queries please contact Louisa Sheward, Nurse Lecturer at Ayr Campus, University of Paisley on 01292 886249 or email : shew-nm0@wpmail.paisley.ac.uk

# THE PATH TO NURSING REGISTRATION

Your answers to the following questions will be used to help develop the questionnaire to be used in the pilot and main study. **Your reasons** are important.

**SECTION A. Please circle the appropriate answer.**

Were you eligible for entrance onto the degree programme. **yes/no**

**Please read on.**

If your answer was **yes, and you accepted** a place on the undergraduate student nurse degree programme please go to section B on page 1.

If your answer was **yes, and you did not accept** a place on the undergraduate student nurse degree programme please go to section C on page 1.

If your answer was **no**, please go to section D on page 2.

**SECTION B.** Please state in your own words what was/were your main reason(s) for accepting a place on the undergraduate nursing degree course.

Please continue overleaf if required.

**Please now go to final section: Section E on page 2.**

**SECTION C.** Please state in your own words what was/were your main reason(s) for **not** accepting a place on the undergraduate nursing degree course.

Please continue overleaf if required.

**Please now go to final section: Section E on page 2.**

**Thank you for your help with this research**.

Once you have completed both sides of the questionnaire please post it in the box provided.

**SECTION D. Please circle the appropriate answer.**

Do you intend to study for a degree at a later date? **yes/no**

**Please read on.**

**If no**, please state in your own words what is/are your main reason(s) for **not** intending to study for a degree at a later date.

Please continue overleaf if required.

**If yes**, please state in your own words what is/are your main reason(s) for intending to study for a degree at a later date.

Please continue overleaf if required.

**Please now go to final section: Section E on page 2.**

**SECTION E Please tick/complete the following demographic questions.**

1. Please list ALL qualifications you have passed at secondary school, college etc.

| TYPE OF QUALIFICATION | SUBJECT | RESULTS | | TYPE OF QUALIFICATION | SUBJECT | RESULTS |
|---|---|---|---|---|---|---|
| e.g.Standard Grade | Biology | B | | | | |
| | | | | | | |
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**Thank you for your help with this research**.

Once you have completed both sides of the questionnaire please post it in the box provided.

Qn. No.

# THE PATH TO NURSING REGISTRATION

## Pilot Study

### About this questionnaire

- This questionnaire may appear long, but not all sections will be relevant to you.
- The expected time to complete the questionnaire is 10 minutes.
- You will be asked to complete Section A first. This is a newly developed scale which measures attitudes towards obtaining a degree. In order to test how reliable this scale is I would like to repeat Section A of the questionnaire in a few weeks time. This requires being able to anonymously match both sets of responses. To do this each questionnaire has a number in the right upper corner. This matches the number on the detachable slip below. Please detach this slip prior to returning the questionnaire in the box provided. I will ask you to keep this number in a safe place until the questionnaire is repeated. The second time you repeat the questionnaire you will be asked to staple this number to the repeated questionnaire prior to returning it in the box.
- You will then be asked to complete Section B.
- You will then be asked to complete EITHER Section C or D.
- You will then be asked to complete Section E.
- Remember it is your opinions that matter, please answer the questions as they apply to you.
- Finally, there are a few questions on the completion of the questionnaire itself.

✂----------

**THE PATH TO NURSING REGISTRATION-Pilot Study**
**Please keep this slip in a safe place.**
**I am very grateful for your help with this research.**
If you have any queries please contact Louisa Sheward,
Nurse Lecturer at Ayr Campus, University of Paisley
on 01292 886249 or email : shew-nm0@wpmail.paisley.ac.uk

Qn. No.

**SECTION A.**

The following is a list of statements about obtaining a nursing degree. Please indicate the extent to which you agree or disagree with each statement by circling a number on each line.

**OBTAINING A NURSING DEGREE .....**

| | Strongly Agree | Somewhat Agree | Undecided | Somewhat Disagree | Strongly Disagree |
|---|---|---|---|---|---|
| 1. Will help nurses develop their career | 1 | 2 | 3 | 4 | 5 |
| 2. Will help nurses consider jobs outside nursing | 1 | 2 | 3 | 4 | 5 |
| 3. Will increase self confidence | 1 | 2 | 3 | 4 | 5 |
| 4. Will increase knowledge | 1 | 2 | 3 | 4 | 5 |
| 5. Will be more satisfying than obtaining a nursing diploma | 1 | 2 | 3 | 4 | 5 |
| 6. Ought to be essential for all student nurses | 1 | 2 | 3 | 4 | 5 |
| 7. Ought to be essential for all nurses | 1 | 2 | 3 | 4 | 5 |
| 8. Will increase professional competence | 1 | 2 | 3 | 4 | 5 |
| 9. Is only essential for nurses who are ambitious | 1 | 2 | 3 | 4 | 5 |
| 10. Will not make nurses better at their jobs | 1 | 2 | 3 | 4 | 5 |
| 11. Will increase professional status | 1 | 2 | 3 | 4 | 5 |
| 12. Will improve the patient care provided by nurses | 1 | 2 | 3 | 4 | 5 |
| 13. Will not help nurses consider a wider range of job opportunities in nursing | 1 | 2 | 3 | 4 | 5 |
| 14. Is the gold standard for nurses | 1 | 2 | 3 | 4 | 5 |
| 15. Is what employers of nurses want | 1 | 2 | 3 | 4 | 5 |
| 16. Is essential to be a good nurse | 1 | 2 | 3 | 4 | 5 |

**OBTAINING A NURSING DEGREE .....**

| | Strongly Agree | Somewhat Agree | Undecided | Somewhat Disagree | Strongly Disagree |
|---|---|---|---|---|---|
| 17. Is easier as a student nurse because in studying mode. | 1 | 2 | 3 | 4 | 5 |
| 18. Will be difficult for many nurses because they lack the academic ability | 1 | 2 | 3 | 4 | 5 |
| 19. Will increase nurses clinical skills | 1 | 2 | 3 | 4 | 5 |
| 20. Is more likely if nurses are funded | 1 | 2 | 3 | 4 | 5 |
| 21. May put some students off training to be nurses if becomes essential | 1 | 2 | 3 | 4 | 5 |
| 22. May cause problems with qualified staff who do not have a degree | 1 | 2 | 3 | 4 | 5 |
| 23. May cause problems with other students who are not studying for a degree | 1 | 2 | 3 | 4 | 5 |
| 24. Will make nursing a more attractive career option if becomes essential | 1 | 2 | 3 | 4 | 5 |
| 25. Will be easier as a student nurse than post registration | 1 | 2 | 3 | 4 | 5 |
| 26. Will increase choice of nursing jobs | 1 | 2 | 3 | 4 | 5 |
| 27. Will not improve job opportunities in the future | 1 | 2 | 3 | 4 | 5 |
| 28. Is an excellent opportunity as a student nurse | 1 | 2 | 3 | 4 | 5 |
| 29. Should be recognised on the Nursing and Midwifery Council (NMC) Register. | 1 | 2 | 3 | 4 | 5 |
| 30. Should mean higher pay than for nurses with a diploma | 1 | 2 | 3 | 4 | 5 |
| 31. Will promote a two tier system in nurse education | 1 | 2 | 3 | 4 | 5 |
| 32. Is necessary to further a career in nursing | 1 | 2 | 3 | 4 | 5 |
| 33. Will be difficult for many nurses because they lack confidence in their academic ability | 1 | 2 | 3 | 4 | 5 |

**SECTION B**

**Please circle the appropriate answer.**

1. Did you accept a place on the degree programme? **1. Yes** **2. No**

**Please read on and you will be directed to the appropriate sections.**

If your answer was **YES**, please go to section C on page X.

If your answer was **NO**, please go to section D on page X.

**SECTION C - This section is to be completed by those who ACCEPTED a place on the undergraduate nurse degree programme.**

1. Please indicate by a tick, how much the following factors influenced YOUR decision to accept a place on the undergraduate degree programme.

| | **To a great extent** | **To some extent** | **To a little extent** | **Not at all** |
|---|---|---|---|---|
| 1. To improve my clinical skills | | | | |
| 2. For personal satisfaction | | | | |
| 3. To improve patient care | | | | |
| 4. Having funding | | | | |
| 5. To increase my self-confidence* | | | | |
| 6. In studying mode now | | | | |
| 7. Feeling motivated now | | | | |
| 8. To increase my knowledge | | | | |
| 9. No other commitments at present | | | | |
| 10. Degree seen as the gold standard | | | | |
| 11. Excellent opportunity | | | | |
| 12. To increase my professional competence | | | | |
| 13. Confidence in my academic ability | | | | |
| 14. To gain a higher academic award | | | | |
| 15. Because employers want it | | | | |
| 16. Can gain degree in 6 months rather than 2 years post registration | | | | |
| 17. To enable me to consider jobs outside nursing* | | | | |
| 18. To enable me to consider a specific career pathway | | | | |
| 19. Preferable to returning to study for a degree later in career | | | | |
| 20. To enable me to consider a wider range of job opportunities within nursing | | | | |
| 21. To improve my job opportunities in the future* | | | | |
| 22. Modules offered were of particular interest | | | | |
| 23. Other, please specify | | | | |

* Adapted from Davey B. and Robinson S. (2002) Taking a degree after qualifying as a registered general nurse: constraints and effects. Nurse Education Today. 22, 624-631.

2. From the list above please indicate in the space provided what was the **one main factor** that influenced your decision to accept a place on the undergraduate degree programme.....

.....

**SECTION D - This section is to be completed by those who did NOT accept a place on the undergraduate nurse degree programme.**

1. Please indicate by a tick, how much the following factors influenced YOUR decision to NOT accept a place on the undergraduate degree programme.

| | **To a great extent** | **To some extent** | **To a little extent** | **Not at all** |
|---|---|---|---|---|
| 1. Lack of confidence in my academic ability | | | | |
| 2. A degree will not enhance my clinical skills* | | | | |
| 3. Lack of motivation | | | | |
| 4. Some modules taught some distance away | | | | |
| 5. Lack of clinical experience | | | | |
| 6. Lack of knowledge to complete degree | | | | |
| 7. Did not like assignments | | | | |
| 8. Financial commitments | | | | |
| 9. Employment commitments | | | | |
| 10. Choice of modules did not interest me. | | | | |
| 11. Found previous assignments difficult | | | | |
| 12. Too stressful | | | | |
| 13. Did not like type of assessments for degree modules | | | | |
| 14. Want to gain more post registration clinical experience first | | | | |
| 15. Want to concentrate on clinical practice before registration | | | | |
| 16. Too much extra academic study in final 6 months | | | | |
| 17. Want time to gain confidence in final clinical placements | | | | |
| 18. Want to undertake further study for a degree at a later date | | | | |
| 19. No specific career plan for which a degree will be useful* | | | | |
| 20. Want to concentrate on improving theoretical knowledge in final placements | | | | |
| 21. Want to concentrate on improving clinical skills in final placements | | | | |
| 22. Did not wish to change to a new personal tutor for degree modules | | | | |
| 23. Want to study for a degree relevant to a specialist area after registration | | | | |
| 24. Other, please specify | | | | |

Adapted from Davey B. and Robinson S. (2002) Taking a degree after qualifying as a registered general nurse: constraints and effects. Nurse Education Today. 22, 624-631.

2. From the list above please indicate in the space provided what was the **one main factor** that influenced your decision to NOT accept a place on the undergraduate degree programme.....

**SECTION D cont'd.**

Do you plan to undertake a degree after registration? **1. Yes** **2. No**

If yes, please explain your answer.

.....

.....

.....

If no, please explain your answer

.....

.....

.....

4. Are there any factors which may have changed your mind to accept a place on the undergraduate degree programme. Please explain your answer

.....

.....

.....

**SECTION E. Please tick/circle/complete the following demographic questions.**

1. What is your gender? **1. Male ☐ 2. Female ☐**

2. What is your age? **_____Years**

3. What is your marital status? **Married/Single/Divorced/Widowed**

4. Do you currently have a part-time job? **1. Yes ☐ 2. No ☐**

5. Did you work as a health care assistant prior to commencing your nurse training?

**1. Yes ☐ 2. No ☐**

6. Please list your 1st diet grades for year 1 and 2 theoretical and practice/clinical assignments.

| | Year 1 | | | | Year 2 | | | |
|---|---|---|---|---|---|---|---|---|
| **Theoretical Assignments** | | | | | | | | |
| **Practice/Clinical Assignments** | | | | | | | | |

7. Please list **ALL** qualifications you have passed at secondary school, college etc.

| TYPE OF QUALIFICATION | SUBJECT | RESULTS | | TYPE OF QUALIFICATION | SUBJECT | RESULTS |
|---|---|---|---|---|---|---|
| e.g. Standard Grade | Biology | B | | | | |
| | | | | | | |
| | | | | | | |
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8. Do you have any dependent children who live with you? **1. Yes ☐ 2. No ☐**

9. Do you have any dependent relatives who live with you? **1. Yes ☐ 2. No ☐**

**Thank you for your help with this research.**
**Please return the questionnaire in the box provided.**

**As I am piloting the attached questionnaire I would greatly appreciate your assistance by completing the following questions on the completion of the questionnaire itself.**

1. **How long did it take you to complete the questionnaire?**

2. **Were the instructions clear?**

3. **Were any of the questions unclear or ambiguous? If so, will you say which and why?**

4. **Did you object to answering any of the questions?**

5. **In your opinion, has any major topic been omitted?**

6. **Was the layout of the questionnaire clear?**

7. **Any comments**

**THANK YOU.**

# THE PATH TO NURSING REGISTRATION

## Pilot Study

Qn. No.

Section A of the questionnaire, which you completed a few weeks ago, is a newly developed scale, which measures attitudes towards obtaining a degree. In order to test how reliable this scale is I said that I would ask you to repeat this section of the questionnaire after a short period of time.
It is important that I can anonymously match your previous set of responses with this set. Therefore I would like you to staple the slip with your original number to this retest questionnaire prior to returning it in the box. If you have lost the slip, but remember the number, then please write it in the box on the right hand side of this page. Thank you again for all your help.
Please now complete Section A again. This is slightly shorter now, because a few questions have been removed as a result of the first pilot.

**SECTION A**

The following is a list of statements about obtaining a nursing degree. Please indicate the extent to which you agree or disagree with each statement by circling a number on each line.

**OBTAINING A NURSING DEGREE .....**

| | Strongly Agree | Somewhat Agree | Undecided | Somewhat Disagree | Strongly Disagree |
|---|---|---|---|---|---|
| 1. Will help nurses develop their career | 1 | 2 | 3 | 4 | 5 |
| 2. Will help nurses consider jobs outside nursing | 1 | 2 | 3 | 4 | 5 |
| 3. Will increase self confidence | 1 | 2 | 3 | 4 | 5 |
| 4. Will increase knowledge | 1 | 2 | 3 | 4 | 5 |
| 5. Will be more satisfying than obtaining a nursing diploma | 1 | 2 | 3 | 4 | 5 |
| 6. Ought to be essential for all student nurses | 1 | 2 | 3 | 4 | 5 |
| 7. Ought to be essential for all nurses | 1 | 2 | 3 | 4 | 5 |
| 8. Will make nurses better at their jobs | 1 | 2 | 3 | 4 | 5 |

## OBTAINING A NURSING DEGREE.....

| | Strongly Agree | Somewhat Agree | Undecided | Somewhat Disagree | Strongly Disagree |
|---|---|---|---|---|---|
| 9. Will increase professional status | 1 | 2 | 3 | 4 | 5 |
| 10. Will improve the patient care provided by nurses | 1 | 2 | 3 | 4 | 5 |
| 11. Is what employers of nurses want | 1 | 2 | 3 | 4 | 5 |
| 12. Is essential to be a good nurse | 1 | 2 | 3 | 4 | 5 |
| 13. Is easier as a student nurse because in studying mode. | 1 | 2 | 3 | 4 | 5 |
| 14. Will make nursing a more attractive career option if becomes essential | 1 | 2 | 3 | 4 | 5 |
| 15. Will be easier as a student nurse than post registration | 1 | 2 | 3 | 4 | 5 |
| 16. Will increase choice of nursing jobs | 1 | 2 | 3 | 4 | 5 |
| 17. Is an excellent opportunity as a student nurse | 1 | 2 | 3 | 4 | 5 |
| 18. Should be recognised on the Nursing and Midwifery Council (NMC) Register. | 1 | 2 | 3 | 4 | 5 |
| 19. Should mean higher pay than for nurses with a diploma | 1 | 2 | 3 | 4 | 5 |
| 20. Is necessary to further a career in nursing | 1 | 2 | 3 | 4 | 5 |
| 21. Will be difficult for many nurses because they lack confidence in their academic ability | 1 | 2 | 3 | 4 | 5 |

**Please ensure that you have stapled or written your original number on the questionnaire prior to returning it in the box.**

**Thank you.**

**I am very grateful for you're your help with this research.**

Qn. No.

# THE PATH TO NURSE REGISTRATION

## Main Study

## About this questionnaire

- This questionnaire may appear long, but not all sections will be relevant to you.
- The expected time to complete the questionnaire is 10 minutes.
- You will be asked to complete Section A first. This is a newly developed scale which measures attitudes towards obtaining a degree.
- You will then be asked to complete Section B on whether you accepted a place on the degree programme or not.
- Depending on your answer you will then be asked to complete EITHER Section C or D which asks about factors that influenced your decision to accept or not.
- Finally you will all be asked to complete Section E based on demographic questions about you.
- Remember it is your opinions that matter, please answer the questions as they apply to you.

**SECTION A.**
The following is a list of statements about obtaining a nursing degree. Please indicate the extent to which you agree or disagree with each statement by circling a number on each line.

**OBTAINING A NURSING DEGREE .....**

| | Strongly Agree | Somewhat Agree | Undecided | Somewhat Disagree | Strongly Disagree |
|---|---|---|---|---|---|
| 1. Will help nurses develop their career | 1 | 2 | 3 | 4 | 5 |
| 2. Will help nurses consider jobs outside nursing | 1 | 2 | 3 | 4 | 5 |
| 3. Will increase self confidence | 1 | 2 | 3 | 4 | 5 |
| 4. Will increase knowledge | 1 | 2 | 3 | 4 | 5 |
| 5. Will be more satisfying than obtaining a nursing diploma | 1 | 2 | 3 | 4 | 5 |
| 6. Ought to be essential for all student nurses | 1 | 2 | 3 | 4 | 5 |
| 7. Ought to be essential for all nurses | 1 | 2 | 3 | 4 | 5 |
| 8. Will make nurses better at their jobs | 1 | 2 | 3 | 4 | 5 |
| 9. Will increase professional status | 1 | 2 | 3 | 4 | 5 |
| 10. Will improve the patient care provided by nurses | 1 | 2 | 3 | 4 | 5 |
| 11. Is what employers of nurses want | 1 | 2 | 3 | 4 | 5 |
| 12. Is essential to be a good nurse | 1 | 2 | 3 | 4 | 5 |
| 13. Is easier as a student nurse because in studying mode. | 1 | 2 | 3 | 4 | 5 |
| 14. Will make nursing a more attractive career option if becomes essential | 1 | 2 | 3 | 4 | 5 |
| 15. Will be easier as a student nurse than post registration | 1 | 2 | 3 | 4 | 5 |
| 16. Will increase choice of nursing jobs | 1 | 2 | 3 | 4 | 5 |

**OBTAINING A NURSING DEGREE .....**

| | Strongly Agree | Somewhat Agree | Undecided | Somewhat Disagree | Strongly Disagree |
|---|---|---|---|---|---|
| 17. Is an excellent opportunity as a student nurse | 1 | 2 | 3 | 4 | 5 |
| 18. Should be recognised on the Nursing and Midwifery Council (NMC) Register. | 1 | 2 | 3 | 4 | 5 |
| 19. Should mean higher pay than for nurses with a diploma | 1 | 2 | 3 | 4 | 5 |
| 20. Is necessary to further a career in nursing | 1 | 2 | 3 | 4 | 5 |
| 21. Will be difficult for many nurses because they lack confidence in their academic ability | 1 | 2 | 3 | 4 | 5 |
| 22. Should only be offered to student nurses who achieve 'good' grades for their assignments in years 1 and 2 | 1 | 2 | 3 | 4 | 5 |

**SECTION B**

**Please circle the appropriate answer.**

1. Did you accept a place on the degree programme?

Please tick the one most appropriate answer below.

| | | |
|---|---|---|
| 1. | I accepted a place and plan to study for the degree programme | |
| 2. | I originally accepted but have now withdrawn my acceptance on the degree programme | |
| 3. | I did not accept a place on the degree programme | |

**Please read on and you will be directed to the appropriate section.**

**IF YOU TICKED NUMBER ONE, PLEASE GO TO SECTION C ON PAGE 3.**

**IF YOU TICKED NUMBER TWO, PLEASE GO TO SECTION D ON PAGE 4.**

**IF YOU TICKED NUMBER THREE, PLEASE GO TO SECTION D ON PAGE 4.**

**SECTION C - This section is to be completed by those who ACCEPTED a place on the undergraduate nurse degree programme.**

1. Please indicate by a tick, how much the following factors influenced YOUR decision to accept a place on the undergraduate degree programme.

| | To a great extent | To some extent | To a little extent | Not at all |
|---|---|---|---|---|
| 1. To improve my clinical skills | | | | |
| 2. For personal satisfaction | | | | |
| 3. To improve patient care | | | | |
| 4. Degree was funded | | | | |
| 5. To increase my self-confidence* | | | | |
| 6. In studying mode now | | | | |
| 7. Feeling motivated now | | | | |
| 8. To increase my knowledge | | | | |
| 9. No other commitments at present | | | | |
| 10. Degree seen as gold standard | | | | |
| 11. Excellent opportunity | | | | |
| 12. To increase my professional competence | | | | |
| 13. Confidence in my academic ability | | | | |
| 14. To gain a higher academic award | | | | |
| 15. Because employers want it | | | | |
| 16. Can gain degree in 6 months rather than 2 years post registration | | | | |
| 17. To enable me to consider jobs outside nursing* | | | | |
| 18. To enable me to consider a specific career pathway | | | | |
| 19. Preferable to returning to study for a degree later in career | | | | |
| 20. To enable me to consider a wider range of job opportunities within nursing | | | | |
| 21. To improve my job opportunities in the future* | | | | |
| 22. Modules offered were of particular interest | | | | |
| 23. Having a degree is the 'norm' | | | | |
| 24. Other, please specify | | | | |

* Taken from Davey B. and Robinson S. (2002) Taking a degree after qualifying as a registered general nurse: constraints and effects. Nurse Education Today. 22, 624-631.

2. From the list above please choose the **three main factors** that influenced your decision most to accept a place on the undergraduate degree programme. Please write the appropriate numbers in the boxes below.

| 1. | | | 2. | | | 3. | | |
|---|---|---|---|---|---|---|---|---|

**PLEASE NOW GO TO SECTION E ON PAGE 6.**

**SECTION D - This section is to be completed by those who did NOT accept a place on the undergraduate nurse degree programme.**

1. Please indicate by a tick, how much the following factors influenced YOUR decision to NOT accept a place on the undergraduate degree programme.

| | **To a great extent** | **To some extent** | **To a little extent** | **Not at all** |
|---|---|---|---|---|
| 1. Lack of confidence in my academic ability | | | | |
| 2. A degree will not enhance my clinical skills* | | | | |
| 3. Lack of motivation | | | | |
| 4. Some modules taught some distance away | | | | |
| 5. Lack of clinical experience | | | | |
| 6. Lack of knowledge to complete degree | | | | |
| 7. Financial commitments | | | | |
| 8. Employment commitments | | | | |
| 9. Combined pressures of academic workload, family and work commitments | | | | |
| 10. Found previous assignments difficult | | | | |
| 11. Choice of modules did not interest me | | | | |
| 12. Too stressful | | | | |
| 13. Did not like type of assessments for degree modules | | | | |
| 14. Want to gain more post registration clinical experience first | | | | |
| 15. Want to concentrate on clinical practice before registration | | | | |
| 16. Too much extra academic study in final 6 months | | | | |
| 17. Want time to gain confidence in final clinical placements | | | | |
| 18. Want to undertake further study for a degree at a later date | | | | |
| 19. No specific career plan for which a degree will be useful* | | | | |
| 20. Want to concentrate on improving theoretical knowledge in final placements | | | | |
| 21. Want to concentrate on improving clinical skills in final placements | | | | |
| 22. Want to study for a degree relevant to a specialist area after registration | | | | |
| 23. Did not wish to change to a new personal tutor for degree modules | | | | |
| 24. Other, please specify | | | | |

*Taken from Davey B. and Robinson S. (2002) Taking a degree after qualifying as a registered general nurse: constraints and effects. Nurse Education Today. 22, 624-631.

2. From the list above please choose the **three main factors** that influenced your decision most to NOT accept a place on the undergraduate degree programme. Please write the appropriate numbers in the boxes below.

| 1. | | | 2. | | | 3. | | |
|---|---|---|---|---|---|---|---|---|

**SECTION D cont'd. overleaf**

## SECTION D

3. Do you plan to undertake a degree after registration?

Please circle the appropriate answer. **1. Yes** **2. No**

If yes, please explain your answer.

.....

.....

.....

If no, please explain your answer

.....

.....

.....

4. Are there any factors which may have changed your mind to accept a place on the undergraduate degree programme. Please explain your answer

.....

.....

**PLEASE NOW GO TO SECTION E ON PAGE 6.**

**SECTION E. Please tick/circle/complete the following demographic questions.**

1. What is your gender? **1. Male ☐ 2. Female ☐**

2. What is your age? **_____Years**

3. What is your marital status? **Married/Single/Divorced/Widowed/Other**

4. Do you currently have a part-time job? **1. Yes ☐ 2. No ☐**

5. Did you work as a health care assistant prior to commencing your nurse training?

**1. Yes ☐ 2. No ☐**

6. Please list your 1st diet grades for year 1 and year 2 assignments.

| | Theoretical Assignments | | | | Primary Care | | Continuing Care | |
|---|---|---|---|---|---|---|---|---|
| Year 1 | Skills | CD and CM | DOH | PPD | Summary | Poster | Profile | Oral |
| | | | | | | | | |

| | Theoretical Assignments | | | | Clinical Assessments | | Oral Exams | |
|---|---|---|---|---|---|---|---|---|
| Year 2 | HT1 | HT2 | Core Skills | PPD | | | | |
| | | | | | | | | |

7. Please list **ALL** qualifications you have passed at secondary school, college etc.

| TYPE OF QUALIFICATION | SUBJECT | RESULTS | | TYPE OF QUALIFICATION | SUBJECT | RESULTS |
|---|---|---|---|---|---|---|
| e.g. Standard Grade | Biology | B | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
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| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

8. Has anyone in your immediate family previously studied for a degree in any subject?

**1. Yes ☐ 2. No ☐**

9. Do you have any dependent children who live with you? **1. Yes ☐ 2. No ☐**

10. Do you have any dependent relatives who live with you? **1. Yes ☐ 2. No ☐**

**THANK YOU FOR YOUR HELP WITH THIS RESEARCH.**
**PLEASE RETURN THE QUESTIONNAIRE IN THE BOX PROVIDED.**

| ***Correlation between those who accepted a place on the degree programme and those that did not based on demographic variables*** | ***Pearson's correlation coefficient*** | ***p-value*** |
|---|---|---|
| Age over 22 | -0.166 | 0.097 |
| Age over 26 | -0.082 | 0.413 |
| What is your gender? | -0.036 | 0.719 |
| What is your marital status? | -0.085 | 0.389 |
| Do you have dependent relatives who live with you? | -0.086 | 0.386 |
| Do you have dependent children who live with you? | -0.188 | 0.057 |
| Do you currently have a part-time job? | 0.042 | 0.676 |
| Campus attended | 0.290 | **0.003** |
| Did you work as a Health Care Assistant prior to commencing your training? | -0.173 | 0.081 |
| Highest Qualification<br>Group 1<br>Group 2<br>Group 3 | -0.143 | 0.250 |
| Has anyone in your immediate family previously studied for a degree in any subject? | 0.048 | 0.632 |

**Table. 38. Correlation between those who accepted a place on the degree programme and those that did not based on demographic variables**

| *STATEMENT* | ***Pearson's correlation coefficient*** | ***p-value*** |
|---|---|---|
| 1. Will help nurses develop their career | -0.285 | **0.003** |
| 2. Will help nurses consider jobs outside nursing | -0.184 | 0.062 |
| 3. Will increase self confidence | -0.166 | 0.092 |
| 4. Will increase knowledge | -0.170 | 0.085 |
| 5. Will be more satisfying than obtaining a nursing diploma | -0.404 | **0.000** |
| 6. Ought to be essential for all student nurses | -0.208 | **0.035** |
| 7. Ought to be essential for all nurses | -0.235 | **0.017** |
| 8. Will make nurses better at their jobs | -0.325 | **0.001** |
| 9. Will increase professional status | -0.299 | **0.002** |
| 10. Will improve the patient care provided by nurses | -0.267 | **0.006** |
| 11. Is what employers of nurses want | -0.213 | **0.030** |
| 12. Is essential to be a good nurse | -0.109 | 0.270 |
| 13. Is easier as a student nurse because in studying mode. | -0.509 | **0.000** |
| 14. Will make nursing a more attractive career option if becomes essential | -0.329 | **0.001** |
| 15. Will be easier as a student nurse than post registration | -0.333 | **0.001** |
| 16. Will increase choice of nursing jobs | -0.238 | **0.015** |
| 17. Is an excellent opportunity as a student nurse | -0.376 | **0.000** |
| 18. Should be recognised on the Nursing and Midwifery Council (NMC) Register. | -0.483 | **0.000** |
| 19. Should mean higher pay than for nurses with a diploma | -0.514 | **0.000** |
| 20. Is necessary to further a career in nursing | -0.286 | **0.003** |
| 21. Will be difficult for many nurses because they lack confidence in their academic ability | -0.122 | 0.216 |
| 22. Should only be offered to student nurses who achieve good grades for their assignments in years 1 and 2 | 0.121 | 0.222 |

**Table 39. Correlation between those who accepted a place on the degree programme and those that did not based on attitude responses.**

| **Correlation between demographic variables and campus attended** | ***Pearson's correlation coefficient*** | ***p-value*** |
|---|---|---|
| Age over 22 | 0.022 | 0.828 |
| Age over 26 | -0.141 | 0.159 |
| What is your gender? | 0.010 | 0.924 |
| What is your marital status? | 0.049 | 0.623 |
| Do you have dependent relatives who live with you? | -0.050 | 0.618 |
| Do you have dependent children who live with you? | -0.016 | 0.873 |
| Do you currently have a part-time job? | -0.066 | 0.507 |
| Did you work as a Health Care Assistant prior to commencing your training? | -0.090 | 0.368 |
| Highest Qualification<br>Group 1<br>Group 2<br>Group 3 | 0.024 | 0.847 |
| Has anyone in your immediate family previously studied for a degree in any subject? | -0.137 | 0.172 |

**Table. 40. Correlation between demographic variables and campus attended**

Possible uses of a SNEDS:

- to produce Exit Interview Reports
- To examine trends regarding student nurse demographics, academic achievements
- To link anonymous data to other information systems as appropriate
- To provide data to influence and facilitate decision making
- To contribute towards advancing teaching as an evidence based profession
- To consider the outcomes of cohorts and whole programmes.

**SNEDS basic variables**

**Appendix 13**

| Recruitment and Selection data |
|---|
| ID |
| Name |
| Demographic data |
| Numeracy Test Result |
| Literacy Test Result |

| Registry Database data |
|---|
| ID |
| Name |
| Demographic data |
| Matric Number |
| Cohort |
| Entrance Qualifications |
| Student status |

| Pathways Study Skills data |
|---|
| ID |
| Name |
| Matric Number |
| Referral Date |
| Reason for referral |
| Outcome |

| Special Education Needs data |
|---|
| ID |
| Name |
| Matric Number |
| Special Educational needs |

| Clinical Placement data |
|---|
| ID |
| Name |
| Matric Number |
| Clinical Placement Name |
| Outcomes met/not met |
| Grade |

| Academic Achievement data |
|---|
| ID |
| Name |
| Matric Number |
| Academic achievement data for each module |

| Attendance Issues data |
|---|
| ID |
| Name |
| Matirc Number |
| Attendance Issue(s) |
| Date referral to Programme Leader |
| Outcome |

| Professional Issues data |
|---|
| ID |
| Name |
| Matric Number |
| Type of Professional Issue(s) |
| Date referred to Director of School |
| Outcome |

| Programme Referral data |
|---|
| ID |
| Name |
| Matric Number |
| Referral to Programme Panel |
| Date of referral |
| Outcome |

| Degree Transfer data |
|---|
| ID |
| Name |
| Matric Number |
| Personal Tutor recommnedation to transfer |
| Accepted Transfer to Degree |
| Main reason(s) to reject |
| Main reason(s) to accept |
| Outcome |
| Date withdrawn |
| Reason(s) |

| Attrition data |
|---|
| ID |
| Name |
| Matric Number |
| Reason for Leaving programme |
| Date for leaving programme |