ENROLLED NURSE TRANSITION TO DEGREE LEVEL STUDY BASED AT A RURAL SATELLITE CAMPUS

A thesis presented in partial fulfilment of the requirements for the degree of Master of Arts in Nursing at Massey University, Albany, New Zealand.

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2002

ABSTRACT

The demise of enrolled nurse training programmes and the disestablishment of enrolled nurse positions in many health care areas in New Zealand in the 1990s, hastened the development of transition programmes that enabled these nurses to undertake shortened courses leading to registration. The polytechnic was approached by health care providers from rural settings to deliver a programme offering transition to degree/registration for enrolled nurses who were not able to meet the time and travel commitments of a course based at the main campus. In 1998, a special two year six month transition to degree/registration programme based at the satellite campus of the polytechnic was offered to enrolled nurses. In recognition of the requirements of these nurses with family and work commitments, the course was developed to enable them to continue working while studying, as well as finding appropriate clinical placements/ learning activities as near as possible to their home environment.

An exploratory, descriptive, qualitative research study utilising focus group interviews was undertaken to examine the factors that assisted or hindered these enrolled nurses in their transition to degree level study. Ten mature age female students and six female teachers were the participants.

Two major categories emerged from constant comparative analysis of the data. One category entitled *relearning how to learn,* demonstrated the cognitive and behavioural adaptations the students made throughout the transition. The other major category - *barriers and catapults*, demonstrated the external forces that influenced the students' transition.

ACKNOWLEDGEMENTS

There are many people who deserve recognition for the part they played in this research study. Primarily I would like to sincerely thank the students who willingly gave their time as well as their commitment to share their thoughts and experiences with me. I am grateful for your forthrightness and honesty and am in genuine awe of your ability to handle the challenges and diversities that the course presented.

I would like to express my thanks to my colleagues, not only for the time they gave as part of the study, but for their unending support and encouragement. I am also grateful for the support offered by the polytechnic to enable me to complete this study.

To my supervisors, Mary Finlayson and Judith Mahood, who have shared their knowledge and guidance, and supported me in spite of setbacks, I owe you both a debt of gratitude.

To my husband Nick for his longsuffering support and unwavering belief that I would complete this study, I am eternally grateful.

Finally, a mention of two hairy, loyal companions, Jock and Muffy, who sat by my feet hour after hour until the wee small hours as I plugged away at the computer, the company of two small beating hearts was a comfort.

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CHAPTER ONE

Introduction

In 1998 I took up a position as a nursing lecturer at a polytechnic in a small provincial New Zealand city. As part of my responsibilities as a senior lecturer I was requested to manage the co-ordination of a nursing programme that had commenced six months previously in July. This was a shortened programme for enrolled nurses (EN) who wished to gain the Bachelor of Health Science (Nursing) degree and comprehensive nursing registration. The programme was mainly delivered at the satellite campus of the polytechnic and it was the first time this programme had been offered at a site other than the main campus. Transition to degree/registration had been offered to enrolled nurses at the main campus since the instigation of a degree programme in 1995 and this attracted three to four enrolled nurses each semester intake.

This research study was instigated by my desire to explore the factors that assisted or hindered ten enrolled nurses, five of whom identified as Maori, as they undertook degree level study and transition to comprehensive registration at the satellite campus. An exploratory, descriptive, qualitative research study was undertaken, using focus group interviews to collect data, and the data analysed utilising a comparative analysis method associated with grounded theory.

Definitions of Terms Used in This Study

Enrolled Nurse is a person who has completed a twelve-month course of training prescribed by the Nurses Act 1977. Frequently termed a second level nurse.

Registered Comprehensive Nurse is a person who has completed a three year programme of integrated study leading to registration under the Nurses Act 1977. Frequently termed a first level nurse.

Diploma programme is a three-year programme of study leading to the qualification of Diploma in Nursing.

Bachelor of Health Science (Nursing) is a three-year programme of study leading to a degree in health science (nursing). The three years are divided into six semesters. Each semester consists of modules related to nursing knowledge, professional practice, human biological science/pathophysiology, and social science knowledge.

Recognition of prior learning is defined by Day (1997, p.1) 'as a mechanism by which people can gain recognition, or credit, from an educational provider for learning achievements they have gained elsewhere so that this credit can be counted toward some qualification'.

The Treaty of Waitangi is an agreement between the tangata whenua (people belonging to the land) and the New Zealand Crown, and stands as the original negotiated relationship.

Background

In 1990 the Educational Amendment Act granted technical institutes the right to confer degrees and this resulted in a restructuring of nursing programmes throughout New Zealand. After examining the possibilities of developing their own degree programme the study polytechnic decided to purchase the degree programme from a large technical institution in 1995. The rationale for this decision was that although there were principal and senior lecturers within the polytechnic qualified to develop a degree curriculum, the franchised degree already matched the philosophical beliefs held by the nursing department. These beliefs embraced the Treaty of Waitangi, New Zealand's founding document and the concept of partnership in teaching and learning. The nursing department believed that nursing practice in New Zealand had to be congruent with the Treaty of Waitangi because it provided the cornerstone for a bicultural society based on the sharing of power and resources in a mutual and mature partnership. This philosophical belief, shared by both institutions, was particularly relevant for the polytechnic, which was situated in an area with a 30.3% Maori population. The total population of Maori in New Zealand at the 1996 census was 14.5% (Statistics NZ, 1996, p. 69). The academic processes, the learning outcomes and assessment criteria remain largely identical to the franchised programme, although the content for modules and clinical placements have been adapted to be congruent with the geographical and

social environment in which the polytechnic is situated (Curriculum Document, 1998).

This new degree programme had been running for approximately eighteen months when the polytechnic was approached in 1998 by a number of health providers from outside the city to explore the possibility of offering the programme to enrolled nurses within their employ. These enrolled nurses were unable to commit to the required full time study at the main campus for a variety of reasons, many of them had family and work commitments that prevented them from travelling away from home for a semester at a time.

In accordance with the New Zealand Nursing Council requirements, a programme was developed that encompassed 1000 hours of clinical experience and 1000 hours theory, and recognised the enrolled nurses' previous education and experience. The students were granted recognition of prior learning for four first year degree modules - nursing knowledge, nursing practice, and clinical experience modules related to the application of basic nursing skills. This shortened their programme to two and a half years. Teachers from the main campus travelled to the satellite campus to deliver their modules in three-day block periods, which allowed the students to continue working part-time as well as staying within their family unit. To meet the clinical requirements the students had to travel to the city to gain clinical experience in mental health, family and child health, as well as medical and surgical nursing. The majority of time spent for each clinical learning experience was five weeks, during which time the students stayed in the city, travelling home at weekends. The health service providers had made a commitment to support these students to registration, and during their time away gaining the required clinical experience, their work positions were held open.

To situate the present study in context it is necessary to present an overview of nursing education in New Zealand and examine the socio-political climate that influenced the development of the enrolled nurse transition programme at the satellite campus.

Nursing Education in New Zealand

Registered nurse training in New Zealand was undertaken in the form of traditional apprenticeship models in hospitals until 1973. This apprenticeship style of training was based on the Nightingale model where nursing was learnt as the students provided service in the hospital wards. Medical staff taught subjects such as medicine and surgery while nursing tutors taught nursing skills utilising step-by-step procedural manuals. Medical staff were also instrumental in defining nursing curricula, writing nursing texts, and monitoring examinations. The medical socialisation of nursing was very apparent as the teaching was based around medical specialties. Many of the medical staff were strongly opposed to the transition to technical institutes, as it was perceived they would lose control of the curricula. Medical staff continued to teach much of the classroom content and write the majority of nursing texts until the 1970s (Dyson, 1998). These training programmes led to a range of separate registrations including general, obstetric, psychiatric, psychopaedic and male. There was a separate roll for enrolled nurses and their training is discussed later in this chapter.

A high attrition rate, lack of parity with the education of other health professionals, and concerns about the quality of teaching and learning, led the New Zealand government in 1970 to contract the services of a World Health Organisation consultant, Dr Helen Carpenter to review the nursing education system. Carpenter's 1971 report criticised the medically focussed curricula identifying that there was minimal emphasis on health education and community welfare. The lack of educational qualifications amongst nursing tutors was also an area of concern for Carpenter when she identified that only 30% of all tutors held the minimum recommended teaching qualification, the one-year diploma from the School of Nursing Studies at Victoria University. McCallin (1993) however, noted that this was the only qualification available to prepare nurses for leadership and teaching roles at this time. It wasn't until 1973 when Massey University and Victoria University commenced baccalaureate programmes for registered nurses, that nurses were able to gain degree qualifications particularly related to nursing knowledge. Massey University commenced both

extramural and locally based Bachelor of Arts (Nursing) programmes for registered nurses while Victoria University offered registered nurses a locally based Bachelor of Nursing programme. Prior to that, a small number of registered nurses achieved degree qualifications in the social sciences such as psychology, sociology and education. In 1982 the Nursing Council of New Zealand circulated a statement on nurse teachers' qualifications on entry to Technical Institutes and Community College Departments of Nursing, and to Hospital Schools of Nursing (Department of Health, 1988). In this document it was stated that nursing tutors employed after January, 1985 would be required to have completed a university degree relevant to nursing. The Nursing Council did however acknowledge there would be problems in implementing this, such as limited paid study leave and only two universities with nursing departments offering nursing papers.

Dr. Carpenter's (1971) recommendations provided the impetus for the change of nursing education from hospitals to polytechnics, although her recommendation was to move nursing education into colleges rather than polytechnics (Carpenter, 1971). Carpenter also suggested, in recommendation 1.6 of her report that a committee be set up to study her proposals and make recommendations to the government on the most suitable setting for the colleges. The "1.6 Committee" was subsequently set up in 1972 and recommended that nursing education be transferred from the Department of Health to the Department of Education. This committee also recommended that nursing education be conducted in technical institutes (Taylor et al, 1981). As a result of Carpenter's recommendations, pre-registration nursing education was progressively transferred to the fourteen polytechnics from 1973. The overall aim of the transfer was to prepare nurses educationally and vocationally to work in the rapidly changing cultural and socio-political environment of the heath care sector. These nursing education programmes combined general, obstetric, psychiatric and psychopaedic components into one course leading to a Diploma in Nursing and registration as a New Zealand Comprehensive Nurse. Nursing lecturers assumed control of student learning in both the classroom and clinical setting. The last graduates from the hospital based training programme were

registered in the mid 1990s. This transition from apprentice to student status was a major fundamental change for nursing education.

The decision to transfer nursing education from hospital-based programmes into the technical institutes has been a controversial one. Rummel noted that in 1993 there were still some registered nurses, educated in the hospital-based programme, who believed that the technical institute trained nurse was inferior to their earlier professional colleagues, although the evidence does not support this view (Taylor et al, 1981). Rummel believed that graduates and students from comprehensive programmes in the early 1990s still carried the burden of this opinion.

The next major change in nursing education occurred following the Amendment to the Education Act 1990. This legislation led to the establishment of the New Zealand Qualifications Authority and enabled educational institutions other than universities to award degrees for the first time. Undergraduate nursing degrees based on both three and four-year models were accredited and approved, but there were significant funding implications for four-year programmes and market forces dictated that the three-year model would predominate (KPMG, 2001). Pre-registration nursing degrees are now also available in a small number of universities following recent changes in the structure of some tertiary institutions. Carpenter initially put this forward as a recommendation thirty years previously.

Enrolled Nurses in New Zealand

Initial preparation and recognition of the second level nurse did not occur until 1939, up till then these nurses were registered under the 1925 Nurses' and Midwives' Act as nurse aides (Adamson, 1997). In 1966 the nurse aid programme was replaced with an eighteen-month programme that led to the qualification of community nurse. These programmes for community nurses, later known as enrolled nurses, were managed by Hospital Boards who were able to utilise these nurses as a labour force throughout their training. Enrolled nurses were also able to extend their basic course by gaining six-month 'endorsements' in their specialty area. The programme was reviewed in 1977 as

a result of the high attrition rate among community nurses and the concern that their initials, RCN, would be confused with the new comprehensive graduates. The name change to enrolled nurse, and shortening of the programme to twelve months occurred overnight following the passing of the Nurses' Act in 1977. Adamson (1997) noted that many enrolled nurses felt frustrated with the lack of consultation in relation to the length of their programme and name change, as they perceived their qualification had been diminished.

In 1983 an amendment to the Nurses' Act made it a requirement for enrolled nurses to practise under the supervision of a registered nurse or medical practitioner (Dixon, 1996). Adamson (1997) noted that this amendment was the beginning of major changes for enrolled nurses, as the profession attempted to define their scope of practice in relation to registered nurses. The Department of Health provided guidance for registered/ enrolled nurse ratios in the workforce in 1986, stating that the ratio would be governed by the complexity and dependency of the patient care required (Dixon). Brownie (1993) noted that confusion over the role of the enrolled nurse and what constituted supervision, was still apparent in 1993, with supervision being described as two to four hours per week, to total direct supervision in the workplace. Brownie's report also suggested that enrolled nurses were too expensive in relation to the level of responsibility they could assume for patient care.

Socio-Political Environment

Beginning in the 1980s with the Labour Government in power from 1984-1990, and continuing through the 1990s with the National Government, major economic changes and reforms occurred. The stated aim from political circles for restructuring the health care system in the 1990s was to improve the health care delivery service to the public of New Zealand (Upton, 1991). However, at the societal grass roots level, the belief was that the changes were made more for economic rationalisation rather than for an improved health service (Rummel, 1993). With reduced funding Area Health Boards undertook measures to reduce costs and as part of these measures many Boards opted to diminish or discontinue enrolled nurse training programmes. The process of discontinuation of enrolled nurse training occurred haphazardly across the

country with the last candidates from the programmes completing examinations in March 1994 (Dixon, 1996).

Escalating costs in the health sector have seen rationalisation occur on a large scale. Shorter hospital stays, high acuity, deinstitutionalisation and the growth of the community-based health sector have increased the need for nurses to be able to manage and deliver a diverse range of patient care services, requiring them to assume high levels of responsibility as well as being critical thinking and problem-solving practitioners. With the changes that had occurred in the health sector by the mid 1990s, positions for enrolled nurses were under threat with many being made redundant or transferred to different care facilities. At this time the National Government disestablished Area Health Boards and created a new entity - Crown Health Enterprises (CHE). One CHE disestablished enrolled nurse positions then offered the enrolled nurses work as health care assistants on reduced pay. A number of the nurses were major providers in the family and reluctantly accepted these new positions (Hodgson & Lauchland, 1999).

Many enrolled nurses, now aware of the implications of the health sector changes on their future work security, began undertaking transition programmes leading to comprehensive registration. The Nursing Council of New Zealand, who approved and audited these programmes, also specified the number of clinical and theoretical hours, but there was not a single prescriptive programme and the transition programmes offered varied from polytechnic to polytechnic. Some polytechnics allowed a reduction in content and time, while others provided no acknowledgement of the enrolled nurses' previous experience. This lack of consistency proved to be frustrating and devaluing for many of the enrolled nurses not offered recognition for their prior learning and experience. The length and structure of the programmes also depended on whether the enrolled nurses were gaining a degree or diploma qualification in conjunction with comprehensive registration. A number of polytechnics offered a two-year programme leading to diploma and comprehensive registration, while others offered a two and a half year programme leading to the degree qualification.

For many of the students in this study the opportunity to undertake the transition to degree/registration was influenced not only by the disestablishment of enrolled nurse positions but by the desire of long held ambitions to gain the registered nurse qualification. In personal communications with the students a number had stated that they initially wanted to undertake a registered nurse programme when they left school but were prevented from doing so by a lack of educational qualifications, or financial means. Family influences also played a large part in the suggestion that enrolled nurse training was an acceptable choice while waiting for marriage (Adamson, 1997). The majority of students had completed the eighteen-month programme, which enabled them to gain rapid employment, but they now perceived that the qualification of registered nurse would allow them to progress in their careers as well as offering enhanced remuneration.

Mature Age Students

The students in this study were women of mature age ranging from 35 to 52 years. Mature age students frequently face learning difficulties when returning to study, and the enrolled nurses had undertaken training in an era where it was not appropriate to question and challenge the teacher. The students' previous experience of education in their enrolled nurse training would have exposed them to a 'chalk and talk' method of teaching, which would not necessarily have given them the skills to be mature learners. However, there is sufficient evidence to support the view that frequently the mature student performs significantly better than younger students. This is attributed to their high levels of motivation (Houltram, 1996; Ofori, 2000). The mature age student is also viewed as having life commitments that extend beyond the singular focus of the traditional student (MacKinnon-Slaney, 1994). This was the case with the ten students in the current study, who would not have undertaken the programme if it was not offered at the satellite campus allowing them to meet family and work responsibilities.

Transition to Degree Level Study

Changes to lifestyle or career invariably bring with them anxiety, apprehension and a certain amount of fear of the unknown. Central to the successful outcome

of transition is the sense that one has control over this period of change and that one has the skills and knowledge required to handle the change associated with this (Carter & Cook, 1995). A sense of control in the learning environment appears critical to psychological wellbeing and the ability to make effective decisions around learning. Super (1990) has suggested that effective decision-making and problem solving requires an internal locus of control, noting that individuals with an internal locus of control are more likely to seek information and resources that support adjustment and coping behaviour. The students' previous educational experiences would not have provided them with many opportunities to have control over their learning environment, or engendered self-directed learning, due to the socio-political constructs of education at the time of their training. However, their subsequent positions of responsibility as enrolled nurses, especially in rural areas, where many had assumed levels of responsibility more appropriate to registered nurses, promoted the development of these skills.

Maori Students

Fifty percent of the students in this study identified as Maori, which is well above the nine percent figure for Maori graduates published by the Ministry of Education in 1998 (Manchester, 2000, p. 12). The fifty percent figure reflects the high Maori population within the polytechnic's geographical location (30.3%), and the students were encouraged and supported, many financially, by their local iwi (tribe) and employers, to complete their programme. The KPMG (2001) report identified that the demand for Maori nurses will continue to increase, but also noted that there is a significant problem in attracting more Maori to the profession. Anderson (2001) believes that there are minimal incentives in career structures and salaries to attract Maori students, that the vocational aspects of nursing are not enough of a reward in today's climate, where there are many more career opportunities for females. The KPMG report stated that attracting and retaining Maori students would depend critically on incentives, mentoring, iwi support and funding. It suggested that better support strategies, for example, mentoring by experienced Maori nurses, would alleviate pressure on new Maori graduates.

Significance of This Study.

The purpose of this study was to examine the factors that assisted or hindered the students as they undertook the transition to degree level study based at the satellite campus, removed from many of the polytechnic's support structures and resources. Nurse educators and researchers have long been interested in identifying factors that predict academic outcomes in nursing students. Numerous academic, psychological and demographic variables that may be valid predictors of academic success have been studied (Allen, Higgs & Holloway, 1988; Chacko & Huba, 1991; Horns, O'Sullivan & Goodman, 1991). Work by Heinrich and Spielberger (1982), Miller (1980), and Selye (1980) has indicated that a person's stress level plays a complex role in learning, and problem-solving abilities. O'Connor and Bevil (1996) noted that the need to maintain employment while attending nursing school is a reality for many students enrolled in nursing programmes in the USA today and this presents the students with challenges in areas such as time management and priority setting that other students may not have to contend with. These studies investigated the many variables that may influence academic outcomes, but at the time of reporting this present study there have been no identifiable studies that have examined the combination of variables of the present study.

In informal discussions with the Maori students in this study, they commented that once they graduated they would be perceived as role models and mentors for new graduates, as they already had many years of practical experience as enrolled nurses and an understanding of the health care system. A number of students in the study also commented they had a commitment to go back to positions as registered nurses that were being held open for them, especially as employers and local iwi were financially supporting their study. In light of the KPMG report's recognition of the need to attract and retain Maori students, it would appear that the programme at the satellite campus would improve access for mature Maori women and enable them to maximise their potential as well as contributing their knowledge and expertise to their communities.

A new degree programme based at a satellite campus would provide many challenges for students as well as teachers and administrators. That the

programme would endeavour to accommodate the work and family commitments of mature women was an additional challenge for all participants in the programme. The utilisation of focus group interviews with students and teachers in the second year of the programme was deemed to be an appropriate way of gaining valuable insight into the factors that assisted or hindered the students as they progressed though the programme. Changes could then be implemented to maximise the students' successful completion.

It is expected that the results of the study will also provide valuable knowledge on the facilitation of any educational transition programme, not necessarily nursing, that would be implemented and administered away from a major campus and its support structures and resources.

Structure of the Thesis

This research study is presented in seven chapters. In **Chapter One,** the topic of the thesis is introduced and the background and purpose of the study has been outlined. This chapter includes an historical overview and situates the present study in context. **Chapter Two** examines and critiques the literature relevant to enrolled nurse transition. In **Chapter Three** the research methodology is discussed, with a rationale given for the choice of research method. This chapter includes an outline of the study settings, the participants, and the ethical considerations of the study. **Chapters Four and Five** present an analysis of the findings. The data analysis gave rise to two major categories, ***relearning how to learn***, which identified the cognitive and behavioural adaptations the students experienced. Within this category, four sub-categories are presented – *'out of comfort zone', 'finding their voice', 'letting go/grieving', and 'growing the tree'.* ***Barriers and catapults*** was the second major category, which is presented in chapter five. Within this category, three sub-categories are presented – *'clinical role models', rural living', and support services'.* **Chapter Six** contains the discussion of the findings with integration of the literature. **Chapter Seven** concludes the thesis and addresses the limitations and strengths of the study. In this final chapter implications of the study for nursing education and polytechnic administration are noted, and recommendations are outlined.

CHAPTER TWO

Literature Review

Introduction

This chapter examines the literature related to transitional programmes for enrolled nurses. The major concepts discussed are educational mobility; recognition of prior learning; the mature student; the process of transition; and support services. There is very little literature in New Zealand on the educational processes related to enrolled nurse transition, therefore the majority of literature reviewed relates to international programmes, those that have occurred in the United Kingdom (UK) and the United States of America (USA).

An examination of the international literature suggests there are some commonalities that occur within programmes that offer enrolled nurses transition to registered nurse status. A major difference is that the majority of the literature from the USA discusses transition to registered nurse programmes in association with attainment of an associate or baccalaureate degree, whereas the literature related to UK programmes describes the transition to registered nurse with a diploma qualification.

Educational Mobility

Although there is very little literature in New Zealand on the educational processes undertaken by enrolled nurses transitioning to degree, two major academic works have recently been completed which have explored the role and practice of enrolled nurses as they journeyed to registration and beyond. Dixon's (1996) doctoral study explored the difference in practice between enrolled nurses and registered nurses. Her thesis gave a comprehensive review of the socio-political factors that led to the demise of enrolled nurse training as she examined the conflicting viewpoints that surrounded the discontinuation of the programmes. Utilising critical case studies, Dixon stated that critical and feminist perspectives informed the research and put forward the view that her choice of research paradigm was influenced by 'an implicit assumption that

there are underlying power and control issues between registered and enrolled nurses in practice' (1996, p. 63). This assumption was not elaborated on. Dixon also noted the paucity of material related to educational mobility in the literature.

In her 1997 Master's thesis, Adamson investigated the progress made by enrolled nurses as they upgraded to comprehensive registration (with diploma). The main focus for her thesis was discovering a process that promoted self-efficacy and professional development for enrolled nurses as they progressed through the course and then worked as registered nurses. Adamson utilised action research methodology that assisted the students in her research to develop an understanding of the change processes that occurred throughout their learning experience. Her research highlighted the importance of self-efficacy in developing professional accountability, as students made the educational movement from enrolled nurse to registered nurse.

In 1985 the English National Board approved a 52 week conversion course to registered nurse (diploma), for enrolled nurses, and around the same period, the USA, in response to a critical shortage of registered nurses, developed and implemented an accelerated transition programme for licensed practical/vocational nurses (LPN/LVN) (Boyar et al, 1989, Hembrough & Sheehan, 1989). Both the enrolled nurse in the UK and the licensed practical nurse in the USA are described as second level nurses with similar periods of training, usually one year, although this may vary in the USA between states.

The UK and USA have different educational programmes for the registered nurse, with the USA having a longer history of university educated nurses, and nursing students able to complete either a two year Diploma programme, a two year Associate Degree in Nursing (ADN) programme, or a four year Bachelor of Science in Nursing (BSN), although this may vary from state to state (Redmond, 1997). In contrast, in the UK until recently, the majority of registered nurses exited their programmes with a diploma qualification. Currently they have a choice between diploma and bachelor programmes.

Boyar et al (1989) described three programmes that have been implemented in the USA that offer educational mobility for the licensed practical nurse, although

it is not apparent in the literature whether these programmes are available in every state.

A licensed practical nurse may:

1. enter a nursing programme at beginning entry level.
2. enter the second year of a two-year programme after completing a transition course and all pre-requisites
3. participate in an accelerated programme specifically designed for licensed practical nurses (p.361).

Boyar et al (1989) discussed the merits of each option for the licensed practical nurse, suggesting that the first option was lengthy and required substantial time and financial commitments from the student. The second option did not meet the special needs of students who already had nursing experience, and whose previous knowledge, that was assumed to be equivalent to the first year of the programme, may have been outdated by the time they returned to school. Boyar, et al recommended that the third option allowed licensed practical nurses to complete a shorter programme that addressed their particular needs.

A study of the shortened transitional programme was undertaken by Boyar, et al (1989) to evaluate the students' academic achievement and socialisation into the registered nurse role. Results of the role socialisation revealed no significant differences to students in a conventional programme, and also indicated that comparable academic achievement was possible in the accelerated programme.

In the USA transition courses were diverse according to which state was implementing the transition, but there were many similarities within their nursing programmes. Eichenauer (1992) described how curricula from schools for practical nursing were evaluated for content against current programmes for registered nurses. She identified that licensed practical nurses were deficient in areas of nursing process, rationale for nursing procedures, organisation and leadership skills, and psychiatric nursing. To gain an associate degree in nursing the students were offered an accelerated programme that recognised the educational deficiencies in the original programmes. The accelerated course

replaced the first year of the degree nursing course and the applicants were required to enrol in second year nursing courses within two years of completing the transition course. The transition course focused on role transition and adaptation from licensed practical nurse to registered nurse (RN) as well as content that was deemed to be missing from the licensed practical nurse curriculum. Their entry into the second year programme also depended on their success in completing general education courses such as biology, chemistry, psychology, nutrition, English, sociology, and pharmacy.

Also in the USA, Redmond (1997) discussed a similar framework for transition but identified more specific criteria for licensed practical nurses undergoing transition to gain a degree qualification (BSN) as compared to other programmes offering a transition to registered nurse (ADN). The licensed practical nurses had to undertake general education coursework prior to beginning the transition to degree; this coursework was very similar to that discussed by Eichenauer (1992) and would take the students two–three years to complete. In addition, these students were required to undertake courses in research and management. Their previous experience as licensed practical nurses was assessed and the students were given credit for their experiential learning in medical-surgical and long-term care.

Redmond (1997) recommended strategies that would prepare licensed practical nurses for the changing health environment while providing educational mobility. Redmond noted that the changing health trends in the USA meant a paradigm shift in nursing practice had occurred, with health care delivery moving from hospitals to community-based models of health care. Licensed practical nurse's were ill equipped to manage health care in this new environment, according to Redmond, and transition programmes for the licensed practical nurse would need to include management concepts and processes. She stated that registered nurses would require the BSN education to function in a developing community-based, community-focused health care system, and advocated for nursing education that was socially relevant and enabled the practitioner to deal with a racially and culturally diverse society. She

also noted that nurses would need legislative and management knowledge when working in a community-focused health care system.

Educational mobility for the licensed practical nurse has been documented by a number of authors in the USA, with the majority describing licensed practical nurse to registered nurse courses that exist in associate degree programmes (Sullivan & Quaintance, 1990; Vaz, 1992; Williams and Gallimore, 1987). Williams and Gallimore described an associate degree programme that included curriculum design and admission criteria that was designed specifically for the licensed practical nurses. In addition, Gross (1991) who described an alternative transition programme, and more recently Redmond (1997), are authors who have described the licensed practical nurse to BSN programmes.

Transition courses for enrolled nurses in the UK are primarily called conversion courses, and in the reviewed literature conversion to registered nurse was discussed, but it is not evident from the literature what educational qualification the registered nurses exit with other than registered general nurse. The majority of conversion programmes were 52-week courses, but they varied in organisational structure and settings. Crotty (1990) described a 52-week course in which 18 weeks were allocated for the theoretical component and 34 weeks for clinical experience. An introductory module consisted of a 6-week study block followed by one week of clinical experience to consolidate the learning. Grantham (1988) described a 52-week course in which the curriculum was a modular system utilising individual patient care based on a theoretical nursing model. Burley and Teasdale (1991) described an open learning programme in South Lincolnshire to assist enrolled nurses with conversion, by offering a combination of classroom and distance learning methods. Formal and informal evaluations of these programmes as cited by the authors has demonstrated varying degrees of successfulness. Burley and Teasdale reported that evaluation of the programme demonstrated that course objectives were met successfully. Crotty evaluated the effectiveness of the 52-week course using structure, process and outcome evaluation research. From this evaluation, areas requiring consideration were noted, in particular, designing curriculum

content to more specifically meet the student's needs. A weakness in this report however, was the lack of specific detail in the recommendations.

Recognition of Prior Learning (RPL)

A number of authors acknowledged the underlying aims of transition programmes were to provide recognition for the previous learning and experience of the enrolled nurse/licensed practical nurse, as well as to provide educational programmes that would result in competent registered nurses (Cornett, 1995; Crotty, 1990; Redmond, 1997). The majority of literature on recognition of prior learning for enrolled nurses is found in international studies. There is very little literature in New Zealand that identifies the current scope of enrolled nursing in regard to giving recognition for prior learning and experience. However, Day's (1997) doctoral study has given a comprehensive analysis of the process of recognition for prior learning for any student wishing to enter bachelor of nursing programme in a New Zealand polytechnic setting. Day commented that although there has been considerable work carried out overseas on RPL, he noted that RPL is a relatively new activity within education in New Zealand. This may be due in part to nursing education institutions holding back from implementing RPL until many of the issues and problems have been debated and solutions offered. Day defined RPL as a 'mechanism by which people can gain recognition, or credit, from an educational provider for learning achievements they have gained elsewhere so that this credit can be counted toward some qualification' (1997, p. 1). Day noted that the increasing numbers of mature students entering tertiary education promoted the New Zealand Qualifications Authority (NZQA) to endorse awarding credit for prior learning in 1991.

In his study Day (1997) identified that the work completed by the Ford Motor Company in Australia in relation to RPL has had a major influence on the development of RPL in Australia as well as influencing thinking in New Zealand. Day suggested that there is little evidence that RPL credit has been acknowledged in nursing programmes in New Zealand mainly due to the difficulties in implementing RPL into existing nursing programmes. This has

resulted in a cautious approach by nursing schools with very little RPL credit granted.

In anecdotal evidence gained in discussion with other nursing lecturers in New Zealand, there appears to be different processes for recognising prior learning for enrolled nurses. This ranges from granting automatic credit for the first year of a nursing programme, to offering credit for individual papers within a nursing programme. The prior learning credits granted also reflected the type of programme the student was enrolled in, either registered nurse with diploma or registered nurse with degree.

In England, at one school of nursing described by Grantham (1988), enrolled nurses were required to pass a pre-test to ascertain what the students already knew prior to commencing a 52 week conversion course to registered nurse (RN). This programme, which commenced following the English National Board publication of a paper on conversion in 1985, was not to degree level and the core subjects of the conversion course reflected the lack of research and evidence based practice skills required in most degree courses. Core subjects required for conversion to registered nurse were identified as sociology, psychology, health education and communication skills. Grantham stated there were other subjects, but these were not identified in her written paper.

In Ohio, USA, Cornett (1995) described one method of assessing prior learning for baccalaureate education for licensed practical nurses. Once curriculum requirements had been identified, the college offered the students the choice to validate their previous learning by taking challenge examinations for the initial nursing course, as well examinations for courses in nutrition, maternity and pharmacology. Challenge examinations consisted of National League for Nurses examinations that the licensed practical nurse was able to complete. If successful, they were granted credit for that particular module and allowed to continue into the next phase of their programme without having to undertake any additional course work. Students in this programme also had to complete general education courses in chemistry, biology, English, and psychology.

When challenge examinations have been discussed with nursing lecturers in New Zealand, anecdotal evidence suggests that many have disagreed with the concept, viewing it as putting yet another burden on the enrolled nurses to validate their learning and experience. It has been seen to be stressful and unfair especially as most enrolled nurses are usually granted credit for practical experience automatically if their work experience is current. There are examples where enrolled nurses have chosen to take challenge examinations to gain further credits ie examinations in human biology, and been successful. Most nursing schools in New Zealand offer a form of recognition for prior learning, but there is little uniformity. This is in some part due to the wide experience of enrolled nurses who may have gained endorsements to their initial qualifications, by gaining specialty knowledge in their work area. At one New Zealand polytechnic enrolled nurses are granted credit for two practical nursing papers in year one, as well as papers that relate to communication and human development. They are required to complete a social science paper, two bioscience papers and the nursing knowledge paper with its emphasis on health legislation, in year one. This reduces their programme by six months, they then continue into the second and third year with the mainstream students. Anecdotal evidence suggests that this has not always proved satisfactory for some enrolled nurses who have undertaken study at the polytechnic, as they have found their previous experience in rural areas in Northland has had them taking on registered nurse responsibilities with an increase in knowledge gained experientially. Therefore their subsequent experience as mainstream students in some clinical areas has proved frustrating and they have found they required different learning experiences within these contexts to expand and extend their knowledge.

Mature Age Student

Historically in New Zealand, as in other Western countries, the traditional nursing student entering a three-year programme for nurse registration has been a young female school leaver. Recent evidence suggests however that this has changed as more mature women are undertaking nursing education. A mature student is defined as one who is twenty-five years or over, and international university demographics point to a growing number of mature

students, entering university (Kasworm, 1990; Lea and Leibowitz, 1995). O'Connor and Bevil (1996) reported that in the USA the student population includes fewer students entering college immediately after high school and more students who are older, are changing careers, have family responsibilities, and are employed part or full time.

The literature suggests that a variable mix of internal and external forces influences women's decisions to return to nursing education, such as better career pathways, increased monetary reward, and the wish to provide a more knowledgeable level of care (Cornett, 1995). However they bring with them the added problems and challenges of balancing family demands and work requirements with study, and the level of support they require is different to that of the traditional school leaver. Marnell and Blanche (1990) suggest that when mature students return to formal education they experience stress and anxiety about their ability to cope with course work and teacher expectations. Winefield (1990) noted that adult (mature) students might have developmental needs, which can result in frustration with an education system more compatible with the younger student. The mature student has been described as a relatively stressed group at risk of poor psychological well being due to the challenge of the student role, as well as having the stress of juggling many responsibilities. This is compounded by the fact that there is a lack of familiarity in dealing with a tertiary education system (Ash, 1999).

Adamson (1997) noted that although most of the enrolled nurses in her study came with a great deal of life experience in both nursing and in wider society, their needs were very different to other nursing students, in particular they lacked self-esteem, which interfered with their ability to access and utilise appropriate learning and support services.

Process of Transition

Schlossberg (1984) defined transition as 'any event or non event that results in changes in relationships, routines, assumptions, and/or roles within the settings of self, work, health and/or economics' (1984. p. 43). In a more recent description by Brammer and Abrego (1995), transition is described as a journey,

usually to something unknown, requiring courage to take risks and having the ability to cope with fear. Lu (1994) suggested that transitional states create a disorganisation of function that creates the opportunity for psychological growth, but also brings the danger of deterioration in psychological well-being. Watson & Clarke (1984) identified a wide range of emotions that accompany transitions, namely loneliness, frustration, depression, apprehension, anxiety, insecurity, and ambivalence.

There is a substantial body of literature on the process of transition (Brown, 1995; Lea & Leibowitz, 1995; Schumaker & Meleis, 1995; Stolz-Loike, 1995; Waskel, 1991), but Schlossberg is acknowledged as providing a framework for understanding the meaning that transition has for individuals. According to Schlossberg, the four areas to be considered in understanding transitions are – the person whose change or transition it actually is; the triggers of the change; the consequences of the change; and the coping strategies and resources utilised by the person undergoing the transition. Various factors are believed to influence the transition process, including the environment, and individual personality characteristics and coping resources. The research by Heppner, Multon, and Johnson (1994) focused on the psychological resources that individuals utilised in order to successfully make the role changes required for career transition. They identified readiness, efficacy, control, perceived social support, and decision independence as five key factors contributing to successful transition. Their findings are similar to that of recent research conducted with mature students in New Zealand by Ash (1999).

Ash (1999) examined the psychological adjustments made by mature students during the process of career transition. The sample group for this qualitative study consisted of a representative sample of 500 mature undergraduate students across four colleges based at a large New Zealand university. The aim of this research was to 'explore the impact of a range of variables on the four outcome measures of psychological well being, self reported academic performance, stress, and coping' (Ash, 1999, p. viii). Her research identified five major areas of difficulty experienced by the mature students – home/family concerns; finances; future career concerns; study skills; and support issues.

The results suggested that 'the psychological resources of readiness and social support were the most salient for mature students' (p.viii). Ash also noted the lack of research related to mature students in New Zealand, but identified that New Zealand universities experienced a substantial growth in mature student participation during the years 1989-1998.

Support Services

Cornett (1995) identified that the majority of licensed practical nurses returning to study had not attended formal classes for some years, with many not having attended college before and they lacked confidence in manoeuvring within the higher education system. She described the typical licensed practical nurse returning for advanced education as a non-traditional student, with limited earning ability and parental/household responsibilities. She did not elaborate on a definition of a non-traditional student, but an assumption may be that these students were of a different age and ethnic group.

Crotty (1990) highlighted the general issues that relate to all students who are mature learners and identified the need for pre-course preparation. This included assessment of individual learning needs, as well as developing skills in essay writing and stress management, she does not explore the need for other scholarly activities related to degree preparation such as researching and critiquing literature. Crotty also recommended that the teaching faculty were appropriately prepared to meet the special needs of these students, and discussed the use of support strategies, and adult learner requirements. Teaching and learning were viewed as a shared process, with the teacher acting as a facilitator in the learning activities, rather than an imparter of knowledge.

Crotty (1990) identified that as registered nurses were required to accept responsibility for personal and professional development, then it would be essential that the course developed self-direction in learning for the licensed practical nurses. This would be reflected by critical thinking and a positive attitude to change as well as developing 'research mindedness'. In reviewing the transition to registered nurse, Crotty acknowledged that the progression of

study would have been enhanced by the inclusion of negotiated learning, with an emphasis on student profiling to enable the student to develop individual learning objectives.

Williams and Gallimore (1987) recommended ongoing educational counselling for licensed practical nurses undergoing transition courses, as they identified that these students, when mainstreamed with the generic registered nurse students, demonstrated a distinct lack of confidence in their academic ability. Students were instructed how to develop self-assessment skills to identify their own learning needs and were individually assessed for their ability to manage role change. A major aim of this programme was to recognise the competencies the licensed practical nurses already had and develop further skills, which did not rely on repetition of previous clinical work.

Redmond (1997) identified a variety of supports to assist the licensed practical nurses in completing their programme, including information on financial aid and childcare resources. The academic support was offered in the form of a pre-entry workshop that encompassed academic survival skills as well as information to encourage self-care. Services and facilities that were available for these students consisted of a counselling centre, a career and writing centre, as well as a personal tutor to assist with the content of the programme. Students in the United States accessed these facilities, which reflected the general acceptance of college and university education in the US, but in Great Britain where there is not a long history of nurses attending universities, enrolled nurses appeared reluctant to utilise support facilities and teaching assistance (Cornett, 1995). This may have reflected their inexperience within the higher education system as well as the need to demonstrate they had the ability to cope without help. Kenny (1993), in her exploration of the psychology of enrolled nurses, described them as focussing on the 'care' concept, and her view was that enrolled nurses' lack of interest in higher education was due primarily to their preference for bedside nursing. She surmised that unfortunately this lack of interest in higher education was misinterpreted by many nurse researchers as a lack of intelligence.

Adamson (1997) referred to the different educational preparation for enrolled nurses in New Zealand, identifying that enrolled nurses were never encouraged to hold education in high regard.

> *Academic influence on enrolled nurse education was low because they were not seen to have academic ability and the role they played in the health system was one of secondary caregiver with little responsibility.* *(Adamson, 1997, p. 38)*

Adamson also noted that previous social interactions had discouraged enrolled nurses from participating in academic study in New Zealand and their early educational experiences had not always been positive. The decision to enter into enrolled nurse training was frequently influenced by previous academic failure, as well as society's view on women at the time. For many, enrolled nurse training was an acceptable choice while they waited for marriage. For those undertaking transition to registered nurse the experience was daunting, and Adamson identified the students had mixed feelings on entering the course, mainly that they would be faced with academic failure. Adamson suggested that when students enter a learning institution they bring with them personal constructs that foster or hinder their learning ability and these constructs can result in a barrier to learning unless changed through positive learning experiences.

Ash (1999) noted that in a range of studies there was a positive association between social support and psychological wellbeing, and academic performance in students. In addition to being associated with higher academic performance, Huston-Hoburg and Strange (1986) identified that family support was also found to be associated with lower stress in students.

This chapter has explored the literature related to the major concepts of educational mobility, recognition of prior learning, mature students, the processes of transition, and support services. It is noted that while there is abundant international literature related to educational mobility, recognition of prior learning, and support services for enrolled nurses, there is a dearth of New

Zealand literature relevant to these concepts. The two major New Zealand works of Dixon (1996) and Adamson (1997) do much to enlighten the reader on aspects of enrolled nursing in relation to gaining registered nurse qualifications, but they do not fully address the factors affecting the transition process.

CHAPTER THREE

Research Method

The aim of this study was to explore the factors that assisted or hindered the enrolled nurses in their transition to gaining their degree. In this chapter the research method and design will be discussed. The theoretical framework was an exploratory, descriptive, qualitative approach utilising focus group interviews. The reviewed literature demonstrated a lack of research related to degree transition at a rural, satellite campus and an exploratory research approach was decided upon. Data was analysed using the constant comparative analysis method associated with grounded theory and referred to by Stern (1980).

Exploratory Research

As there does not appear to be any previous studies in New Zealand that have examined the transition of enrolled nurses to degree level study while based at a satellite rural campus, this current research project is called an exploratory study. Exploratory and descriptive research do not generate knowledge that is directly transferable to the broader community or to other contexts, the aim is to describe a phenomenon in the context in which it takes place. However, patterns and themes that emerge from data may be useful in providing the impetus for developing further research and broad, general inferences may be interpreted from the data.

Descriptive Research

Descriptive approaches to research are oriented to providing thorough descriptions and interpretations of social phenomena. The purpose is to obtain new knowledge by describing, comparing and classifying observations. Polit and Hungler (1995) describe descriptive studies as having as their main objective the accurate portrayal of the characteristics of persons, situations, or groups and/or frequency with which certain phenomena occur. Descriptive research studies are best suited when the phenomenon related to the research needs a reality explanation on a descriptive scale to find meaningful and

conceptual understanding that derives from the participants' experiences (Orchard, 1999).

Qualitative Approach

The choice of a qualitative approach to my study was governed by the desire to focus on the factors that assisted or hindered the adaptation that enrolled nurses underwent as they transitioned to studying for a bachelor's degree in health science (nursing). The qualitative approach involves the systematic collection and analysis of subjective, narrative materials using procedures in which there tends to be a minimum of researcher imposed controls. The philosophical underpinnings of qualitative methods are based on the recognition that quantitative cause and effect models do not account for the socio-historical context of the human experience (Polit and Hungler, 1995). The goal of qualitative research is to discover patterns that emerge after close observation, careful documentation, and thoughtful analysis of the research topic. What can be discovered by qualitative research are not sweeping generalisations but contextual findings (Maykut & Morehouse, 1994).

The dominance of the traditional positivistic scientific approaches in research, meant that early nurse academics were compelled to engage in elaborate defences of the theoretical and methodological foundation of their research methods (Leininger, 1985). More recently nurse researchers have become increasingly confident in critiquing the limitations of the traditional research approach for developing the kinds of knowledge the practice of nursing requires. Questions that arise in nursing and nursing education are frequently more suited to research methods that are qualitative rather than quantitative. Qualitative research is often described as holistic, in that it is concerned with humans and their environments in all of their complexities. A basic belief of the holistic/humanistic paradigm is that realities cannot be studied independently from their context, nor can they be separated into parts for study. Many qualitative studies are based on the premise that gaining knowledge about humans is impossible without describing human experience as it is lived and defined by the people themselves (Polit and Hungler, 1995). Because qualitative methods focus on the whole experience and the meanings ascribed

by individuals living the experience, qualitative methods permit broader understanding and a deeper insight into human behaviours that might otherwise be possible utilising quantitative methods of research.

Qualitative researchers emphasise six significant characteristics in their research according to Streubert and Carpenter (1995). These characteristics are: a belief in multiple realities; a commitment to identifying an approach that develops understanding of the phenomenon under study; a commitment to the participant's point of view; research conducted in a way that endeavours to maintain the natural context of the phenomenon under study; acknowledgment of the participation of the researcher within the study; and the appropriate writing and reporting format that enables the richness of the participants' narratives to be heard.

The idea that multiple realities exist and create meaning for the individuals studied is a fundamental assumption of qualitative research and the first characteristic according to Streubert and Carpenter (1995). Instead of searching for one reality, which is a basic assumption of quantitative research, qualitative researchers believe that individuals actively participate in social actions and through these interactions come to know and understand phenomena in very different ways.

In the second characteristic, researchers utilising qualitative approaches are committed to exploring multiple ways of understanding the phenomena. The research is said to be inductive rather than deductive in that the research topic leads the choice of method rather than a method leading the research, although grounded theory methodology combines both inductive and deductive research approaches (Streubert and Carpenter, 1995).

The third major characteristic of qualitative research according to Streubert and Carpenter (1995) is the commitment to the participants' point of view. Appropriate methods to collect data are the unstructured interview, observation, and group interviews, and these typically involve the researcher as a co-participant. The researcher may also conduct extensive literature and document

searches to understand the context of what is being studied. The choice of focus group interviews was perceived to be the most appropriate method that would facilitate in-depth discussion of the enrolled nurses' experience, and adaptations they had made when studying for their degrees. The method allowed the participants to take the discussion to a deeper level, as they unravelled the complex nature of their transition. This may not have occurred if individual interviews was the only method of collecting data.

The fourth major characteristic of qualitative research is the researcher's obligation to maintain the natural context of the inquiry as much as possible. In focus group interviewing the researcher has direct and close contact with the participants and the setting, endeavouring to maintain the setting that the participants feel comfortable in or are familiar with. The setting for focus group interviews is one that needs to balance the needs of participants and researcher, usually at a neutral site, as the physical environment of the group interview may influence the nature of the interaction.

The recognised participation of the researcher in the study is the fifth characteristic of qualitative research. The researcher is the interviewer, observer and/or interpreter of aspects of the study and therefore objectivity is not a major focus. Researchers utilising a qualitative approach acknowledge that the research is conducted with a subjective bias but it is often due to the participation of the researcher that the study has the potential for richer narrative. The researcher has direct and close contact with the participants, the setting and the topic under study, and it is the researcher's insights and experiences that are integral to the inquiry and the analysis. This close contact raises issues related to the rigour of the research and will be discussed under the heading *research rigour,* later in this chapter.

The ability to bring a real understanding in the telling of the complex and diverse nature of the lives of the participants, is the sixth characteristic of qualitative research according to Streubert and Carpenter, (1995). The study findings are not reported using statistical analysis, although some statistical data may be included. The findings of the qualitative study usually include quotes and

narratives from the participants' perspective, which add to the understanding of the multiple realities in the complex world of human beings.

The history and tradition within qualitative nursing research originates in the methodologies of several different disciplinary traditions. Qualitative nurse researchers generally sought epistemological credibility in three primary directions: the phenomenological study within philosophy, the grounded social theory study within sociology, and the ethnographic study within cultural anthropology (Thorne, Kirkham & MacDonald-Emes, 1997). While various derivations of phenomenology, grounded theory, and ethnography have been popularised within qualitative nursing research, the methodological principles upon which these approaches are based reflect the philosophy and foundations of those distinct disciplines whose goals may be quite different from those expressed in the discipline of nursing. However, the qualitative research methodologies within these other disciplines provide nursing with tools that are appropriate to discover the multiple realities of human beings situated within their health context, and the underlying philosophical characteristics of qualitative research are relevant to all the social sciences.

Grounded Theory

Grounded theory is a research method that has a systematic procedure called constant comparative analysis, for deriving a theory about a phenomenon. The aim of the grounded theory approach is to discover underlying social forces that shape human behaviour. This method is used to construct theory where no theory exists or in situations when existing theory fails to explain a set of circumstances (LoBiondo-Wood & Haber, 1994). This research method identifies concepts and the relationship between these concepts in an inductive manner, with the aim being to generate theory about social and psychological phenomena (Chenitz & Swanson, 1986). In this method, theory remains closely connected to data through descriptive examples that provide direct empirical evidence that the theory fits the phenomenon under investigation. Theory generated in this manner may then serve as a conceptual framework on which to base testable hypotheses and subsequent quantitative studies (Powers & Knapp, 1990).

Glaser and Strauss (1967) were the first to address grounded theory as a research method when they studied the experiences of dying patients. The study and exploration of the social processes that occur with human interaction, is directly linked to symbolic interactionism. In the theory of symbolic interactionism, described by Mead (1964, cited in Streubert and Carpenter, 1995, p. 149), it is believed that people behave and interact with each other based on how they interpret and give meaning to specific symbols in their lives. Symbols such as words, meaning and language are learned through interaction and are used to represent the individual's definition of a given situation. Drawing on the work of Mead, Herbert Blumer (1969, cited in Denzin and Lincoln, 1994, p. 124) claims that human beings confront a world that they must interpret in order to act, rather than a set of environmental stimuli to which they are forced to respond. Using a symbolic interactionist perspective, grounded theory provides a way to study human behaviour and interaction.

The major difference between grounded theory and other approaches to qualitative research is its emphasis upon theory development. Stern (1990) differentiated grounded theory from other qualitative approaches and identified five basic differences within grounded theory that include the following: 1) the conceptual framework is generated from the data rather than from previous studies; 2) the researcher attempts to discover dominant processes in the social scene rather than describing the unit under investigation; 3) every piece of data is compared with every other piece of data; 4) the collection of data may be modified according to the advancing theory; that is false leads are dropped, or more penetrating questions are asked as needed; 5) the researcher examines data as they arrive, and begins to code, categorize, conceptualise, and to write the first few thoughts concerning the research report almost from the beginning of the study, hence - constant comparative analysis.

According to Chenitz and Swanson (1986) grounded theory studies can be reported at both the descriptive and theoretical levels. The researcher may stop at any level of analysis and report findings, for example, Melia (1982) reported a descriptive category in her research of the world of student nurses and

Fagerhaugh and Strauss (1977) wrote of multiple processes when they researched the politics of pain management.

Strauss and Corbin (1990) identified the difference between theory and description in grounded theory as follows. Theory uses concepts, similar data are grouped and given conceptual labels, these concepts are then related by means of statements of relationships. In description, data may be organised according to themes, these themes may be conceptualisations of data, but are more likely to be a precis or summaries of words taken directly from the data, there is no attempt to relate the themes to form a conceptual schema. In this descriptive study, data was coded into categories using ***level 1*** and ***level 2 coding*** as described by Stern (1980)

Data Analysis

As part of the process of comparative analysis, data collection, coding and analysis occur simultaneously. ***Level 1 codes***, also known as *in situ, in vivo, or open codes,* are those in which small portions of data are conceptualised, using the participants' words as much as possible (Schreiber & Stern, 2001). Level 1 coding requires the researcher to apply a system of open coding which involves examining the data and identifying recurring phrases. During the process of level 1 coding, substantive codes are made. These codes identify the substance of the data and the participants own words are frequently used. Other substantive codes, called 'implicit codes' are constructed by the researcher, based on concepts obtained from the data. These substantive codes are then compared with other codes to uncover characteristics and relationships (Stern, 1980). For this research study the process of coding is discussed under ***Data Analysis Process, p. 47.***

In **level 2 coding,** level 1 codes are re-examined, compared with each other, and assigned to clusters or categories according to fit. Categories are coded, data clustered together and may result from the collapsing and condensing of level 1 codes (Stern, 1980). Deciding on specific categories is facilitated by questioning what each level 1 code might indicate and then comparing each level 1 code with all other level 1 codes. This enables the researcher to

determine what particular category would be appropriate for the grouping of similar level 1 codes. Each category is then compared with every other category to ensure that they are mutually exclusive (Streubert & Carpenter, 1995). When a researcher identifies a concept from the literature that fits the data, it is called an 'emergent fit' (Schreiber & Stern, 2001).

To continue the process in developing theory, Stern described level 3 coding, which identifies the basic psychological process occurring from the data. Basic psychological processes are a type of core variable that illustrate social processes as they continue over time, regardless of varying conditions (Glaser, 1978, p.10). Basic psychological processes are essentially the title given to the central themes that emerge from the data. The limitations of this masterate study prevent data analysis progressing to level 3 coding, and this study is reported at the level of category identification.

Use of Literature

In grounded theory the researcher brings some knowledge of literature to the study, but an exhaustive literature review is not undertaken initially. This is to allow theory to emerge directly from the data, although related literature is reviewed continuously throughout data collection and analysis. All literature is treated as data and compared throughout with the other data collected by interviews or observations. Strauss and Corbin (1990) identify that literature is useful in providing concepts and relationships that are checked out against actual data. Published descriptive materials often give accurate descriptions of reality, with very little interpretation and may help researchers generate questions to ask their own study participants. Research publications often include quoted materials from interviews and field-notes, and these quotations can be used as secondary data sources for the researcher's purposes. For this current research, the decision to utilise the constant comparative method to analyse the data from the focus group interviews was influenced by the recognition that the very large volume of data and the interaction within the group would need a structured framework to analyse the wealth of information gained from the group interviews and literature. In researching the literature for data analysis for focus groups many recent publications identify the difficulty in

analysing the group interaction (Kitzinger, 1994, Carey, 1995, Reed & Payton, 1997, Sim, 1998).

Focus Groups

Kreuger (1988, p.18) defined a focus group as a "carefully planned discussion designed to obtain perceptions in a defined area of interest in a permissive, non-threatening environment". Glesne and Peshkin (1992) suggested that interviewing more than one person at a time proves useful as some people need company to be emboldened to talk, and some topics are better discussed by a small group who know each other. Brown et al. (1989) suggested that group interviews are not just convenient ways to accumulate the individual knowledge of the members, they give rise synergistically to insights and solutions that would not come about without them. Blumer (1969, cited in Patton, 1990, p. 76) considered a carefully selected group of well-informed people to be a real panel of experts about a given situation.

Patton (1990) believed that a focus group interview is just that – an interview. He argued against trying to come to a consensus, or to attempt to be a problem-solving group, he argued that the object of the group is to get high quality data in a social context where people can consider their views in the context of the views of others. In contrast, DesRosier and Zellers (1989) suggested that focus groups can be used to identify innovative solutions to practical problems and to involve participants in project or practice developments. Focus group interviews also provide some quality controls on data collection in that participants tend to provide checks and balances on each other that weed out false or extreme views.

As identified in the description of qualitative research, a commitment to the participants' point of view is a major characteristic of the qualitative approach. The focus group interview is a technique used to obtain data about feelings and opinions of small groups of participants about a given problem, experience, service or other phenomenon (Basch, 1987). Stewart and Shamdasani (1990) have identified that one of the more common uses of focus groups is to learn

how respondents talk about a phenomenon of interest, which in turn may be a richer source of information than can be gained by individual interviews.

Group interviewing has ordinarily been associated with marketing research, where the focus group method has been used for some time to gather consumer opinions on product characteristics, advertising themes, and service delivery. This format has also been used to a considerable extent by political parties and candidates who are interested in voter reactions to issues and policies (Basch, 1987). During the past decade social scientists have rediscovered the focus group method and are beginning to use the method more extensively to better understand the human experience. Focus group interviews are known by at least three names: focus group interviews, focused interviews, and group depth interviews, and they usually contain the following core elements:

- The group is an informal assembly of target persons whose points of view are requested to address a specific topic
- The group is small, 6 to 12 members, and is relatively homogeneous
- A trained moderator with prepared questions and probes sets the stage and induces participants' responses.
- The goal is to elicit perceptions, feelings, attitudes, and ideas of participants about a selected topic.
- Focus groups do not generate quantitative information that can be projected to a larger population (Vaughn, 1996, p. 5).

As identified by Vaughn (1996), quantitative information that is able to be generalised to a larger population is not usually generated by focus group interviews, but Guba and Lincoln (1989) have suggested that transferability of data is feasible in qualitative research if the findings fit other contexts. The concept of 'fittingness' is discussed later in the chapter.

Lederman (1990) identified the following assumptions underlying the focus group interview – (1) people are valuable sources of information, particularly about themselves; (2) people are capable of reporting about themselves and

are articulate enough to put opinions about their feelings and perceptions into words; (3) the best procedure for obtaining an understanding of people's feelings is through a structured or semistructured group conversation in which information is solicited by the moderator; (4) there are effects of group dynamics that enhance the likelihood that people can speak frankly about a subject, and these cannot occur through individual or small-group interviews. Related to this assumption is the believe that the information obtained from a focus group interview is genuine information about what each person feels rather than a group mind in which people conform to what others believe (cited in Vaughn, 1996, p. 7).

Advantages of Using the Focus Group Method

Sim (1998) summarises a number of advantages in using focus groups as follows:

- They are an economical way of tapping the views of a number of people;
- They provide information on the 'dynamics' of attitudes and opinions in the context of the interaction that occurs between participants;
- They may encourage a greater degree of spontaneity in the expression of views than alternative methods of data collection;
- They can provide a 'safe' forum for the expression of views, for example, participants do not feel obliged to respond to every question;
- Participants may feel supported and empowered by a sense of group membership and cohesiveness (p. 346).

Carey (1995) suggested that focus group interviews can be used appropriately across a broad array of diverse disciplines, and with varying degrees of precision. Kitzinger (1994) believed that focus group interviews tap into a variety of communication, which is important as everyday forms of communication such as anecdotes, jokes or loose word associations may tell us about what people know. In this sense focus group interviews "reach the parts that other methods cannot reach -- revealing dimensions of understanding that remain untapped by the more conventional one-to-one interview or questionnaire" (p.109). In addition, focus groups facilitate the collection of data on group norms, often a

particular phrase will instigate group consensus that identify the norms within the group. This makes focus groups a data collection method particularly sensitive to cultural variables (Kitzinger, 1995). Morgan and Kreuger (1993) also identify that focus group interviews, when conducted in a non threatening and permissive environment, are especially useful when working with groups of people who have historically had limited power and influence, including those with limited income or lower literacy skill.

Another major advantage according to Stewart and Shamdasani (1990), is that focus group interviews let the researcher interact with the group, therefore responses can be clarified and follow-up questions asked at that time, and large and rich amounts of information can be obtained in the group's own words.

Limitations of Method

Focus group interviewing appears to be a quick and cost-effective way of gathering data. Much of the literature on focus groups highlights this advantage and there are many books written describing the mechanics of setting up and running focus groups in order to make them effective (Greenbraum, 1988; Kreuger, 1994; Morgan, 1988, 1993, 1997; Morgan & Kreuger, 1997; Templeton, 1994; Vaughn, 1996;) but some of the earlier texts do not give very clear accounts on methods to analyse the data. Reed and Payton (1997) also note that although there is a plethora of papers describing focus groups, they lament that many do not address issues related to the analysis of group interaction. Kitzinger comments that 'reading such reports [of focus group studies] it is hard to believe that there was ever more than one person in the room at the same time' (1994, p. 104).

The large amounts of complex data can be a limitation of the focus group method and an appreciation of the complexity of the data is necessary during the process of analysis. With the goal of understanding the focus group members' interpretation of their social reality, the researcher needs to identify the integral component of the 'group effect' on the data (Carey, 1995). Few articles on focus group research report group characteristics, but Carey

believed that an appropriate description of the group dynamics is necessary to incorporate in analysis, for example, a heated exchange or dominant member.

Censoring and conformity can also be a concern in-group interviews as members often adjust their comments in response to their own needs and to their understanding of their appropriate roles in the group (Carey, 1995). In the process of censoring, a group member may withhold potential comments, often due to lack of trust in other members or the interviewer, or concern about how the data may be used in the future. In conformity, comments may be tailored in accord with the member's understanding of the expectations of the interviewer and other group members, this has been identified by Janis (1972 cited in Carey, 1995, p. 489) as 'group think'. Burrows and Kendall (1997) also discussed the development of group norms as having an inhibitive influence in the sharing of ideas or producing unnatural and unwanted group conformity. These problems of group dynamics can be minimised by expert group facilitation. Confidentiality may also be a problem between participants in the group situation. To ensure confidentiality was maintained within the group for this research, a clause alerting participants about anonymity and confidentiality of the content was included in the consent form signed by all the participants (Appendix 3).

Another limitation of the focus group method is the inability to generalise from small groups of non-randomly selected participants. Basch (1987) suggested that focus groups are generally not appropriate for drawing inferences about larger populations. As well as the limitations of the small sample size, specific members of groups may dominate while others may not participate and therefore generalizability may be problematic. A further limitation is that only individuals who are capable and willing to verbalise their views can be studied in focus groups.

Templeton (1994) raised the issue of moderator bias as a limiting factor in conducting focus group interviews. Bias may result as a consequence of cueing participants on the responses sought. A moderator's personal biases may seriously mislead both the moderator and the group and Templeton believed it

is difficult to prevent bias from appearing, even in inflections and facial expressions. Stewart and Shamdasani (1990) believed an important aspect of moderator preparation is to develop an understanding of the sources and nature of biases that can affect the validity of the focus group data, as well as an understanding of the steps that might be taken to cope with these biases.

Role of Research Facilitator

Morgan (1988) declared that researchers must decide what they want their interview materials to produce and then make decisions about moderator/facilitator involvement in line with these goals. He suggested that low levels of moderator involvement were important for goals that emphasise exploratory research, alternatively, high levels of involvement were more appropriate when there is a strong externally generated agenda. A negative aspect of a highly involved moderator is that a biased moderator will produce data that reproduces these biases, but a positive aspect is that a highly involved moderator has the ability to cut off unproductive discussion and to probe for more in-depth discussion on the research topic. In my role as facilitator I alternated between allowing the discussion to meander where the participants took it and at times refocussing the participants on points of discussion that required elaboration. Bellenger et al (1976, cited in Morgan, 1988, p. 50) suggest this as walking a tightrope between 'understanding empathy' and 'disciplined detachment'. Also high moderator involvement allows for adjustments in the discussion and can spark discussion in groups where everyone already shares an implicit perspective.

Low level moderation in focus groups can lead to groups that are relatively disorganised in their content; also the group may not raise some topics. This may not reflect a disinterest in the topic, rather a lack of direction from the facilitator. By using a low level of moderation with the first focus group interview with the enrolled nurses, it was evident that the students frequently veered into general discussion and socialising, and I realised I had to take a more active questioning role that allowed me to probe for more complex responses than were originally given. In preparing for the second round of interviews I was clearer about what I wanted clarified from the first interviews and decided to

mail out some questions I wanted discussed and elaborated on. I felt that the students and teachers were able to put forward their views comprehensively in the first interviews, and I believed that I could now take a more directive role. Also, I wanted the enrolled nurses to have time to reflect on the questions and responses before we had our next meeting. Morgan (1988) described a solution of choosing between high and low level moderation similar to the one I implemented, except he suggested to begin with a set of self-managed groups and use the data they produce to develop and interview a second set of more highly moderated groups. Due to the geographical and participant limitations for this study, the process of beginning with a set of self-managed groups suggested by Morgan was not utilised.

Stewart and Shamdasani (1990) noted that the moderators may have to wear many hats and assume different roles throughout the course of the discussion. They explained that moderators have the difficult task of 'dealing with dynamics that constantly evolve; they must handle the problems by constantly checking behaviour against attitudes, challenging and drawing out respondents with opposite views and looking for the emotional component to the responses' (p. 70). Time management is another essential skill of the moderator, in particular, noting when a topic has been exhausted and further discussion will yield little new information.

Researcher Involvement

The literature on focus groups addresses researcher familiarity with participants (Burrows and Kendall, 1997; Bogdan & Taylor, 1975; Hanson, 1994). Kreuger (1988) argued that the investigator who conducts the interviews should also analyse the data to ensure the richness of the context, which develops within the interviews, is not lost. Hanson (1994) believed that familiarity with participants enables researchers to gain insight into their conceptual framework, while Bogdan and Taylor (1975) suggested that facilitators with inside knowledge may lack critical distance and objectivity. I considered these arguments carefully and decided that by conducting the interviews with a co-interviewer I would hopefully be more open to discussions and not cut off any avenues raised by the participants. I also canvassed the opinion of the students

giving them options of who they would prefer conducting the interviews. When given the choice, the students clearly stated they would prefer that I conducted the interviews. This raised ethical issues around student/teacher conflict that will be addressed under ethical considerations. I also concluded that my involvement in the interviews was consistent with the tenets of qualitative research and researcher participation. Hanson (1994) suggested that qualitative researchers familiar with the setting, participants and cultural norms gain valuable insight that can enhance the meaningfulness of data. For the purposes of this study the terms moderator and interviewer are used interchangeably.

Role of Co-interviewer.

In recognition that fifty percent of the students were Maori, I judged that the co-interviewer would need to be a person who was culturally appropriate for this student population. A Maori nurse educator was engaged as the co-interviewer after consultation with all participants. The Maori students were also given the option of a separate focus group interview with this co-interviewer, which they declined, stating they did not think it necessary. This offer was again given to the students and teachers following both focus group interviews, but the students identified they would have nothing further to disclose. The role of the co-interviewer was also to manage the recording of the interviews and other practical aspects, allowing the main interviewer to focus on the discussion and participant interactions.

Maximising Participation Between Participants

Kitzinger (1994) discussed the importance of the group interaction in generating significant data on complex issues. She believes it is useful to work with pre-existing groups because they provide one of the social contexts within which ideas are formed and decisions made. The fact that the participants in my research group knew each other had the advantage that they could relate each other's comments to actual experiences in their shared daily lives. Initially they did not challenge each other's views, but as they became more comfortable with the interview format challenges occurred. The use of the group process encourages participants to verbally formulate their views and as Kitzinger noted, the researcher is able to 'draw out the cognitive structures which previously had

been unarticulated' (1994, p. 106). Kitzinger also identified the importance of difference within the group, describing the role of argumentative interaction in forcing people to articulate their view and clarify or justify why they feel the way they do. Exploring difference between group participants ensures that the data is interconnected and underlying assumptions and frameworks are uncovered. The facilitator needs to be particularly skilled in managing the conflict to ensure that all members of the group feel heard and valued. In analysing data from group interactions, Kitzinger noted that it was important to identify shifts in group opinions and highlight complementary and argumentative interactions.

Applications in Nursing

Focus group methodology is an effective, cost efficient way to generate data to meet the goals of nursing in education, practice and research. Applications in nursing include Hart and Rotem's (1990) report of using focus groups to identify clinical learning opportunities for registered nurses. Brooks, Fletcher and Wahlstedt (1998) assessed the continuing education needs for the advanced practice nurse using focus group methodology, and Lankshear (1993) used focus groups to study the attitudes to student nurse assessment. DesRosier and Zellers (1989) obtained information for strategic planning for the retention of nurses, and Dyson (1998) explored the role of the lecturer in the preceptor model also utilising the focus group method. Other recent studies that have utilised the focus group method include – rehabilitation nursing (Easton, 1999); prevention of substance abuse (Reiskin et al, 1999); improving patient satisfaction (Capitulo, 1999); curriculum development (Kooker et al, 1998) and identifying health and lifestyle issues in the elderly (Davis-McFarland et al, 1998).

Study Setting

For this study the participants were students and teachers in a special nursing degree transition programme for enrolled nurses based at the satellite campus of a rural polytechnic in New Zealand with a geographically high Maori population. The sites for the focus group interviews were considered with care, with students and teachers interviewed separately at different venues. I anticipated that holding separate group interviews would facilitate a more open

exchange of ideas and also reduce a possible power imbalance that may have occurred because of the teacher-student relationship. The sites selected for the group interviews were situated away from the teaching campus in neutral, quiet, conference rooms that minimised interruptions. Choosing a site away from the campus I believed would take the participants away from the classroom and school issues and focus them more clearly on the study. I also allocated 20 minutes socialising time prior to the interviews but the student group required more time to deal with study issues before we were able to proceed with the initial group interview. The student group also required redirecting throughout the interview as they frequently digressed into socialising and discussing issues related to their nursing programme.

Participant Selection

The study sample was purposive. All students within the transition programme were asked whether they would like to participate in the study, and all teachers within the faculty were given the opportunity to be part of the second focus group. Both students and teachers were given an information sheet which outlined the study, gave guidelines about informed consent, disclosed the expectations of the researcher and gave a two week time frame to return the signed consent form if they wished to participate (Appendices 1 & 2). It was made very clear to the prospective participants they were under no obligation to participate, but the students in particular were very motivated to be part of the study as they were at the time undertaking a research paper as part of their study programme and were very keen to be part of a research process. All ten students agreed to participate in the student focus group and six out of ten teachers agreed to participate in the second group, both group sizes being within the norm for focus group interviews (Morgan, 1997). The research committee of the polytechnic granted approval for the research project once all ethical requirements stipulated by both the polytechnic and the university human ethics committee had been met.

Participants

All participants were women, with ages ranging from 35 – 52 years. The students were in the final year of their two and a half year programme, and the

teachers all had experience in teaching enrolled nurses transitioning to degree status. Five of the students and one teacher identified as Maori, and to ensure sensitivity to this cultural group my co-interviewer was the cultural safety nurse lecturer within the department. The polytechnic Kaumatua (Maori elder) had also given his approval for the study. Due to the uniqueness and therefore restrictiveness of the programme based at a satellite campus it was considered appropriate to include the teachers of the programme as well as the students in the research study. This enabled the researcher to gain comprehensive data from two diverse groups involved in the same programme. The decision to use teachers and students within the same study highlighted ethical concerns that needed to be addressed, and these are discussed under ethical considerations.

Ethical Considerations

Initially I was involved in teaching and assessing the students in the first year of their nursing programme, but when I took over the co-ordination of the programme, (before commencing the research study) my role changed to one of managing resources, co-ordinating the teachers in the programme and dealing with other management issues. I had no direct involvement in teaching or assessing the students during the study, however, as a senior lecturer within the nursing department there was the possibility of exploitation of the power relationship that occurs between teacher and student. Including a co-interviewer skilled in cultural safety, for the group interviews, was a measure to ensure that power issues related to the student/teacher relationship would be acknowledged and the power imbalance hopefully diminished. By having separate group interviews for students and teachers, I was also able to facilitate a more open discussion about the factors that assist or hinder the transition to degree status for enrolled nurses. The student group were very candid about what they considered helpful attributes of a teacher and I am confident this candour would not have been expressed if the groups had been combined.

The research study was granted ethical approval by the university and polytechnic once all the conditions to protect the participants had been met. Research participants had the right not to participate or could withdraw from the study at any time with no detrimental affects to their future study or

employment, although data they may have contributed would stay within the study as it contributed to the collective process of focus group interviews. Due to the fact that the polytechnic was small and the transition nursing programme unique, it was presumed that the participants could be identified. Therefore a sentence was included in the consent form that precluded the participants from disclosing any information from the interviews, and alerting them to maintain the confidentiality of the participants (Appendix 3).

Both students and teachers were given information that outlined their rights and responsibilities as research participants, and were given two weeks to peruse the information and discuss their concerns prior to giving their written consent to be participants. Each participant was allocated a code as a further measure to ensure anonymity and these were kept confidential to myself as researcher and the co-interviewer. As the participants had given their consent to audio-taped interviews, the transcriber as well as the interviewer and co-interviewer, were obliged to sign declarations of confidentiality (Appendices 4 & 5). During the research process the tapes and transcripts were stored safely at the researcher's home and will be destroyed in three years. Access to the data on computers is protected by a password known only to the researcher.

Data Collection

The hallmark of focus groups is the explicit use of group interaction to produce data and insights that would be less accessible without the interaction found in a group (Morgan, 1997). Often this interaction is accompanied by words and gestures that are not able to be picked up by audiotape, and as the use of videotaping is not recommended for focus group interviews, as it is too intrusive, it is deemed appropriate that short notes be taken (Kreuger, 1994). This requires the participation of a second interviewer with a major objective to take adequate notes to illuminate the discussion transcribed from the tapes. This enables the primary interviewer to focus on facilitating the group. This process was followed for this research study with permission from the participants. The co-interviewer was also chosen to ensure the cultural requirements of the Maori students were recognised and addressed.

Data Analysis Process

In this research, observations and transcripts from the focus group interviews were examined line by line with recurring phases highlighted and rewritten into a card system linking recurring codes. During this process of level 1 coding, substantive codes were made. These codes identified the substance of the data and the participants own words were frequently used. For example one participant commented that she had to ***'let go old ways of learning'*** while another stated that in studying for the degree she was ***'having to look through a different window'.*** Other substantive codes, called 'implicit codes' were constructed by the researcher, based on concepts obtained from the data, One example of an implicit code is the concept of ***'finding their voice'.*** These substantive codes were then compared with other codes to uncover characteristics and relationships.

During this initial level 1 coding it appeared there were differences between the data emerging from the student and teacher focus groups. This required the researcher to undertake the second focus group interview with the students to clarify meaning. Following further analysis of the new data with the previous transcripts, it was identified the differences were related to the language used in the two groups. The teachers were using the sophisticated language of educationalist, and the students were describing their experiences and feelings in populist language. For example, where a teacher had described that the students had to 'unpackage previous learning and reframe their knowledge' (L,2,9) a student had explained this as 'looking through a different window' (A,3,9). When the meaning within the data was compared, the similarity of the content became evident.

In level 2 coding, level 1 codes were re-examined, compared with each other, and either condensed or collapsed into categories. Deciding on specific categories was facilitated by questioning what each level 1 code might indicate and then comparing each level 1 code with all other level 1 codes. Each category was then compared with every other category to ensure they were mutually exclusive.

Audit Trail

To provide an audit trail and illustrate this process of coding, the journey taken to identify the category ***'relearning how to learn'*** will be described. In order to maintain confidentiality for the participants, the use of quotes has been coded. The participants are denoted alphabetically, the number of the focus group and the page number of the original transcripts are denoted numerically, for example A (2) (34) equates to participant A, the first number reflects the number of the focus group, the second reflects the page number of the transcript.

As coding progressed, codes emerged that were initially categorised into the cognitive, behavioural or environmental factors that had influenced the student's transition. This was useful from a teacher/researcher's perspective in organising the data but did not give true meaning to the students' experiences, and researcher/teacher bias was recognised. To accurately reflect their experiences, the naming of the majority of sub-categories was selected directly from the dialogue of the students. For example, the teachers described the different cognitive processes required for studying for a nursing degree as requiring 'critical thinking and reflection' (N, 2,2), whereas a student described the same processes as 'growing the tree' (B, 3,1). Although both participants were discussing the cognitive processes required in degree level study, the student's comment engendered a general consensus among the other individuals and more accurately reflected their transition and therefore this sub-category was labelled ***'growing the tree'***.

This sub-category ***'growing the tree'***, signifies the major cognitive adaptations the students had to make if they were to be successful in the programme. One student commented that 'although the teachers have planted the seed, its up to us to grow the tree'. All the other students agreed with this comment and used similar gardening analogies like 'nurturing the plant', and 'getting rid of useless weeds'. Asked to elaborate, one student explained that 'the old ways of rote learning were not helpful in the degree programme, and she had to 'relearn how to learn' (E,3,27). The teachers also made comments about 'planting the seeds of learning' and suggested that the students had to 'unlearn old behaviours', as well as commenting that 'mind shifts' were required. This sub-category was

originally coded as 'leaping the gap' but with further comparisons of the codes, and after taking the initial findings back to the participants, 'growing the tree' had the better 'fit' for both students and teachers.

With further examination of the codes, other sub-categories emerged that made it clear that a major factor in the students' transition was the concept of relearning. Following condensing and collapsing of the substantive codes, three other sub-categories emerged that enabled this category to be named as ***'relearning how to learn'***. Together with '***growing the tree'***, these other sub-categories are entitled '***out of comfort zone'; finding their voice'***; and '***letting go/grieving'*** and are discussed in detail in chapter four.

The second major category that emerged - ***'barriers and catapults'***, was related mainly to the environmental factors that had hindered or assisted the students' in their transition. This category consists of the sub-categories entitled '***support services'; 'living rurally'*** and '***clinical role models'*** and is discussed in chapter five.

Research Rigour

Because the data in qualitative research is usually emergent, attention to rigour in the process and the reporting of that process is critical to an interpretive description, according to Thorne, Kirkham & MacDonald-Emes (1997). But Sandelowski (1993) believes that there is an inflexibility and an uncompromising harshness and rigidity implied in the term rigour, that threatens to take qualitative researchers too far from the versatility and artfulness that mark qualitative research.

Lincoln and Guba's (1985) framework for establishing the trustworthiness of qualitative data has been discussed by many authors (LoBiondo-Wood & Haber, 1994; Polit & Hungler, 1995; Talbot, 1995) and the Lincoln and Guba framework was utilised for this research to ensure the trustworthiness of the data and the process. The key criteria for examining the rigour of this research were credibility, transferability, dependability, and confirmability.

Credibility refers to the confidence in the truth of the data and conclusions. Credibility can be demonstrated by ensuring that the research is carried out in such a way that the findings are believable, and that there are identifiable steps taken to demonstrate credibility. Lincoln and Guba (1985) suggest that one way to enhance credibility is through prolonged engagement with the participants, which may lead to the identification of the contextual factors that might impact on the study. My involvement with the students encompassed a period of two years in which I had the roles of co-ordinator, manager and originally teacher. I was well aware of the difficulties faced by both students and teachers in the delivery of their programme and was able to ascertain the contextual factors influencing their transition.

Another process is to involve the participants in checking whether the researcher has 'captured' their meaning in the interpretation of the data. Thorne et al (1997) advise against taking raw data back to the participants as credibility checks such as this may create contradictions, but instead suggest taking beginning conceptualisations representing the whole sample back for critical consideration by the participants. They believe that often important insights about a conceptualisation can be formulated from participants' perceptions of why it doesn't fit rather than why it does. This was verified when I took initial categories back to the participants for clarification. Originally, as stated, I had categorised the findings into the cognitive, behavioural and environmental factors influencing the students' transition, but in a presentation of preliminary findings, the students commented that they could not hear their voice. On a subsequent presentation, following re-examination and re-categorisation of the data, both students and teachers came to a consensus on the naming of the categories, with the students commenting that the new categorisations really captured their experience, they felt that the findings were 'grounded' and were an accurate representation of their reality.

Transferability refers to the extent to which the findings from the research can be transferred to other groups or settings, the possible generalizability of the data. Lincoln and Guba (1985) identify that the researcher has to provide sufficient descriptive data in the research report so that readers of the report

can evaluate whether the data may be applicable to other contexts, this is frequently referred to as the 'fittingness' of the data. Sandelowski (1986) reports that a study meets the criterion of fittingness when its findings can fit into contexts outside the study context and when the reader views its findings as meaningful and applicable to their own experiences. Lincoln and Guba (1985) argue that providing enough clear description of the methodology is given, transferability is not the responsibility of the researcher, but rather of the person who uses the research to make claims about the broader population

The **dependability** of qualitative data refers to the stability of data over time and over conditions (Polit & Hungler, 1995). The specifics of dependability are not described well by Lincoln and Guba (1985), however it is suggested that dependability and confirmability may occur simultaneously (Talbot, 1995). **Confirmability** is described as the ability to show the way in which interpretations have been arrived at from the research. Methods to demonstrate dependability and confirmability include having two separate teams analysing the same data then comparing results, or by the use of an audit or decision trail. A study and its findings are deemed auditable when another researcher can clearly follow the 'decision trail' used by the initial researcher. Auditability is demonstrated primarily in the research report. An audit trail is initially identified on page 22 of this chapter, but is further evident in chapters four and five. Guba and Lincoln (1989) further elaborated on confirmability and identified that confirmability had been established when credibility, transferability, and dependability had been achieved.

This chapter has discussed the exploratory, descriptive, qualitative approach of this research study and the relevance of this approach to the nursing context. The focus group method of collecting data has been examined and the constant comparative analysis method of analysing data according to Stern (1980) has been described. Issues relating to selection of participants, ethical considerations and research rigour have been outlined.

CHAPTER FOUR

Relearning How to Learn

This chapter examines the category – **relearning how to learn**, the codes making up this category are: ***'out of comfort zone', 'finding their voice', letting go/grieving'*** and ***'growing the tree'***. What emerged from the data was the knowledge the students had gained during their previous enrolled nurse training and subsequent nursing practice, had to be examined, and relearned, to allow them to reframe the knowledge and thought processes required for degree level study. While the teachers believed this required the students to unlearn aspects of previous knowledge and learning processes, the students preferred this process to be labeled as 'relearning' or 'mind shifting'. A student commented that she felt the term 'unlearning' devalued the previous knowledge gained as an enrolled nurse. During this process of relearning both students and teachers believed the students experienced psychological and behavioural changes that tracked alongside the cognitive changes that occurred as they progressed through the transition.

Out of Comfort Zone

The students' enrolled nursing experiences and ages both assisted and hindered them when it came to making the transition to degree level study. Many of the students initially chose to enter enrolled nurse training because they did not want to undertake the three years required for the general or diploma programmes, but a few believed that they could not achieve the academic requirements of the general/diploma programmes. These students also expressed their concern about not succeeding in the present programme, but thought their years of experience as enrolled nurses would be an advantage. The type of learning in most of the original enrolled nurse training programmes was very prescriptive and teacher directed, as one teacher noted:

> *It was fairly descriptive really, I mean, as far as I can remember, they were incredibly spoon fed, and they were given information*

they were supposed to retain and apply, and that was the style of education. There weren't many thought processes that were drawn on. M (2)(1)

The students had difficulty in remembering the educative processes involved in their original training, although one noted that it felt very superficial. She didn't feel the superficiality was a real problem originally, as she wasn't going to be making major decisions, those would be left to the registered nurses. Others felt their training was good preparation for working in hospital settings where there were other nurses to ask for help and guidance. One noted that the initial training did not really prepare her for work in the community, but once she had gained experience in hospital settings she felt able to work in the community alongside registered nurses. However, this student noted that it wasn't long before she was working by herself in a community setting, often taking on registered nurse responsibilities, primarily when there was a lack of registered staff in the rural setting where she lived.

Many of the teachers had been involved in teaching enrolled nurses right up to the demise of the programmes, and they believed that the programmes were not intended to foster critical thinking or problem-solving, rather, the enrolled nurse was supposed to be a semi-educated participant in a process where they would be directed to complete nursing tasks.

The role itself was to take orders, to not think, I mean the role was not to learn to critically think and apply it to practice, it was actually to learn to be told to go and do the tasks --- it was very task-oriented. N (2)(2)

The teachers agreed that the enrolled nurse students would experience some difficulty initially with the type of learning required for the degree, primarily the need for self-direction in looking for new ways of gaining information, especially as the students were looking to the teachers for the transmission of all knowledge. Historically, the students had experienced training that was teacher and content driven. They had little confidence in incorporating their previous

knowledge and skills as they could not immediately relate it to study at degree level. Some students believed that their past learning experiences as enrolled nurses had not assisted them in developing confidence and skills in speaking up and asking questions. One of the older Maori students disclosed that that it wasn't just her past training and subsequent nursing experience that had limited her confidence but also the era and the way she was raised.

> *The way I was brought up was never to question and not to speak up when we had people come to the house. I find I just don't have the confidence in myself and I'm always putting myself down. It always looked like I was the one who had to ask the dumb questions in class and I hated to ask because everyone would have known I was a 'dummy'* E (1)(43)

Many students agreed with her comments, saying that earlier in the programme they did not want to expose their lack of knowledge or understanding and appear vulnerable in front of their peers and teachers, so they left it to one or two vocal members of the class to ask the questions, and unless called upon did not participate in class discussions. When asked why they had such a reluctance to ask questions, one student said she felt out of her 'comfort zone' and thought that as an enrolled nurse she would be expected to have a lot of the answers already and lacked confidence in putting her ideas forward. Many students expressed their lack of confidence in coping with the degree programme, and not wanting to 'appear stupid in front of their mates'. A Maori student said it was a great relief when she realised that the Pakeha students were struggling with essay writing as well as her, as it meant she wasn't just another 'dumb Maori'. Another student commented that as the programme progressed and they developed trust in the teachers it became easier to ask questions, but they frequently left it to the two or three most vocal in the class because it was easier and they could stay in their 'comfort zone'.

Teachers commented that they also recognised the students' general lack of confidence within the class (with one or two exceptions), and linked this to the

lack of self-esteem that is frequently associated with enrolled nurses re-entering the education system (Adamson, 1997).

One teacher noted:

> *On a personal level, their re-entry to tertiary education must have some implications for their self-esteem. They come into a programme as quite experienced enrolled nurses and there is status and value of work that goes with that, and they lose that status. Like all of that gets suddenly taken away and there is recognition that maybe they were practicing unsafely. They become quite lost in terms of personal self-worth and esteem as well, and there is not a lot to replace that with initially.* P (2)(4)

One student noted that for her:

> *The lack of confidence comes in the more knowledge you get, because you didn't know a hell of a lot really, compared to now, and you thought you were doing the right thing. When I think back, I think, oh ---, its sort of like the more I know now the less confident I become because it shows up all the inadequacies you had before. There are a lot more 'ifs' 'buts' and 'maybes' in life now, more than the concrete.* C (1)(20)

A major area where the students felt vulnerable was their lack of computer and information technology (IT) skills. A few students had undertaken computer courses prior to commencing the course and other students had picked up some information while helping their children, but the majority felt overwhelmed by having to learn these skills as well as the content of the course. The students were able to present their assignments in longhand, but there was an expectation that by the end of second year they would be utilising the computer for assigned work. This raised issues of access that will be discussed in the next chapter in relation to support services, but a key issue for the students was their lack of confidence in acquiring computer and IT skills.

A number of teachers commented on the reluctance of a number of students to acquire computer and IT skills. Three teachers who had made concerted efforts to assist the students in gaining these skills, were frequently thwarted by failing systems at the satellite campus, but more so by the student's attitudes and reluctance to persevere.

> *I think a lot of their reluctance can be related to their self-esteem. Many of these students do not see that they are entitled to our assistance, and frequently feel they are taking up too much of your time, even though you have set aside tutorial time specifically to help them get on board with IT skills.* R (2)(34)

Some students' unwillingness to persevere with developing IT skills prevented them from accessing all the databases available to them. There were many reasons for this, but primarily these students said it was just too difficult for them. One said she had allocated a certain amount of time in her busy life for the degree programme and was not able 'to fit in' the extra time needed to learn IT skills. Those students who brought IT skills with them to the programme were heavily relied upon by the other students to access databases.

The majority of students were working part time throughout the programme, which frequently caused role conflict and at times undermined their confidence, but as the programme progressed and the students were successful in both classroom and clinical assessments, the teachers noted there were obvious signs they were making the transition to studying at degree level. The students were questioning more, seeking other sources for information, challenging ideas presented in the classroom and becoming confident in using academic language. One student noted that while others had opinions different from her own she now did not believe that it meant she was wrong, just that they had a different perspective. She said she was becoming more comfortable with that, and now did not always feel compelled to change the other's view or see the challenge as a personal attack.

Finding Their Voice

Initially the students were very reluctant to assume responsibility for developing direction for their study and relied heavily on the teachers for supervision and direction for learning. Teachers commented on what they observed to be 'dependent behaviours' such as 'repeatedly asking for instructions on completing course work' and 'wanting step by step guidelines for everything'. One teacher noted that the students 'appeared to lack initiative' especially when compared to the students from other programmes, she noted:

> *For the other students they ask questions that are really off the wall because they have never been in the box, but the enrolled nurses always ask questions within the box. They really need pushing to see other options, and they frequently appear to lack the initiative to explore these options.* L (2)(10)

The teachers commented that this perceived lack of initiative appeared to be related to the student's sense of self-esteem, and as they successfully completed components of the programme, the teachers noted that the students were not always looking to the teachers for the answers and they appeared to be comfortable in challenging the teachers and their colleagues and able to voice their concerns.

The students' work and life experiences were of great assistance when it came to organizing and prioritising their study with their work and home commitments but although the students recognized they had developed skills in managing their work and family lives, this did not automatically transfer these into managing the new style of learning required by the degree. As their previous knowledge was incorporated with new knowledge and reframed, the students began to value their work and life experiences and gained confidence in assuming responsibility for their learning. One student noted that she realised she was finding her voice and making the transition when she started to question what she was doing at work.

> *It's strange but at work now I feel less confident, because I've never understood the actual depth of knowledge and implications of being an RN. I think as an enrolled nurse I just rode across the top and did my work, and now I am starting to say, if I make this decision---- and I am looking at myself and the way I'm working and I'm thinking, oh boy, I think this is too much responsibility.*
>
> B (1)(16)

In the second focus group interview with the students some weeks later, this same student expressed how satisfied she was at work now.

> *At work for the last ten to fifteen years I've felt extremely frustrated with my job and I felt I was of average intelligence and could therefore do something about my frustration. I just feel so much satisfaction now, even though I'm not always confident, but I am actually learning and understanding concepts of nursing and people in a totally different light. It is of immense satisfaction to me to be able to see outside the square.* B (3)(42)

Many students commented about looking outside the square or being outside their comfort zone, both at work and in some of the activities they had to present for assessment, but they believed that real learning occurred for them once they had realized their success was really up to them. One student stated that a major factor that assisted her in taking responsibility for her success was 'risk-taking'. She described that part of this was 'speaking up at work' against entrenched ideas, even though she knew it made her unpopular at times. Other students commented on how difficult it was to express their new knowledge in their workplace, and frequently felt unsupported by the older registered nurses in their work area. They said they were frequently challenged by these registered nurses, many of whom did not have degree qualifications, to explain how having a degree was going to make them a better nurse than one with a diploma and years of experience. One student said that as she wanted to go back and work in this area after registration, she found herself frequently 'biting her tongue, but not feeling good about it'. Another student noted that the

biggest problem she had was with the 'nurse aides' in her work area, many of who had been there for 20 years or more.

> *My problem is not with the RNs, we have some new grads who are really trying to do innovative stuff, but the nurse aides are really giving them a hard time. These aides are old and set in their ways and many are really bossy, and you try and make a change and they will be on top of you no sweat. We have lost two great new grads because of them.* E (3)(13)

This same student then went on to describe how she was responding differently to the aides now, and wouldn't get involved in putting down the RNs, but found ways to support their changes without antagonising the aides too much. She discussed how she had really learnt to choose her time before commenting in support of the RNs, and felt 'quite chuffed' at the skills in communication she had gained. Another student believed that this was representative of the professional development that she felt all the students were undergoing as part of the transition to become registered nurses.

One student found her workday was much longer now, and she put that down to really thinking a lot more about what she was doing. Other students agreed when she said she was 'not leaving things at the door anymore' and she would find herself 'sticking her head in a textbook' when she got home, to enable her to make better sense of her working day and the decisions she had made.

A Maori student commented she was feeling more confident in her learning now that she was doing things the 'Maori way'. When asked to elaborate, she described that she was using 'a lot of talking over the new ideas with other Maori colleagues and putting things into visual pictures' and this really helped put things in perspective, rather than 'writing out lots of words'. She added what really helped with her assessments was being able to present in song, actions and with humour, as well as the conventional methods of assessment required in the course.

The comments by the students and teachers indicated a development in the students assuming responsibility for their learning and being able to put forward their views confidently. This supports one of the major factors identified by Ash (1999) as being part of the transition process that occurs when people undergo changes and movement in their lives. Literature by Belenky et al (1997) also supports the students' perceptions of 'finding their voice' as they gained confidence in their ability to achieve within the degree programme.

Letting Go/Grieving

The concept of grieving was raised first by the teachers, who perceived that when they entered the programme, the enrolled nurses were losing a lot of the value and status they had in their working lives, as they assumed the student role with all the associated issues that student life engenders. One teacher explained her previous experience with enrolled nurse students as working with 'lost souls'

> *I feel they go through a grieving process, because they are not enrolled nurses anymore, but they don't yet have all the skills and knowledge to be registered nurses. Many of them became really frightened at having to make that transition to assuming responsibility as registered nurses, and have a real sense of loss for when they were competent enrolled nurses.* M (2)(4)

Another teacher noted:

> *You know its not even just being an enrolled nurse, its mature women being put in student role. The thing they hate the most is being a student. For many, after working for years they have real difficulty in what they perceive to be the student role, and we as teachers need to know how to value and utilise all their experience and knowledge.* Q (2)(5)

Many of the teachers had noted the frustration and anger some of the students displayed when events initially did not flow smoothly, especially in relation to difficulties in accessing databases and library support. At times the anger and

frustration seemed out of proportion to the problem, as one or two of the students kept returning to old issues and grievances. For the teachers they felt this was indicative of the grieving process, as the students used tangible situations that enabled them to legitimately vent their anger as they underwent the transition process.

> *I think their anger is a result of the frustration they are feeling with having to take on board new ways of learning and trying to see how it fits with their previous nursing experience. I see them fighting this change where they have to give up old learning habits, and they are transferring this frustration into fighting all the concrete things that they feel are not going well, like problems with classrooms and difficulty in accessing journal articles. They feel that every article they want will be at their fingertips, and haven't yet factored in the time it takes to access suitable resources.* R (2)(24)

When the teachers' comments were taken back to the students at their second interview, a few did not agree that they had gone through a grieving process. These students felt that as they were still working as enrolled nurses, they did not feel any particular sense of loss, just frustration with the problems that were occurring in the educative process. One student agreed that initially she may have been going through a grieving process, but as the course progressed and she continued to be successful in all her assessments, she could see the possibilities opening up for her. She stated that she could never go back to what she was. There was just so much more she could do now and had so many opportunities open to her. Another student acknowledged that she did have a sense of loss for the simpler time she used to have at work as an enrolled nurse, but she also recognised the frustration she felt at the limitations of that work.

Growing the Tree

The nursing degree programme in which the students were enrolled has five degree processes that underpin the qualification - critical thinking, competency, communication, valuing and professionalism. These processes are evaluated in

each of the modules that make up the programme, although there are different emphases in each module. Due to their past nursing experiences the enrolled nurses perceived they had a workable understanding of four of the processes – communication, competency, valuing and professionalism, but although they may have utilised critical thinking in their past work life, many were unable to articulate the processes that embodied critical thinking in their practice.

'G*rowing the tree'* signifies the major cognitive adaptations the students had to make if they were to be successful in the programme. For many, working as enrolled nurses meant that if they were unsure of what nursing actions to take or lacked the knowledge to implement care, they would defer to the registered nurse. They did not feel they had to accept responsibility for seeking out the required knowledge in the clinical area, therefore the process of having to accept responsibility for self-direction in learning in the programme proved very frustrating for the majority of students.

> *It wasn't just going back to school. It was a lot more than that. At school you were told what to learn, but on this course the frustration is about not being told exactly what to do, but to achieve your outcomes you have actually got to do a lot of the work yourself, and we had no prior training to know how to do it.* C (3)(27)

Many of the students commented on the difficulties they experienced in 'learning how to learn' and felt frustrated with the teachers who wouldn't always give them the answers but wanted them to explore possible solutions from their own experience or search out the information for themselves.

As part of the learning involved in the nursing degree, there is the expectation that students will seek information from a variety of sources other than the initial sources given by the teacher. Students are given workbooks, related readings, and frameworks for guided study, as well as timetabled lectures, group activities and tutorials. The expectation of the teachers, was that these students would complete the required work and then, utilising their previous knowledge and experience, be able to identify areas that required more in- depth study. Many

of the students had difficulty with this type of learning, and although many put in long hours of study, they often felt unsure about the depth and level of the work required.

> *I was really not aware of a realistic workload, I would put in hours of study and find it was 'nice to know' stuff rather than 'must know' stuff.* C (3)(26)

These were mature, competent women both in their work and home lives, and there was an expectation from the teachers that with tutorials these students would be able to quickly develop skills in reflection, critical thinking and problem solving that would enable them to achieve well in their shortened programme. Most teachers believed that if the students' practice wisdom could be uncovered and applied, they would be able to recognise the processes involved and be able to put new knowledge into existing schema. The students found this extremely difficult to do in the initial stages of the programme.

> *I have never had to learn this way before. My enrolled nurse training was very much being told what to learn and then learning it. Nothing in my previous work and life had prepared me for this type of learning. I was really struggling.* E (3)(27)

The teachers believed that the students had to relearn how to learn and that many would have difficulty in relinquishing the security of old habits and also in accepting the uncertainty of student centred learning. The expectation by the teachers was that the students would be able to identify deficits in their knowledge as well as assume responsibility for developing the necessary learning skills with the support of teachers, learning tutorials and student support staff.

In the initial stages of the transition programme, some students felt their years of experience as enrolled nurses were not helping with the level of study required. The teachers suggested that they exhibited signs of mature age students returning to study for the first time, with many not having the skills of

mature learners. They brought with them a believe in the old style of 'chalk and talk' teaching, where the teacher was presumed to have all the knowledge that would be imparted to the student in the form of lectures and notes, which the student would then rote learn, and present back to the teacher in written examinations. The students had little confidence that their wealth of work and life experience would be of value in attaining their degree.

Many were hesitant to participate in class, believing that they had little to offer, while others would 'capture' the teaching session, describing in detail their experiences that they believed were relevant to the topic under discussion. Teachers recognised that both of these behaviours reflected the students' unease at the position they now found themselves in. These were mature competent woman now in a student role and very unsure about what was expected of them and how they were to respond. One teacher also noted that these students were quite unique in the fact that they were not integrated with the mainstream students, and therefore unable to compare their behaviour and achievements in regard to other younger and novice nursing students.

> *These students are special because their programme is held off campus, but that means that they are quite isolated from the other mainstream students, and also from other enrolled nurses who are integrated with the mainstream students. There is no comparison for them, they are unable to compare their perceptions with others, and I'm not sure whether that is a good or bad thing.* M (2)(10)

All the students expressed the view that the first year was particularly difficult. Many doubted they had the ability to succeed, especially in relation to the biological science papers. Although they felt they had been informed that the first year would prove challenging, the majority said that in reality, if they knew what they were letting themselves in for they would not have enrolled in the programme.

> *If I had to go to the city to do the programme I wouldn't have done it. It was only because you were going to run the programme up*

here in the north and I could still work and be close to my family, that I considered it, although in the beginning I really didn't think I would make it. All the work was overwhelming, and if I had known it was going to be this hard I wouldn't have done it. E (3)(23)

Other students expressed the same sense of being overwhelmed, and used words like 'drowning', and 'going under'. When asked what specifically engendered the sense of being overwhelmed, two students believed it was because the papers were running concurrently, and they had to keep switching from topic to topic. They felt they would have liked to complete one paper before starting another, and even though they knew the papers were interconnected and built on one another, they had difficulty integrating the knowledge and seeing the connections. For the teachers this initiated a discussion around enrolled nurses having to 'unlearn' not just content but previous learning habits which were frequently proving unproductive and a hindrance to developing critical thinking skills.

Their original course would have been really superficial in regards to content, and they would have been taught to rote learn, which is really a hindrance when we want them to be problem solvers and critical thinkers. They have to unlearn so much, both in content and ways of learning. P (2)(35)

When the teachers' comments were referred to the enrolled nurses for discussion, there was debate on whether 'unlearn' was appropriate for what they were experiencing. One student commented that unlearning devalued what the enrolled nurses had done in their working life.

Regarding 'unlearning'. I don't see it as that. I see that as devaluing what we have been. The right word is not unlearning, rather I see it as mind shifting. Mind shifting from being task oriented to being a complete, practical, theoretical person, you have now got theory on board. As an enrolled nurse you knew what you had to do and we

just went and did it, whereas now we are actually thinking about what we are going to do and why'. C (3)(10)

Other students also agreed they felt they were undergoing a mind shift from rote learning information to actively endeavouring to gain understanding, which they felt was more difficult. However, one student found the experience 'really exhilarating'. When asked to clarify her statement, she felt that she had found a mind she didn't know was there.

Its like I am growing a tree. The teachers have given us the concepts, planted the seeds, and its now up to me to grow the tree. They were giving us just enough to develop an inquiring mind, and I felt I had to go and research it all and make sense of it for myself. You come out of your comfort zone if you want to achieve and learn, and you have to keep the tree growing.

B (3)(1)

The majority of students agreed with the above sentiment, saying it really described the changes they have had to make from the more traditional styles of learning. The students commented that gardening analogies helped describe their transition and suggested others such as 'nurturing the plant' and 'getting rid of useless weeds'. Many still felt they had a long way to go with this process of learning where they were active rather than passive learners, but they recognised that this type of learning which facilitated problem solving and critical thinking was going to be crucial for them to function as registered nurses.

As the students clearly stated they were not 'unlearning' ways of being an enrolled nurse, they were asked to explore the processes that underpinned the 'mind shift' they believed had occurred. One student explained:

My enrolled nursing experiences were valuable, and now doing the degree programme I'm going up several steps and looking through a different window. A (3)(9)

Another student described the process as:

> *It was like hitting a brick wall. No matter how much I studied, it didn't seem to be enough. It was like there was no end to the new knowledge I needed, and I felt I would never get on top of it. I knew I had to try a different approach.* E (3)(17)

The student recognised that with the vast amount of new knowledge with which she was faced, her old style of learning, mainly rote learning large amounts of data, would prove problematic. She found that she was looking for ways to connect the knowledge, and when she started on the process of reflection, which was required for her clinical experience, she was able to link experiences from her work as an enrolled nurse and integrate this with new knowledge. One student said that it wasn't until she had a really good teacher in the clinical area and she understood what was meant by reflection, that things started to fall into place.

> *This teacher was able to explain things in terms and language I understood. She would relate what I had done back to my previous nursing experience and then ask questions about what I just did, and what would I have done as an enrolled nurse and what was I doing differently now, and why.* G (3)(20)

Reflection was identified by a number of students as a key factor that helped them make the mind shift to degree study. Although one student noted that she really did not understand what was required in reflection until she was quite a way through the programme. She felt she was just going through the academic steps as outlined in their clinical logs, which required them to reflect on their clinical practice, but was not able to fully appreciate the thinking involved in the process. She said that the impetus to fully understand the critical thinking that occurs with reflection came in a clinical situation that she had not encountered before, which galvanized her into wanting to understand what happened. She believed she was really ready to learn and things 'just fell into place' at this

point. The teachers also noted they saw marked changes in the students' learning behaviour where insight was apparent and the students demonstrated a 'readiness to learn'. One teacher found this readiness to learn often followed a situation where the student had been emotionally affected by a clinical situation, as one student explained, 'that could have been my daughter in there'.

Another teacher believed, to enable the enrolled nurses to take risks and explore outside their sphere of reference, it required the facilitation of an experienced, competent teacher to help the students 'reframe' their practice wisdom. If the students were able to deconstruct their knowledge and identify the underlying assumptions and frameworks, this would facilitate their ability to reconstruct and integrate new knowledge. The wide clinical and life experience of the students enabled the majority to attach new knowledge to real examples, so where there may have been some initial difficulty with new concepts, once the students were able to construct this new knowledge with previous life and work experiences, subsequent knowledge was quickly assimilated.

One student felt that she would never get on top of the new language. She said she had little difficulty with the increased medical terminology found in the biological science modules, but had problems understanding the language of the nurse theorists. Other students agreed with this, but one added that once she had used humanistic nursing theory in the clinical area and directly saw the relevance to family nursing, she was 'hooked'. For her it felt like 'all the pieces of the jigsaw came together'.

Many students felt that as enrolled nurses with many years experience, they had an advantage over novice students in relation to linking theory to practice. They were able to leap the gap between theory and practice with increasing confidence as they identified how to access their wealth of practice knowledge.

One student noted:

> *I was talking to one of the 'normal' students and she was talking about what they had learned as theory and the gap between what they were learning in practice, but I think for us we don't have that gap. Because we are looking at it more as working, like where does this fit into our working day, and we are attaching the theory to our practice, where they are trying to attach new practice to theory, and its quite a different way of looking at it.* B (3)(44)

The theory-practice gap engendered discussion with both the students and teachers, with many explanations, and suggestions put forward to minimise the perceived gap. Both students and teachers agreed that the most important element in minimizing the gap was a degree educated clinical teacher who was able to draw on the enrolled nurses' life and work experience and facilitate the reframing of this knowledge with new knowledge. This will be discussed further in chapter five under *'clinical role models'* .

This chapter relates the sub-categories – ***out of comfort zone, finding their voice, letting go/grieving,*** and ***growing the tree***, to the category of '**relearning how to learn**'. Both students and teachers recognised the style of learning required for degree study, but their use of different language to describe similar concepts was noted. Whereas the teachers believed that the students had to 'unlearn' the traditional methods of learning that was part of their original enrolled nurse training, the students perceived this to be 'mind-shifting'. The information from both groups however, suggests that the processes of learning required for the transition to degree status, meant the students were required to develop critical reflection, and move away from 'received knowledge' to 'constructed knowledge' as described by Belenky et al (1997), where knowledge is actively construed within the social contexts of the students' experience.

The sub-categories ***'out of comfort zone', 'finding their voice'*** and ***'letting go/grieving'*** are indicative of factors associated with psychological and emotional adjustments that occur during a transition process (Ash, 1999). Both teachers and students agreed on the concepts of 'out of comfort zone', and

'finding their voice' that occurred during the students' transition, but a few students disagreed that grieving was a valid concept for them as part of the transition. These students believed that this related to the fact that they were still working part-time as enrolled nurses and they suggested they did not have a sense of loss associated with losing their identity as enrolled nurses that others in the group may have experienced. Teachers noted that the sense of loss and grieving did not just reflect the students' beliefs about their work as enrolled nurses, but also reflected the loss of familiar ways of learning and being. As the students progressed through the transition process they were learning how to cope with their anxieties, fears and concerns and developing the skills to situate themselves in the practice world not as enrolled nurses but as aspiring registered nurses.

CHAPTER FIVE

Barriers and Catapults

The three codes (sub-categories) that come under the category barriers and catapults, are ***living rurally, support services***, and ***clinical role models***, and they relate to what the students and teachers perceived to be the major environmental factors that influenced their transition. When first asked about the external factors that had hindered their transition the students identified that, primarily, having to travel and be away from families while they attended study days and clinical placements was a major barrier. The second was having to cope with the difficulties they experienced at the satellite campus in accessing data. The major factors that assisted their transition were working with experienced, supportive registered nurses, and having clinical teachers who had a good understanding of the level of thinking and knowledge required for the degree.

Living Rurally

The majority of students had to travel long distances from different areas of Northland for their study days, which meant they had to find accommodation for those days. They also had to find accommodation while they completed their medical, surgical, paediatric and psychiatric clinical experience at the city hospital. Initially they gained funding from the Clinical Training Agency (CTA) for travel and expenses, but this funding needed to be continually applied for and couldn't be relied upon. The majority of the students had families, and a few were solo parents, which required them to organise reliable family care while they were away. The students disclosed that they found it very difficult being away from their families, and even though they kept in touch frequently, they acknowledged that distance precluded them getting home to deal with problems unless they were major.

> *Being away from family was one of the hardest things I had to deal with. I was always worrying about what was happening and found I*

was ringing home two or three times a day. I had real difficulty focusing on study initially, but once things settled down and I knew they were coping okay without me most of the time, I could start to let go a bit and concentrate on the work. J (1)(38)

A number of the students with families talked about the sacrifices their families had to make to enable them to complete this course. Not only were the students assuming the responsibility for their learning and subsequent success in the course, but families were having to assume more responsibility in managing the households, albeit reluctantly. One student saw a real change in her children as household duties were delegated, commenting that a growing sense of maturity in her children was a great spin-off from the course, although she hadn't yet sorted out how to win the battle for control of the computer.

The students were given the opportunity to make up clinical time at a later stage in their programme if due to family reasons or ill health they had to take time away from their clinical experiences. This option was crucial in allowing students to participate in the course, but proved difficult for the clinical co-ordinator, who due to geographical location and limited clinical placements, had to book clinical placements for the students a year in advance.

With the exception of a few who were supported by work managers, the majority of students had to meet most of the fees and course expenses themselves. Even though they had budgeted for the course there were many additional expenses that eventuated due to the fact they were living in rural areas. A number of students found they had to limit getting together in study groups outside the allocated study days, as the expense of traveling to the different homes became too high.

Its okay for those living close together, they can get together and work together at home, but for others like me who live a long way from anyone its really expensive to keep traveling to each other's house. Even phone calls become over the top when you're on a

> *tight budget. One good thing though is having the free 0800 number to get hold of teachers.* B (1)(6)

Another student noted:

> *Living rurally, you can't just nip down to the library if you find that the articles you got initially weren't any good. It meant you had to be really organized weeks in advance before each assignment was due, because frequently you didn't have the right resource material. I wasn't used to being like that, having to be organized that far in advance and I was always asking for extensions (for assignments) at the beginning.* C (1)(38)

The teachers also commented on the difficulties associated with conducting classes at the satellite campus, without the usual amenities and support services that were located at the main campus. A major issue was ensuring they had all their teaching resources, as well as the resources the students may have required. Not all the rooms were satisfactory, with lack of amenities and blackout curtains, as construction on the campus had yet to be completed. The teachers were given the option of staying in a motel for the time required, but as the majority had children they chose to make the hour and a half journey daily.

Support Services

There was an expectation by the students that certain library and computer facilities would be available to them at the satellite campus once their programme had commenced. Unfortunately, technical difficulties in establishing networks and computer links delayed access to the library databases. Those students who had internet connections at home had access to the polytechnic web page and online library databases, but this process of accessing data was limited to the few students who were comfortable using the computer. When the students experienced difficulties with the malfunctioning systems it just increased their anxiety and deepened their aversion to learning the technology. There was also conflict between the satellite campus computer services and the

nursing lecturers, who were travelling to the campus to teach the nursing modules, as to who was responsible for teaching the students how to use the campus computers. The campus did not have designated computer teachers and requests for peer teachers for the students was agreed to but never eventuated.

> *I just found it all too much. A computer teaching session was organized by a teacher which we all travelled down for and then the system was down. This happened so frequently I just gave up, it really wasn't worth the hassle. The teachers knew the difficulties we were having, so once they started to bring us boxes of articles and books to look through, I gave the computer away. Maybe when all this is finished and I have the energy I'll look at it again.* E (1)(4)

This student also stated that although she wasn't using the computer to access CINAHL (Cumulative Index of Nursing and Allied Health Literature), she was using the hard copy indexes at the satellite campus, but didn't find them particularly useful, as many of the articles she wanted were in journals not held by the polytechnic library.

The need for computer skills was discussed by the students and they all acknowledged that if they were to be professional registered nurses working in the new millennium they would need these skills, but they believed that in the reality of where they were working or planned to work, computer skills would barely be utilised.

> *I know they have computers at ..... Hospital but I rarely see the nurses using them, it's mostly the office staff and I have never seen a laptop computer used by the nurses in the community. I suppose there are some who do, but I have never seen them, this area up here is so poor I doubt whether they could afford them anyway.*
>
> C (1)(4)

The students discussed the need for pre-entry computer courses and were divided as to whether a computer course should be a pre-requisite for the nursing programme. The majority stated that if required to complete a course prior to commencing the degree programme they would not have enrolled, mainly because of the extra expense and time required. These students suggested having an optional course running alongside the nursing programme. Two students had completed computer courses at their local high school prior to commencing the programme and found it really minimised the frustration they had noted in the other students and they strongly recommended that a pre-requisite computer course be available at satellite campuses. One student summarized how a number of the students were feeling in relation to developing IT skills.

> *For me, one of the biggest things that zapped my confidence was not having computer skills. I could see some of the others were able to use the thing, but I didn't even know how to turn it on, and when I did seek help, the IT tutor was so far away from where I was, it was just too embarrassing. And another thing, when we finally got access up here at Keri Keri, the system was always breaking down. It was all too much, especially on top of the study. Personally I would have liked to have done a computer course prior to studying for this course, because I am that sort of learner, can't take everything on board at once.* *F (1)(6)*

The nursing teachers who organized and taught the students how to access databases, were also frustrated by the system failures, as their time was limited at the satellite campus in teaching the shortened programme for the students. Two teachers also identified that a number of the students were very reluctant to persevere with developing the required computer skills to enable them to utilise the databases.

> *Having to use the hard copy system of CINAHL is really time consuming, as it doesn't allow you to link subjects. I'm finding more and more that I'm bringing up a selection of articles for the students*

and although I understand their frustration with the system, they really need to realize that they just have to keep at it, as often that's what it takes to get your degree, perseverance to stick with the frustrating bits. R (2)(34)

The limitations of the library service for the satellite campus was a cause of complaint by the majority of students. At the beginning of their programme the students were brought down to the main campus for orientation to the polytechnic and its services, but many found the orientation programme unsatisfactory.

The library session was inadequate for us as mature learners and especially since we were going to be off campus students. I'm sure if we had a decent session, and had a chance to have a practical go of trying to get information, with a tutorial, I think things would have fallen into place earlier. B (1)(2)

One student disagreed and said she found the orientation sufficient, it was just that she used the library so infrequently she kept forgetting where things were, and how to access the databases.

The shortened nursing programme was not deemed to be a distance learning programme as the students were taught the same modules as the students completing the three year programme, but at a satellite location. There were module and delivery adaptations that recognised the students' previous education and experience, but the students had timetabled lectures and tutorials and were not expected to work at their own pace through guided study workbooks, which is normally associated with distance learning programmes. However, due to their limited access to the library and other services, some students perceived they were distance learners.

One student noted:

> *I really don't think they understand our situation as distance learners. If we were having problems locating books or getting access to the computer for databases, they suggested we come back next day. Well that's just not on. We can't just come back next day. They need some sort of booking system for the stand alone computer, as that was the only one that was reliable, not networked, and the one I felt comfortable with. I really felt disadvantaged as a distance learner.* C (1)(3)

The satellite campus and library had organized a delivery system to and from the campus for textbooks, which proved effective, although reference texts were unable to be utilised. With the hard copy set of CINAHL on loan at the satellite campus, the students were able to identify the journal articles they required and fax their journal requests to the nursing technician at the main campus, who would send the requested articles to their home. This system proved satisfactory for those students who were organised and confident in using the indexes, but meant they were limited to accessing the indexes when they were down at the satellite campus for study days, which were already very tightly programmed. Those students who were working at rural hospitals identified that many of the hospitals had CINAHL hard copies that they were able to utilise at work that assisted them.

The teachers talked about the conflict they experienced in trying to facilitate the students' research skills, (which they believed were crucial for a degree programme), while recognizing the physical difficulties the students were having accessing information.

> *We had students learning from a distance without the benefit of a distance library service. Although the library had set up some services they really weren't satisfactory for these degree students. I was really torn between trying to facilitate research skills and acknowledging the problems they were having in getting the*

information they needed. In the end I decided on a compromise and started bringing a whole lot of relevant articles to the study days for them. I know it probably defeated the purpose in having them become really skilled in accessing information systems, but I didn't see any other option. Q (2)(35)

This teacher also said she ended up taking the students into her office for individual teaching sessions on how to use computerized databases whenever they were down at the main campus, but found she was frequently thwarted by network failures.

When the students were asked how these support services could be organised to better suit their needs, they identified that library personnel should be available to instruct them on using the computer databases. When questioned on who should instruct students on the computer skills required, to enable them to access the databases, the students did not believe that it required in-depth computer knowledge.

It wouldn't take much to have some simple instructions above each computer for dummies like me. Just stuff like how to scroll down and how to print off, I don't want to learn anything fancy, I just want to know what information is available to me and where I can get it. I really liked the idea of having other students as roving peer teachers, but I never found one. D (1)(3)

Another student expressed the concern that having a computer course prior to commencing the programme would just elongate the programme and she believed the programme would not have been so attractive then. This comment was supported by a number of students and discussion was generated on possible solutions, discussed further in the chapter on recommendations

Other issues related to library access were discussed by the students, but they felt many problems were diminished once the library relaxed their rules

regarding overnight loans for them, and the delivery service to the satellite campus was improved.

The utilization of other support services was discussed with the students, and their reluctance to access learning support teachers was raised. When the students underwent their original enrolled nurse training, student counsellors and support teachers were not available and were therefore unfamiliar, and many of the students felt that to use these services meant that they weren't coping.

> *I felt I must have been a real dummy to have to get learning support, none of the others were doing it, or they weren't saying they were doing it. But when I hit a brick wall and lost what confidence I had I really needed help. Then when I finally went for help there were heaps of people available to me it was just great, I don't know why I had left it so long. I have been much happier since, but I also think that we need prior learning on how to learn. Yeah, I think the hardest thing was going to ask for help.*
>
> E (3)(32)

This same student also identified that the support services would have been improved if they had nurses with degrees as part of the service. She felt that the support teachers were very helpful in developing good study skills, but she also wanted help with nursing content which they were not able to give her. When asked whether she had sought guidance from the nursing teachers, she identified they were very helpful, but she had found it difficult to contact them as they were frequently out in the clinical area. A teacher paging system had been organised for the students, but this did not always prove satisfactory.

Other students acknowledged they knew the learning support services were there for them, but the majority felt that as mature enrolled nurses they should have been able to manage without them. Some students were reluctant to discuss this topic further, which, at a following discussion with one of the

students, was due to the fact they did not want to embarrass the students who had disclosed they were using the services.

Clinical Role Models

The feeling of being vulnerable and out of their comfort zone, previously identified in chapter four, also persisted into their clinical practice experiences where it could have been presumed that the students would have felt more confident. Recognising that frequently the enrolled nurses would not admit to feeling vulnerable and scared especially in their role as students in clinical practice, was quite a crucial factor in facilitating learning, according to one teacher. This teacher discussed the concept that for the enrolled nurse students their 'normal day's work was not normal any longer'.

> *When I said their normal days work is not normal anymore, I meant that they were now questioning a lot of the things they were doing in their practice as enrolled nurses were unsafe. I said this must have been 'really scary for them'. The majority of the students agreed, but they didn't speak up, because they were out of their comfort zone and did not want to acknowledge that they might have been unsafe in their practice as enrolled nurses.* M (2)(4)

All the students agreed that competent clinical role models played a crucial role in their transition. The students discussed the characteristics of clinical nurses who had facilitated their learning, with the majority believing expert clinical knowledge alone was not sufficient. The students believed that the clinical nurse/teacher also needed to have a good understanding of the thinking processes, for example reflection and problem solving, required for degree. They also put a strong emphasis on the clinical nurse's willingness to take the time to explain what they were doing and to demonstrate patience in allowing the students to work alongside and ask questions.

> *Fortunately I was lucky to have a buddy that her way of teaching me was to let me do it and she talked me through it, which was great as she gave lots of praise, but was really honest when it was*

> *obvious I wasn't thinking it through. She was always asking me if I wanted to see different procedures. I really felt she was interested in my learning and she wasn't put off by all my questions, although she did say I asked harder questions than the ordinary students. I suppose that was because I already had a lot of knowledge as an enrolled nurse.* C (1)(28)

One student observed that being an enrolled nurse helped in her 'survival' but really hindered her as a student. When asked to elaborate, she believed that as an enrolled nurse she already had the practical skills and knew how to do the 'basics', like managing patient hygiene care, and mobilising patients, as well as a good understanding of procedures and infection control. She felt she was often called upon to use these skills especially when the ward was busy or short-staffed, but frequently these enrolled nurse activities took precedence over her learning requirements as a student.

> *You could see what had to be done when the ward was busy, so often you just leapt in and did it, even though it may not have been your patient, and it meant you were bustling about all the time. The RNs were really grateful when you helped in the ward, but it meant that the learning outcomes that we had as students frequently did not get met.* C (1)(24)

When asked why the learning outcomes did not take precedence, she believed it was because it was often easier to work as an enrolled nurse, than move out of her comfort zone into new territory. Another student commented that it made their life easier, as the registered nurses were always grateful for the help in the ward, but not always forthcoming in helping them learn the registered nurse role. One student put this down to the fact that the registered nurses were not used to having students who already had nursing knowledge and were asking quite challenging questions. Another student felt that their questions were threatening as they were looking for rationales for the registered nurse's actions, and many of the registered nurses were unable to give the scientific rationale for what they did.

> *They didn't know how to relate to us, as we were more self-assured than the other students. We weren't these 17 year olds that they could just tell what to do, or fob us off with superficial answers. We were there as colleagues, we could see whether their practice was okay or not and I think we were a threat.* G (1)(25)

Some of the students agreed they felt they were a threat to many of the registered nurses and believed that was why some of the registered nurses did not want to be their 'buddy'. Other students said they had no problems with any of the nurses they worked with, and they felt the registered nurses went out of their way to help them learn, and it was all just a matter of the student's attitude, and when to pick the appropriate time to ask questions.

One teacher discussed the difficulty she had in finding clinical 'buddies' for the students, as some of the registered nurses did not 'have the energy to cope with those stroppy enrolled nurses'. She commented that she saw evidence of 'horizontal violence' directed towards the students, as fatigued and stressed registered nurses did not want to assume the responsibility for teaching students who frequently questioned their practice. All the teachers agreed that it took a confident, knowledgeable registered nurse who had a good understanding of the degree curriculum, and was prepared to work with the students, to facilitate their learning. The concept of preceptorship was raised by another teacher, and recognizing that not all clinicians were degree prepared, she identified the need for teachers and clinicians to work closely together with the students. The hospital did not have a preceptor programme for students, but as they had recently instigated a programme for new graduates, it was hoped that a student programme would be developed before long. Many teachers expressed their frustration at the slow progress of instigating preceptors for the students, but recognised that this type of programme required the participation of full-time staff to be truly effective, and with a large number of registered nurses working part-time they believed there would be many problems in setting up the programme.

The teachers noted that there were difficulties in some areas due to the enrolled nurses' assertiveness in getting their learning outcomes met. The teachers believed that some of the students were reluctant to carry out nursing activities that they felt they had already accomplished, and wanted only to be involved in procedures new to them. This created conflict at times, as the students were expected by clinical staff to meet all the nursing needs for their allocated clients. When discussing how these problems could be resolved, the teachers believed that the clinical staff, student and teachers needed to be involved in setting individual goals or learning contracts for each student, but did not see this happening until the clinical staff were comfortable with the preceptor role.

> *I am really reluctant to push for preceptors for our students until they have seen the advantages for the new grads and themselves. There are so many part-timers at the hospital, its very hard for them to commit to a student who is not working their shifts. If we really want it to work then we will probably have to have the students working weekends and possibly night shifts as well. I don't see that working somehow as many of the students are committed to jobs.*
>
> R (2)(26)

Another student commented on their age playing a factor in how the registered nurses responded to them.

> *Many of the RNs were a lot younger than us and I think they found it hard telling us or teaching us because it was like teaching their older sister or their mother, and I think many of them found that difficult. Often they would say "oh, you know what to do, I don't need to help you", and you really felt silly saying –" well no, actually I need some help here". I really think they were threatened by our practice and our age.* D (1)(25)

This same student commented on how extremely busy all the registered nurses appeared to be and said she felt guilty asking questions or seeking help, as

they would frequently tell her they didn't have time. She expressed her concern about the apparent lack of professional responsibility exhibited by some of the registered nurses in regard to their role of teaching the students.

> *I mean we have paid a lot of money for this course and I know the polytech has paid money to the hospital to have their students in the wards, so I really think their attitude stinks. Some of the wards are really not student friendly, and I was surprised to see how disempowered the RNs were. They complained and bitched about their workload and their situation but none of them seemed prepared to take any steps to do anything about it. They really should be questioning management about the money from the polytech that is supposed to be used by the wards to help teach us. I was quite disillusioned by their lack of professional responsibility.*
>
> D (1)(29)

Another student felt she was not extended in the medical or surgical wards, not because there weren't good role models, but because she was already working in these areas in a rural hospital and frequently assumed RN responsibilities.

> *In a rural setting you just have to cope with what comes in, and I've been there a long time now and working alongside the RNs you just pitch in and get the job done together, so I suppose I have been taking on RN jobs frequently, and when I came down to base hospital, sure the equipment and technology is new, but it doesn't take long to get that on board. So I felt I had learned all I needed to in the first two weeks.* G (1)(24)

The teachers commented that if a student felt she wasn't extended, then both the student and clinical teacher were not utilising all the possible learning activities that were available to them. One teacher noted that a difficulty she had with many of the enrolled nurses in the clinical area was moving them away from just trying to learn new procedures to have them reflecting on their practice, and bringing in their new knowledge that examined the rationale

underpinning the procedure. She was endeavouring to facilitate the student's understanding of the conceptual frameworks inherent within the degree programme to enable new knowledge to be assimilated. This required a change in thinking for the enrolled nurses, from learning new treatments and practice skills, to applying conceptual knowledge to a variety of new situations, and for many this was problematic

A student explained that as she was working as an enrolled nurse part-time she found it very difficult to assume the student role, especially as the registered nurses were grateful that she continued to work as an unpaid enrolled nurse during her student placement. She described this role conflict as 'what hat do I have on today' and said she found the switching back and forth difficult and tiring. She said it was easier to focus on the learning of concrete tasks, than try and understand all the psycho-social complexities involved in family centered nursing.

A number of students said they would have preferred more time with a really experienced teacher, preferably in clinical tutorials, where they would be encouraged to reflect on their practice and what they would do differently as registered nurses. This generated a lengthy discussion by the students about recognition of prior learning for each student, where they could identify the areas they wished to gain experience, and how this could be achieved. The teachers had discussed the concept of individual learning contracts following assessment and recognition for prior learning, and when this was brought back to the students, they felt this would be a satisfactory solution, but they identified that this type of individual programme would require expert clinicians and teachers to facilitate student learning. One student believed that although the majority of their clinical teachers were highly skilled clinicians, not all were degree educated and she really noticed the difference in their ability to get her 'thinking outside the square'.

> *I was really impressed by the wealth of clinical knowledge this one clinical teacher had, but she didn't have her degree, and she didn't see the need to get her degree either, but then when I had a*

> *teacher with both her degree and expert clinical knowledge, she was mind-blowing. I learnt so much from her, not just clinical knowledge, but going outside the square and trying new things. She really challenged my thinking, and gave me so much confidence in myself I really believed I could do anything*
>
> C (2)(20)

The teachers had also discussed the need for expert clinical teaching, especially in facilitating learning for the enrolled nurse students, who had special learning needs.

> *I think in a lot of ways they probably need more from the teachers than the ordinary students, mainly because we have to help them unpackage their clinical knowledge and develop new ways of thinking. We have to be able to tap into the knowledge and skills they already have and extend them and push their boundaries, and I think that takes high quality clinical teachers who know how to facilitate that.* P (2)(9)

Both students and teachers agreed that the transition to degree relied heavily on the clinical role models the students would work with in both hospital and community settings. There was the recognition by the teachers that until the majority of registered nurses had gained their degree or other post-registration qualifications, finding registered nurses with a good understanding of the degree programme and the learning outcomes for these particular students, could prove problematic.

The codes - ***living rurally, support services,*** and ***clinical role models*** describe the environmental factors that influenced the students' transition to degree level study. Together these codes make up the category 'barriers and catapults'. Living in a rural area and enduring ongoing problems related to accessing data proved to be major hurdles facing the students, but their resourcefulness and perseverance, which developed as their confidence grew, enabled them to overcome these barriers.

The facilitation by expert clinical role models was the major catapult to their learning. The students became critical of registered nurses who they had originally held in high esteem, when these registered nurses demonstrated a lack of knowledge and/or professionalism, but they quickly recognised the attributes, skills and professionalism demonstrated by expert clinical role models.

CHAPTER SIX

Discussion

The aim of this study was to examine the factors that assisted and/or hindered enrolled nurses as they transitioned to degree level study while based at a satellite campus in rural New Zealand. Constant comparative analysis of focus group interviews identified two major categories entitled **relearning how to learn,** and **barriers and catapults.** The sub-categories that make up relearning how to learn include *'out of comfort zone', 'finding their voice', 'letting go/grieving', and 'growing the tree'.* The sub-categories that make up barriers and catapults include *'clinical role models', 'rural living' and 'support services'.* It should be noted that although these sub-categories have been allocated to different categories there is the recognition that the factors that influenced the students' transition are interwoven. For example, the role played by clinical role models, discussed in **barriers and catapults** was highly influential in the students' transition when **relearning how to learn.**

MAKING THE TRANSITION		
CATEGORIES	**RELEARNING HOW TO LEARN**	**BARRIERS AND CATAPULTS**
Sub-categories	***Out of comfort zone***	***Clinical role models***
	Finding their voice	***Rural living***
	Letting go/grieving	***Support services***
	Growing the tree	

Table 1. **Categories and Sub-Categories of the Transition**

Making the Transition

As discussed in the literature review, Schlossberg (1984) has described transition as any event that results in changes in relationships, routines,

assumptions, and/or roles within the person's life and work settings. This would suggest that the notion of transition creates a period of disequilibrium which then requires action in terms of life organisation and identity. Brammer and Abrego (1995) noted that this journey required the courage to take risks as well as the ability to cope with change. Transitions are invariably related to change and development, and because there are connotations of both time and movement, transition can be thought of as linking change with 'experienced time'. Chick and Meleis (1986, p. 239) describe transition as 'a multiple concept embracing the elements of process, time span, and perception. Process suggests phases and sequence, time span indicates an ongoing but bounded phenomenon, and perception has to do with the meaning of the transition to the person experiencing it'. The process involves both the disruption that the transition occasions and the person's response to the interference. The findings of the current study would indicate that the students found the major disruptions occurred when they had to undertake clinical experience in the city away from their families and support systems. Initially the students' response was expressed as frustration with the constraints of the allocated clinical experience but as they adapted to the requirements of the curriculum, major adjustments were made to home life activities, with students identifying that a pleasant unexpected result of the course was that many of their families were assuming more responsibility in managing the household.

The time span extends from the first anticipation of transition until stability in the new status has been achieved (Chick and Meleis, 1986). Many of the students in the study noted that they began to feel comfortable in their student role when they were able to utilise aspects of their enrolled nurse experiences into the degree learning activities. Their comments also reflected that this transition required the assistance of a competent clinical teacher with knowledge of the degree. Perception of the transition affects how the associated role ambiguity and threat to self-concept are experienced (ibid). The findings from this study demonstrated that the students initially found the change to their status from competent enrolled nurses to new students unsettling and a challenge to their confidence and the sense of 'who they were'. The students found that their old ways of learning were not helpful and this required them to change their

patterns of thinking and studying. The teachers commented on the major changes undertaken by the students to accommodate this new way of thinking and learning and noted that the students were highly motivated and focused on achieving well. The recognition that mature students are frequently perceived as more motivated than younger students is supported in the literature by Richardson (1995) who also suggests that this intrinsic motivation to learning promotes a deeper approach to learning.

Research by Ash (1999) on career transition and mature age students summarised domains of difficulty related to the transition, with the most frequently identified as home and family difficulties, followed by financial and study difficulties. Studies conducted on registered nurse transition to degree (RN-BS) (Cervero, 1988; Redman and Cassells, 1990; and Thompson, 1992) describe similar factors impacting on the adult students' educational transition, mainly the need to balance multiple roles, the need for part-time study, and the impact of life events on the commitment to continue with their study. Chang and Daly (2001) examined the literature on the process of transition from senior student to graduate nurse and identified that the transition was multifaceted, complex and problematic. They noted that the nursing profession continues to be concerned with the experience of transition for graduates of undergraduate nursing courses on entry to the world of clinical practice, mainly because of the ongoing changes in the clinical practice environment and questions about the adequate preparation of new graduate nurses.

O'Callaghan et al (1993) examined factors influencing registered nurse transition to master's degree and suggested that these periods of transition were either brought about by major changes or else instigated major changes in the lives of the registered nurses. In O'Callaghan's study the students related numerous factors that had assisted as well as hindered their transition and they grouped these factors into three themes - programme strengths, facilitators, and barriers to progression. These themes are familiar to the factors identified in the current study and it would appear that educational transition, no matter what the level of qualification attained, brings about similar barriers and issues.

Relearning How to Learn

Brammer and Abrego's (1995) description that undertaking a transition requires courage was well evidenced by the findings of this present study, with both students and teachers commenting on the changes required by the students to manage new and threatening learning experiences. The students' comments that there were many challenges to their thinking and learning is supported by the teachers who also had to rethink some of their teaching approaches to foster independent learning in these mature age students.

Adult Learning

The students' initial difficulty in adapting to the role of independent learner was attributed to their previous educative experiences as enrolled nurses, as well as their subsequent positions in the nursing workforce. Working in paid employment under the direction of registered nurses did not promote a sense of inquiry for the enrolled nurses, as mainly they left difficult decisions requiring comprehensive nursing knowledge to others. The findings from the study recognized that as mature women, the students brought with them life skills and work experience, but this did not necessarily translate into the attributes required by mature learners and many of them stated they were ***out of their comfort zone*** in this new learning environment. Enrolled nurse education historically relied on teaching and learning principles derived from patriarchal world views. Since the inception of all nurse training programmes, the teacher-student relationship had been one of deference. The underlying assumption was that the teacher had the authority with all the knowledge and the student had to absorb this knowledge without question. This perspective reinforced the context of a dominant-subservient relationship that evolved from this patriarchal teaching model (Muff, 1988). The comments from the teachers in the present study confer with the literature in this aspect, when they noted that the students' behaviour demonstrated more deference for their position than the behaviour of the ordinary students, some of whom were the same age.

The students were all mature aged women, and the teachers believed that their previous learning experiences were reflected early in the programme with their unquestioning acceptance of new knowledge, and little understanding of the

active role they would need to play in their learning. The literature suggests that the application of adult learning theories is essential for teachers with mature age students. Knowles' (1980) discussion on adult learning, although dated, is still relevant, and he identified several assumptions about adult learners. Primarily, an adult's accumulation of life experiences may form a rich source for learning, and as time perspective changes, adults are more motivated to learn if the new knowledge has immediate and practical application. He also noted that as people mature, they become more self-directed in their learning, although he suggests that they may become more dependent in certain situations.

The notion that adults may become more dependent in certain situations, was evidenced by the students' initial dependency on the teachers for 'the right answers', and their reluctance to utilise and build on their previous experience. The students' behaviour reflected that they felt ***out of their comfort zone*** as they grappled with this new way of learning. This is supported in the literature by Adamson (1997), Alderman (1997), Crampton (1992) and Crotty (1990) who all noted similar aspects of vulnerability and discomfort among enrolled nurses undertaking transition courses.

The students' progression to independent learning was instigated mainly by them recognizing the worth of their previous work and life experiences, reframing this knowledge, and ***finding their voice***. The teachers, by validating and utilising the students' previous experiences, and facilitating a collegial approach, also assisted their transformation to independent learners. Rogers (1983) assigns particular value to the role of the facilitator of learning. He states that an effective facilitator can offer the individual learner the opportunity to become self-directed in pursuing areas of interest, as well as unleashing a sense of inquiry, with the ability to question and recognise that everything is in a process of change. The findings of this study suggests that it was not until the teachers utilised and validated the students' previous knowledge, by incorporating and reframing their experiences, that they began to move out of the traditional patriarchal teacher-student mode of learning, and question and challenge the teachers and their colleagues with increasing confidence.

Women's Ways of Knowing

The majority of the students were back in a classroom for the first time since their original training, which for many was at least twenty years. Originally some identified they felt uncomfortable with the collegiality of the 'modern' approach to teaching and had difficulty using the first names of teachers. The findings of this study found that many would not participate in discussions unless directly asked and very rarely put forward their point of view, which reflected their adherence to the old style of pedagogical learning. As mature women, the students' approach to learning reflected concepts described by Belenky, Clinchy, Golberger, and Tarule (1997) in their work entitled 'Women's Ways of Knowing'. These authors identified that in comparison to male learners, one of the important differences for women was their use of **'voice'**. As described by Belenky et al, voice means not only the ability to articulate one's own thoughts, it also includes the sense of self, and considering what is said as a valid expression of knowing.

Belenky and her colleagues construed the metaphor of voice to characterise the development of women's ways of knowing through a number of levels from silence to constructed knowledge. The authors described silence (level one) as an impoverished way of self-expression where the women are unable to trust their own experience as knowledge, unable to express their own opinion and are without a voice. Received knowledge (level two) is described as listening and speaking with the voice of others, thinking the same way as their peers. Learning is described as receiving, retaining and returning the words of authorities. Subjective knowledge (level three) is explained as the inner voice and the quest for self, where they have begun to value their own voice even though not fully articulated. Procedural knowledge (level four) is the voice of reason, the women use procedures for establishing truth and evaluating other's knowledge. Separate and connected knowing (level five) is where the women work to accept others, yet remain connected even where there is disagreement. Constructed knowledge (level six) is where the women experience themselves as creators of knowledge, who value both objective and subjective strategies for knowing (1997). In this current study many of the students stated they would not initially question or challenge the teachers as it was deemed that the teachers

were the ones with the knowledge, which demonstrated that for many they were initially functioning at level one and two of the framework described by Belenky et al. As the students progressed with the transition they were able to identify the changes that occurred in their thinking especially when they noted that it was up to them to ***grow the tree.*** The students were demonstrating that they were creating their own knowledge, described by Belenky et al as constructed knowledge.

Maori Students Finding Their Voice

Being able to utilise many different approaches to their assessments was identified by the Maori students as one of the major factors that assisted them to ***find their voice*** during the process of transition. There was no identifiable literature to support this finding, although Irihapeti Ramsden has written comprehensively on the topic of cultural safety in nursing education (1990, 1992, 1993, 2000). This ability to negotiate a preferred assessment method, with the student and teacher working in collaboration, reflected partnership, one of the core values of the polytechnic's educational philosophy.

When they entered the programme, the teachers noted that the majority of students including the Maori students lacked tertiary study skills. The perception of the teachers was that the Maori students were doubly disadvantaged as Maori women. Historical studies show that Maori girls in the 1970s and 1980s were almost three times more likely than their Pakeha counterparts to leave school without any formal credentials (O'Neill, 1990). Bray and Hill (1974) claim that the institutional and individual racism inherent in New Zealand's education system in the 1970s had undermined the self-esteem and success of Maori students. Ramsden (cited in Costello, 1994, p. 22) argued at a 1989 hui on student nurses' education, that the high failure rate of first-time Maori sitters of the state examination during the mid to late 1989's did not indicate lower intelligence among Maori compared to Pakeha students, but showed the alienation Maori students were experiencing in culturally unsafe learning institutions. In recent years, Ramsden's work on cultural safety has had considerable impact on nursing education and has engendered many discussions among nurse educators and the public in general. She believed that

there is a need for both Maori and other non-Pakeha nursing students and teachers to have their cultural identity recognised as a way of making them feel less culturally at risk in nursing and midwifery courses (Ramsden, 1992). The findings from the study demonstrated that as the Maori students developed their academic skills, they recognised that these were skills that could be learned, and their confidence and esteem grew, although preferred learning and presentation styles stayed with song, art work, humour, videos and role play. The findings also identified that the confidence of the Maori students was further developed when they recognised there were no cultural differences in the learning abilities between the Maori and Pakeha students. They noted that the difficulties they were having with scholarly writing, were also being experienced by the Pakeha students, the difference between the two groups was the approaches they utilised to meet the challenges.

Self Esteem/Self-Efficacy

The teachers in the study commented they were made aware of the students' individual learning needs quite early in their programme. In comparison to many of the mainstream student classes, the enrolled nursing students were very focused and highly committed from the beginning to getting the most out of each study day, although frequently their thinking was very concrete, and they had some difficulty with conceptual frameworks. This view is supported by the findings of Adamson's work, where she also identified that for the enrolled nurses in her study 'their thinking appeared more concrete, {but} their desire for understanding was immense' (1997, p. 40). The concreteness of their thinking also meant that the students in the current study were highly anxious about the content and process of the curriculum, identifying they were feeling vulnerable and ***out of their comfort zone***. The teachers linked the students' high anxiety and lack of confidence, to their lack of self-esteem. This is supported by the findings of Adamson's study where she noted the 'long term low self-esteem of many {enrolled nurse} students, which affected their learning process in regards to attitudinal change' (p.54).

Self-esteem has been described as a major component in developing a person's sense of self-efficacy, and according to Bandura (1986), is the single

most important determinant in an individual attaining their goals. The concept of self-efficacy is a major construct of social learning theory and Mann (1994, p.43) described it as 'the individual's perception of his or her ability to execute a particular task'. For many students in this study their reluctance to persevere with developing information technology (IT) skills was a reflection of low self-efficacy, which can be associated with a sense of helplessness. The students felt they would never be able to master the skills required, and that, coupled with IT systems failure, initially reinforced their sense of helplessness. With continued support and perseverance by both teachers and IT literate colleagues, those students who had originally expressed that they would never master the computer were able to produce competent essays and powerpoint presentations by the third year of their programme.

A growing sense of confidence and improved self-efficacy was also apparent in the students' learning behaviour in the classroom, particularly as they built on the successes they achieved in the assessment points for the programme. The teachers noted that the students were seeking other sources of information, not relying totally on the teachers for direction, as well as becoming more confident in using academic language. The teachers also commented on the students' growing self-awareness in relation to their changes in attitude. They were recognizing they were becoming more assertive, and were questioning the teachers and their colleagues more openly. This attitudinal change that occurred as the students progressed through the programme is supported in the literature by Adamson's (1997) research into self-efficacy, Belenky's (1986) research on women's ways of knowing, as well as the study of mature age students undergoing transition, by Ash (1999). Adamson noted that the students in her research were able to develop strategies to formulate personal constructs that were informed by experience and theoretical knowledge. Their attitude to developing and acknowledging their new knowledge was enhanced as they gained confidence and demonstrated self-efficacy. Belenky et al described the personal empowerment that resulted in attitudinal change as women constructed their own knowledge, and Ash described the 'success identity' as students developed the confidence to achieve as they underwent the transition process.

International literature related to mature age students and role transition supports the view that high self-efficacy, along with readiness to learn, a sense of control, and good support systems are key factors contributing to successful transition (Brown, 1995; Heppner, Multon & Johnson, 1994; Schlossberg, 1984). Crotty (1990), Williams and Gallimore (1987) and Redmond (1997) discussed the psychological adjustments required by enrolled nurses/LPNs undertaking further study. Williams and Gallimore in particular recommended ongoing educational counselling for these students when they demonstrated a distinct lack of confidence in their academic ability. Redmond described services and facilities that were available to support students to gain academic skills as well as providing information to encourage self-care along with self-direction in learning. This will be discussed further under ***support services*** later in this chapter.

The findings from this study suggests that the students were also confronted with situations in the clinical setting that reflected their initial lack of ***'voice'***, when they stated it was easier to stay working as enrolled nurses rather than openly request assistance with their learning from the registered nurses. As with many New Zealand hospitals in 2000 there were nursing shortages in the majority of wards (Gerritsen, 2001; Williams, 2001) and the students commented that once the registered nurses knew they were also enrolled nurses they were frequently used as 'pair of hands' when the ward was busy.

That the students found it easier to slip back into the role of enrolled nurse reflected the lack of control they perceived they had as students in the clinical setting. The students believed that most of the registered nurses did not know how to work with them, either giving them high workloads, or not accepting an educative role, assuming the students already had the requisite knowledge. This is supported by Adamson's research where she identified that students who were enrolled nurses were either treated by the registered nurses as having no knowledge, or as having enough knowledge to take more responsibility than other students (Adamson, 1997). The students' comments that they were treated by the registered nurses as colleagues one minute and a

'pair of hands' the next, demonstrated the role confusion they experienced in the clinical setting, which the teachers believed was reflected as a lack of confidence. This is also supported by Adamson (1997) who noted that while the students were comfortable completing nursing skills they were familiar with, they initially lacked confidence in applying themselves to develop the learning strategies required for thinking as registered nurses, for example, critical thinking. She commented that part of her role as a teacher was to assist the students in developing coping strategies as their thinking changed from second level (enrolled) to first level (registered) nurse.

The teachers in the present study commented on the challenges they had experienced in trying to move the students from just learning new technical skills to actively bringing new knowledge into their practice and examining the rationale underpinning their procedures, processes that were required for critical thinking in the degree programme. The majority of the students in this study were still in paid employment as enrolled nurses and the teachers noted the difficulty they had in ***letting go*** the security of staying in enrolled nurse work mode when they were required to meet the prescribed learning activities. Chick, & Meleis (1986, p.240) described disruption to a person's sense of security as 'disconnectedness' associating it with disruption of the linkages on which the person's feelings of security depend. They explained that there is a loss of familiar reference points, and an incongruity between expectations based on the past and perceptions dictated by the present. The teachers also commented that they believed the students were experiencing feelings of ***grief*** at having to let go old ways of behaving and learning, although there is little evidence in the literature to support this view.

The challenges faced by teachers when assisting enrolled nurses to transition to registered nurse was recognised by Crotty (1990) when she identified the need for a comprehensive staff development programme for teaching staff. Cornett (1995) described the need for teachers to be prepared at Master's level to enable them to competently facilitate the student's transition, and Redmond (1997) discussed the need for phenomenological teaching approaches and a pre-entry workshop on academic survival skills. A number of studies have

discussed processes required to assist the enrolled nurse in developing critical thinking skills as part of their transition to registered nurse (Crotty, 1990; Cornett, 1995; Eichenauer, 1987; Redmond, 1997; Williams & Gallimore, 1987). The teachers in this study commented on the awareness required by them not to put unrealistic expectations on the students when endeavouring to facilitate critical thinking skills within the students' existing knowledge frameworks. The teachers also noted that reflection, used as a tool to develop critical thinking, proved to be problematic for many of the students unfamiliar with the process of thinking about and documenting personal reflections.

Reflection

Degree level study as described in the curriculum document for the Polytechnic's 2000 BHSc (Nursing) programme, involves engagement and achievement in five degree processes identified as critical thinking; communication; competency; valuing and professionalism. As described in this degree programme, critical thinking can be demonstrated by reflection in practice and problem solving, and requires the students to be independent learners who are able to incorporate research evidence into their knowledge base and subsequent practice. Of the five degree processes, the students in this study were unfamiliar with the tenets of critical thinking, although the teachers commented that they presumed the students would have used aspects of the process such as problem solving, in their practice as enrolled nurses.

Critical thinking in the students' degree programme required them to utilize their previous knowledge and experience to develop more comprehensive frameworks in which to assimilate new knowledge. In facilitating this development, reflection was a learning strategy that was utilised to foster the student's learning in both the clinical and classroom settings. Paul (1985, p. 263) defines critical thinking as 'the art of thinking about your thinking while you are thinking'. Critical thinking in nursing has been described by Johnson and Webber (2001, p. 57) as 'the deliberate, organised, and sequential intellectual process of identifying the existence and nature of actual and potential relationships and influencing assumptions and variables that have actual or potential significance to nursing situations'. The findings from the present study

indicate that the students had difficulty in examining the underlying assumptions for their practice with some of them staying within the knowledge boundaries set by their original enrolled programme and clinical experience. That not all students are able to utilise critical thinking skills and reflect on their practice is supported in the literature by Mackintosh (1998), and Cavanagh et al, (1995).

Reflection as a learning strategy for critical thinking is currently being debated in nursing education and there is a vast amount of literature in which the topic is discussed (Aitkens & Murphy, 1993; Benner, 1984; Boud, Keogh & Walker, 1985; Burnard, 1995; Burrows, 1995; Carr & Kemmis, 1986; Curzon, 1990; Graham, 1995; Jarvis, 1998; Johns, 1995, Johns & Freshwater, 1998; Mackintosh, 1998; Minghella & Benson, 1995; Palmer, Burns & Bulman, 1994; Richardson, 1995; Schőn, 1991; Shields, 1995; Street, 1991). Reflective learning appears to have its foundations in the cognitive theory of education. Dewey (cited in Curzon, 1990) conceptualised reflective thinking as the process between the recognition of a problem and its solution. Mezirow, in 1981 (cited in Mackintosh, 1998) proposed a revised theory of adult learning and education based on Habermas (1971) and his three generic domains of adult learning. A major domain was that of transformation with a special focus on the functions of reflectivity. Mezirow likens this concept of reflectivity to Albert Camus' definition of an intellectual - 'a mind that watches itself', an ability that an individual can develop only through maturity. This belief that reflection occurs with maturity has been a topic of debate in the nursing literature, where there has been concern expressed at the expectation that all students have the ability to utilize reflection critically (Cavanagh et al, 1995; Mackintosh, 1998; Richardson & Maltby, 1995). The findings from the current study, particularly from the teachers' comments, support the view that not all students are able to utilize reflection, and that maturity in years and work experience does not always equate with maturity in thinking critically.

The term reflection has not always been clearly defined. As a concept it is used loosely in everyday action, and when utilized in education it can be complex and difficult to explain. Reflection by its nature is a very personal experience. The focus of reflection is on self in the context of ones' own practice. It exposes the

person to self-scrutiny, and in this respect reflection may be disconcerting, as taken for granted competence and ways of coping with anxiety may be exposed as inadequate. Exposing contradiction may increase frustration with work especially when new ways of responding to situations are not easily achieved. The fact that the practitioner rationally knows how they would like to respond in certain situations does not mean they actually respond in those ways (Johns, 1998). This supports the comments made by the students in the study who were aware they should have been undertaking health assessments with their clients, but found it easier to work as enrolled nurses (completing practical tasks) rather than undertake the difficult task of in-depth health assessment which required critical thinking.

Reflection in action is the process whereby the practitioner recognizes a new situation or a problem and thinks about it while still acting. Reflection on action is the retrospective contemplation of practice undertaken in order to uncover the knowledge used in a particular situation, by analysing and interpreting the information recalled (Schőn, 1987). The reflective practitioner may speculate how the situation might have been handled differently and what other knowledge would have been helpful. In this current study it was identified that a student was reflecting on action, when she described the process that occurred when working with a person she considered an expert clinical teacher. She had described how the teacher walked her through an interaction with a patient, asking her why she did what she had done, what knowledge she had used, and what she would do differently. This teacher facilitated the student's exploration in examining the difference in her practice when working as an enrolled nurse compared to a degree level student. This student also acknowledged that her thinking started changing when she realised that the teachers could only plant the seed to help develop an inquiring mind, that it was up to her to ***grow the tree*** and develop the skills to think critically.

The teachers noted that the majority of students gained valuable insight into their learning when guided through the reflective process that incorporated their previous clinical knowledge with exploration of the rationale underpinning their current practice. Carr and Kemmis (1986) described reflective praxis as a

complex way of thinking about and interpreting experience that requires new constructive thinking as links are made between elements. This consciousness raising is especially important where nurses may have formed limited personal constructs based on previous nursing experience as the enrolled nurses had. Many of the student's acknowledged the difficulty they had fully understanding how the process of reflection worked, with one student commenting that she didn't believe she was demonstrating reflection even though she may have completed the prescribed learning activities. The teachers also believed that many of the students had great difficulty in reflecting and examining their practice, and the process did not become clear for some of the students until their final year. Both the teachers and students in the study expressed the view that a crucial factor in consciousness raising and development of critical thinking was the role played by expert teachers in the clinical setting. 'Expert' performance has been described by Benner (1984) as consisting of advanced knowledge, conscious, deliberate planning, including the accurate setting of priorities and exhibiting smooth effective performance in practice.

The students in the study were very clear about the role played by clinical teachers in assisting them to '***grow the tree***'. They were aware that they had experienced a 'mind shift' from thinking about completing tasks to critically thinking about the complexity of practice. They were able to explain the process utilised by expert teachers that guided them to see the complexity of nursing practice, when they described the expert clinical teacher talking them through the thinking they were using. They noted that guided reflection played a large part in developing their critical thinking skills and facilitating the integration of theory and practice.

Barriers and Catapults

The findings of the study demonstrated that the students faced many barriers in their transition to degree, but within those barriers were also catapults that facilitated their transition. Where the theory-practice gap acted as a barrier initially, as the students progressed through their programme, their previous enrolled nurse education and clinical experience helped to overcome the theory-practice gap more rapidly than the students within the three year

programme. Cross (1981) summarised numerous studies of barriers for participants in adult education. She classified them under three headings: situational, institutional and dispositional barriers. Situational barriers included job and family responsibilities, lack of money, and childcare. Institutional barriers included availability of programmes, resources and lecturers, and dispositional barriers related to the students' approach to their studies. These barriers have also been cited in studies of registered nurses returning to school (Perry, 1986; Thompson, 1992). The barriers faced by the students in the present study is supported in the literature, especially the research cited by Cross, and although the classifications vary, the themes are similar.

Theory-Practice Gap

The gap between theory and practice was widely debated among the students in this study, who believed they had an advantage over the novice nursing students because of their wide clinical experience. One student explained that because they were still working in paid employment they were constantly looking for ways to apply what they were learning to their everyday practice as enrolled nurses. They felt they were able to integrate new theory to their practice in contrast to the novice students who they believed were trying to apply new theory to new practice and were more conscious of the theory-practice gap. Adamson (1997) and Redmond (1997) support the view that enrolled nurses may have difficulty initially in integrating new knowledge but very quickly become adept at linking concepts and new knowledge once they see the direct applicability of that knowledge. To this researcher's knowledge this aspect has not been discussed in the literature in relation to enrolled nurse transition other than by Adamson and Redmond.

The teachers in the present study commented that once the students were able to identify underlying assumptions and rationale, drawing on their previous clinical experiences as enrolled nurses, it became evident that many of the students were becoming increasingly adept at linking new theory and knowledge to their practice. This integration did not occur easily for a few of the students who commented that the concepts of nursing theory were difficult to integrate into their daily practice especially when they saw very little evidence of

nursing theory being used in clinical practice by the registered nurses. The theory-practice gap has been debated in the nursing literature over the last two decades. Rolfe (1996) views the gap as a consequence of the way in which theory has failed to keep pace with changes in the concept and practice of nursing. Miller (1985) commented that if it is virtually impossible for experienced nurses to relate nursing theory to everyday practice, then there is something very wrong with either theory or practice. Cook (1991) argued that any attempts to close the gap are doomed to failure since the reasons why the gap exists are not adequately understood in the first place. He commented that this is partly due to the fact that the majority of studies in nursing education related to the theory/practice gap are descriptive rather than analytical and therefore do not explore the existence of 'hidden agendas' within institutional settings. These hidden agendas he described as the result of different philosophical perspectives in relation to patient care. He views that many practices in nursing are derived from theoretical frameworks designed to benefit the institution rather than the individual patient. He gave as examples organisational and systems theories that are implemented to promote efficient functioning of the institution and concluded that nursing care is failing the patient because it is institution rather than practice driven.

The students in the current study also commented that although they had difficulties initially in seeing the value of theoretical nursing frameworks in their clinical practice, once they were assisted in utilising frameworks and models they found the structure and organisation of the nursing frameworks greatly assisted them in assessing and organising patient care. One student explained that 'the pieces of the jigsaw came together' after she was assisted by an effective clinical teacher in applying the concepts of humanistic nursing theory to family centred nursing. Both students and teachers in this study agreed that the most important element in minimising the theory-practice gap was a clinical teacher who acted as a ***clinical role model*** as well as being able to draw on the students' life and work experience and facilitate the reframing and integration of theory into their practice. The value of the knowledgeable, well prepared, confident clinical role model in facilitating learning is supported in the literature by Allen (1990), Benner (1984), Farley (1990), and Zimmerman &

Waltman (1986). However, if Cook's point is argued, the role of the expert clinical nurse in facilitating student learning would not be valued highly by organisations whose main aim is efficient management, and nursing care is institution rather than practice driven.

Clinical Role Models

The acceptance by registered nurses to act as a clinical role model and assume an educational role depends on whether they see it as an integral part of their nursing role or a separate and additional responsibility. There is recent discussion in the literature regarding the expectation that registered nurses can assume responsibility for teaching students as well as managing an increasingly complex work environment (Beattie, 1998; Dyson, 1998; Kaviani & Stillwell, 2000; Orchard, 1999). The students and teachers of the present study recognised the increasing workload required of registered nurses and identified the difficulties faced by these nurses in acting as effective clinical teachers. Farley (1990) described clinical teaching as a shared adventure in which the clinical teacher coaches students to be the best they can. Effective ***clinical role models*** are expert practitioners according to Benner (1984) and need to be confident, patient, prepared to discuss skills, let students try, then talk them through the procedure, as well as extending and developing the student's knowledge. Zimmerman and Waltman (1986) found that effective ***clinical role modeling*** could not be described in one or two behaviours but in a collection of behaviours, which included availability to students, professional competence, interpersonal skills, teaching and evaluation practices and personal characteristics.

Clinical teaching is described by McCabe (1986) as central to nursing education, as students consolidate and learn new knowledge, become socialised into the professional role and acquire professional values. Dyson (1998) argues that the quality of clinical teaching is fundamental to learning how to nurse. Learning in the clinical area is less structured than the classroom setting as students are expected to initiate, react and respond to actual clinical events while the safety of the patients must be preserved and maintained at all times. The move to degree preparation for student nurses in New Zealand and

reduced staffing levels within educational institutions has placed increased demands on nurse lecturers and limited their ability to be effective clinical teachers (Orchard, 1999). She argues that in order for some nurse lecturers to meet their teaching demands clinical teaching has become, by necessity, a lower priority, as clinical teaching time erodes into classroom teaching time.

Nurse lecturers are spending less and less time in the practice setting teaching students, rather, their limited time in the clinical setting is focussed on discussion and problem solving with the student. In this study, due to the limited clinical areas for placement, the students were required to complete aspects of clinical education in periods outside the normal academic year which meant that few nurse lecturers were available to supervise them. Relieving clinical teachers were contracted to work with and supervise the students, but the findings of the study demonstrate that this did not always prove satisfactory due to the lack of degree preparedness of some of these clinical teachers. This put increased responsibility on clinical nurses to assume a more direct teaching role with the students, and even though the nursing department like other nursing educational institutes in New Zealand purchased clinical supervision from health providers, this teaching role was severely limited by the current high workload experienced by the clinical nurses. Orchard (1999) identifies that cost cutting in the health sector has meant that for many the purchaser/provider split between education and health has changed the learning environment for students. According to Orchard, contracting for student access to health services heralded the arrival of a market driven era of nursing education and changed the relationship between nurse lecturers and clinical nurses from one based on goodwill to one which is shaped by economic considerations.

This limited capability of the registered nurses to provide clinical supervision is supported in the literature by Orchard (1999). She suggests that the current clinical nursing educative role as perceived by the ten registered nurses in her research study, was not conducive to good clinical education or practice. She commented that the present form of clinical education disrupts relationships and adversely affects the registered nurses' management of their work. While nurse educators remain responsible for planning and supporting student's experience

they now depend on clinical practitioners for access to and the quality of the clinical experience. The findings of the study demonstrate that the students felt guilty trying to get their prescribed learning activities completed when the registered nurses were under so much stress. Several students expressed their anger at what they perceived to be the lack of ***clinical role models*** available who should have been taking an active, educative and supportive role in their learning, especially as they were 'paying high fees' for this experience. One student commented that she perceived the registered nurses to be disempowered in their ability to provide quality nursing care and educative support, and even though the registered nurses complained about their workload and lack of staffing resources, she felt they were not taking any action to improve their situation. The student's view was supported by a number of the other students when she commented that she felt disillusioned about the future for nursing after witnessing the stressed, fatigued and disempowered registered nurses. Empowerment has been described by Knowles (1980) as a climate of mutual respect and trust, collaborativeness, supportiveness, openness, authenticity, and compassion. These are essential attitudes and actions that the teachers also perceived were necessary to set an appropriate climate for adult learning in both the clinical and classroom setting.

Mason, Backer, and George (1991, cited in Diekelmann & Rather, 1993) described the empowered nurse as one who perceives the injustices in the work environment, has positive self-esteem, and believes they can effect change in the power structures of the health care delivery system. They defined empowerment 'as the enabling of individuals and groups to participate in actions and decision-making within a context that supports an equitable distribution of power' (p.232). That the registered nurses in the clinical setting were viewed as disempowered by the students in this study was reflected in the lack of mentoring they were able to provide for the students who perceived that the registered nurses were meant to be effective clinical teachers and ***role models.***

Horizontal Violence

The findings from the study suggest that the majority of teachers supported the students' views on 'disempowered' registered nurses, commenting that they had observed the nurses to be fatigued and had witnessed examples of 'horizontal violence' occurring between the nurses and at times directed to the students. This suggests that the registered nurses would have little opportunity or ability to exhibit the required attributes of empowerment that would enable them to act as appropriate ***role models*** for the students. The teachers' comments on horizontal violence are comprehensively supported in the literature in relation to oppressed group behaviour and feminist issues in nursing. Valentine (1992) states that oppressed group behaviour results from the ability of dominant groups to impose their norms and values on society that are readily enforced because of the power held by the dominant group. She explains that the norms and values of the dominant group are internalised by the oppressed group as they attempt to emulate those in power. Valentine also suggests that nurses, particularly those in institutional settings, exhibit oppressed group behaviour that is demonstrated by persistent conflict among themselves, but who rarely challenge the people or structures that keep them oppressed. Speedy (1987) believes that this creates a submissive-aggressive syndrome which is evidenced where the oppressed person, unable to directly express aggression to those in power, displaces it to members of her own group.

Horizontal violence in relation to oppressed group behaviour has been characterized as 'criticism, denigration and infighting' according to Speedy (1987) who explains that members of an oppressed group view themselves as second class citizens, with low self-esteem. There is a vast amount of international literature related to horizontal violence (Duffy, 1995; Farrell, 1997; Glass, 1997; Morath et al, 1985; Roberts, 1983; Smith et al, 1996) and recent New Zealand literature supports the view that horizontal violence is still evident within the culture of nursing in New Zealand (O'Connor, 1998; Waitere, 1998; Wilson, 2000). Wilson comments that continual change in the health system has taken a huge toll on the nursing profession. The many challenges of constant

reviews and restructuring have in her opinion 'denied benefits to nurses and failed to recognize their contribution to the health sector' (p.24). She has expressed the view that she is in no doubt that nurses have left the profession because of abuse, unable to work in a climate of hostility and lack of support. According to the literature, nurses are also frustrated with being poorly resourced and not having their concerns acknowledged. This is further compounded by 'the disestablishment of nurses' senior positions in health care management which has resulted in the loss of the nurse' ***voice*** in decision making and resource allocation' (Huntington et al, 1996).

Issues related to feminism and nursing have been well discussed in nursing literature for the last two decades and anecdotal evidence suggests there is a growing sense among nurses today that it is time to move on and discard the victimisation that is associated with oppressed group behaviour. Unfortunately, the findings of this study completed in 2001, demonstrate that horizontal violence associated with oppressed group behaviour is still in evidence in New Zealand. Previously the students in this study had been practising as enrolled nurses for many years in a health care structure they had taken for granted and not challenged, and in informal discussions towards the end of their programme many of them believed that they thought things would be different once they became registered nurses with the associated knowledge and decision making authority. Undertaking the nursing degree had been instrumental in changing not only their understanding of the role of the registered nurse, but it now became apparent to many of them that their changing attitude towards nursing now seemed incompatible with the clinical environment, an environment they had not previously recognised as being disempowering and oppressive.

The students reflected awareness of the power structures impacting on what they perceived to be 'disempowered' nurses in the hospital ward and the nurses inability to act as role models and preceptors. Fowler (1996) described the role of the preceptor as one that encompasses orientation of the novice to the work environment, and teaching, particularly in regard to the routine work of the clinical area. According to Morton-Cooper and Palmer (1993) preceptorship involves access to an experienced and competent role model, and a means of

building a supportive one-to-one teaching and learning relationship. Dyson (1998) commented that preceptor programmes have been commonly adopted to assist new graduates in the transition process and she noted that preceptorship is being increasingly utilised in undergraduate nursing programmes. Her research examined the role of the lecturer in the preceptor model and although students weren't interviewed as part of her research, one of the themes - creating a positive learning environment - identified that the skills and attitudes of the clinical staff has a major influence on the nature of the learning experience, which supports the comments of the participants in the present study. However Beattie argued in 1998 that there was no evidence in the literature to suggest that students who were preceptored were more clinically competent or able to adapt to post registration employment more easily than their counterparts who were not preceptored.

Many students expressed disappointment at the perceived lack of leadership displayed by registered nurses and although they understood the constraints the nurses were under due to lack of resources and a constantly changing health environment, they still expressed anger and were critical of the lack of support and poor role modelling exhibited. The teachers noted the students' changing attitude towards some of their registered nurse colleagues who they perceived were not able to give appropriate rationales for the nursing care they implemented. The students were becoming critical not only of the nurses who they perceived lacked evidence based nursing knowledge, but the teachers commented they also demonstrated awareness and were critical of the limitations of their previous practice as enrolled nurses.

Not all the students expressed concern or were critical of their registered nurse colleagues. Many had informative and worthwhile experiences with their 'buddies' who they described as knowledgeable, supportive and who took an active role in assisting the students to gain valuable clinical experience. The major concern expressed by these students was in relation to the limited availability of clinical role models in the rural setting and the effect this had on their learning.

Rural living

It should be noted that although the learning programme in this study was not described as a distance education programme, the students faced many problems that are normally associated with distance education, in particular the lack of educational ***support services*** and clinical learning placements in their ***rural*** areas. To meet the requirements for appropriate clinical experience prescribed by the polytechnic curriculum document, the students were required to travel to the main campus and city hospital for experience crucial for their learning and transition to registered nurse. The findings of the study demonstrated that being away from their families was a major barrier in the students' transition and this created hardship for a number of the students. There is a quantity of literature on distance learning that has some relevance to this study (Armstrong et al, 2000; Billings, 1997; Care & Scanlan, 2000; Clark, 1993; Douglas, & Foote, 1989; Reinert & Fryback, 1997; Sherwood, et al, 1994; Shomaker & Fairbanks, 1997). Issues related to the appropriateness of this format for professional education and the expenses involved in funding these programmes have appeared to be major barriers for both schools of nursing and students enrolled in distance programmes.

Reinert and Fryback (1997) noted that in the current health care environment and nursing shortages, schools of nursing need to respond to a number of challenges, including the need for undergraduate and graduate classes in ***rural*** areas. Although the need for off-campus classes has significant implications for nursing education, there is little research by schools of nursing about the current use of distance learning for undergraduate programmes. Reinert and Fryback conducted a descriptive study that investigated the use of distance learning programmes in nursing schools in the USA. The researchers in this study identified that 353 schools of nursing (80%) responded to questions related to distance education with 135 schools (38%) reporting offering some form of distance learning (p. 421). According to their data, distance learning programmes varied in type, from those offering only one or two courses, to those offering the majority of courses needed for a degree in nursing. Common themes that emerged identified that according to faculty members, students studying by distance required structure, faculty contact and a sense of

belonging, while faculty members required additional preparation time, support, and assistance in developing courses. This research by Reinert and Fryback supports the findings from the current study in identifying the need for structure and ***support*** for both students and teachers involved in distance learning, but their findings were based on questionnaires and interviews with faculty members only, and is therefore limited by the lack of the student voice.

Care and Scanlan (2000) also conducted their research with only faculty members in their descriptive study of registered nurses pursuing continuing education by distance learning. The purpose of their study was to uncover the experiences of nursing faculty and members of a university support unit involved in interdisciplinary development of distance learning programmes. They commented that designing clinical practice courses for distance delivery presented unique challenges for nursing faculty. They identified these challenges as - access to resources; unanticipated costs; roles and responsibilities; and feedback to students. The findings of the present study supports the findings of Care and Scanlan in all of the issues identified, in particular the difficulty experienced by students and teachers accessing resources at the satellite campus.

Although the present programme was designed to allow enrolled nurses in ***rural*** areas access to education and comprehensive registration, economic, organisation and logistic factors affected the students' access to clinical placements to a time and place where they would have appropriate clinical supervision. The students would have preferred to complete their clinical experiences at times and locations that would accommodate their family and work commitments. This would have meant individual clinical placements which were not financially viable. To reduce the costs of travel and accommodation for the students, the polytechnic was able to procure grants from a clinical training organisation. A number of Maori students were also financially supported by their local iwi (tribe) on the provision they would return to their area to work. Care and Scanlan (2000), Reinert and Fryback (1997) and Armstrong et al (2000) all identified costs as a major inhibiting factor to distance education programmes in nursing, but did not discuss funding availability.

Support Services

Individual telephone tutorials proved satisfactory for a number of students who felt comfortable interacting with the teachers using this medium, but it did not suit all students and a few expressed their reluctance to use this method. Proposals for video and telephone conferencing also proved unsatisfactory due to lack of amenities and access. The literature supports the view that there are frequently logistical difficulties in providing appropriate ***support services*** and teacher access to distance learning students (Armstrong et al, 2000; Care and Scanlon, 2000; Reinert and Fryback, 1997; Sherwood et al, 1994). These logistical difficulties relate to poor library access, limited availability of information technology support, unanticipated costs, limited student socialising and support group activity, and face to face teacher instruction. The majority of authors suggest that commencement of a distance-learning programme requires comprehensive preparation.

Armstrong et al (2000) noted that distance education teachers frequently do not have the luxury of deciding what medium or delivery service to use and this is supported by the findings of the present study, where limited access to information technology and support services limited the students' ability to gain maximum advantage of their learning activities. As well as experiencing difficulty with malfunctioning polytechnic systems providing information technology at the satellite campus, the lack of home access to internet nursing data bases proved a major barrier for most of the students. The teachers identified the dilemma they faced when endeavouring to facilitate the student's skills in researching literature and accessing data sources. Due to the difficulties experienced by the students in accessing data, one or two teachers decided to bring hard copy literature to the satellite campus aware they were giving students the information rather than facilitating the students' research skills. The teachers judged this would be balanced by the students' ability to access the main campus library and computer services when they travelled down for their clinical experience. By the end of the second year of their programme, the students were able to access databases once the installation of a computer with CD-Rom capabilities enabling them to access CINAHL was completed satisfactorily at the satellite campus. The library by this time had facilitated the

borrowing of textbooks to the satellite campus via a courier service and had extended the loan period for these students. As stated previously the polytechnic did not have the resources to offer a distance library service to all students, but special consideration was finally approved for this group. In discussion with a teacher at the completion of the programme she commented that both these innovations proved to be major catapults to the students' learning and in their final year of the programme she witnessed major changes to the students' confidence in managing the transition to degree level study. Whether this development would have occurred as a normal consequence of the learning activities involved in degree level study, or whether it was enhanced by the students developing self-efficacy in utilising information technology, is difficult to ascertain.

Harrison et al (1991) described three consistent components of distance education programmes, regardless of the medium, that are required to promote successful implementation of the programme. These are reported as *Instruction,* and include how content needs to be developed and paced, as well as development of methods to provide feedback, counselling, formation of support and discussion groups. *Management,* which denotes organisational structure and support from the originating department and institution. This also includes telecommunication infrastructure, and creation of internal policies. The third component described by Harrison et al is *Logistics* which includes the quality of programming, and instructional support including student services. Of the three components it appeared from the findings in this study that instruction was competently if reactively implemented, but management and logistics, in relation to organisational structure and support from other departments in the polytechnic was deemed to be deficient. The findings indicate that the students were satisfied with the level of instruction delivered by the teachers in the classroom, but had issues with clinical teaching, access to support services, and library and IT resources.

Summary

This study has demonstrated that there were many factors that influenced the students' transition to degree level study, with rural living, low self-esteem,

inadequate support services, horizontal violence, and lack of clinical role models in the rural area arguably the major barriers to their transition. There were many positive aspects to studying at the satellite campus, for example, the ability to stay and work in their communities, but initially the many challenges of studying in a degree programme with limited support services and resources, had a major impact on the students' self-esteem and confidence. The literature on distance education supports the findings of the study in identifying the need for thorough preparation and organisation of resources and services prior to distance education programmes commencing. It can be argued that theoretically the programme was not classified as a distance education programme as the students had timetabled regular study days, but the rural setting and limited access to teachers and resources meant that the programme had components similar to distance education programmes.

The students' previous enrolled nurse work experience and age maturity enabled them to integrate new theory with their current practice and proved to be a catapult for their learning. Their growing confidence and self-esteem enabled them to take cognitive risks and find their voice as they relearned how to learn. However the crucial factor that facilitated their transition was the experience of working with expert clinical teachers and role models who had comprehensive understanding of the level of thinking and knowledge required for the degree.

The following chapter is the concluding chapter for this research report. Included are the implications and recommendations for nursing education as well as the limitations and strengths of the study.

CHAPTER SEVEN

Conclusion

This chapter summarises the study and addresses the limitations and strengths of the research. Implications of the study will be presented and include comments on current political changes that have occurred since this study was completed which will impact on nursing education and enrolled nurses in particular. Arising from the findings of the study are recommendations for consideration that have relevance to nursing education and nursing research.

Summary

An exploratory, descriptive, qualitative research study utilising focus group interviews for data collection was undertaken with two participant groups comprising ten students and six teachers. The findings identified that the enrolled nurses faced many challenges in their transition. In particular, as mature age, women students entering the tertiary education sector, their previous learning experiences had not prepared them for degree level study. Relearning how to learn required the students to take cognitive and emotional risks in letting go unproductive methods of learning. Clinical role models, able to facilitate the students' integration of their enrolled nurse experience and reframe this experience into comprehensive nursing knowledge, played a pivotal part in their successful transition. The students' qualification as enrolled nurses facilitated as well as hindered their transition. Their previous knowledge and work experience enabled them to quickly integrate new knowledge and thereby reduced the theory-practice gap frequently experienced by mainstream students. However, early in their transition, their reliance on old ways of learning and their 'silence', as described by Belenky et al (1997) reflected traditional methods of learning, and initially acted as a barrier to their learning. Living rurally and having limited access to resources and support services also initially hindered the students, but their commitment, motivation and resourcefulness in accessing information from a variety of sources, and supporting each other in study groups overcame these barriers.

Limitations and Strengths of the Study

This study has a number of limitations that must be acknowledged. The study was conducted at the satellite campus of a polytechnic in a small town and the number of participants was limited to this geographical area, therefore the generalisability of the findings is limited. However, from the findings, patterns emerged that were supported in the literature, for example, the experience of mature women in tertiary education, which would indicate the usefulness of the findings for other nurse educators.

The time limits of this master's study did not allow for data saturation to be reached, but certain findings, such as the role of clinical role models, support services and resources, would be valuable for nurse educators and administrators, who are based in similar geographical sites and facilitating transition programmes.

The use of data triangulation to generate and collect data from diverse sources would have been an appropriate method to generate a more comprehensive database for this study. The study would have benefited from the inclusion and comparison of a separate focus group of enrolled nurse students who were based at the main campus, although their numbers were small. However, the teachers were in the position of facilitating learning with both groups of enrolled nurses and their comments on the comparison of the groups, although not reported in the findings, is interesting and may lead to another study.

The utilisation of focus groups, as well as providing a degree of spontaneity and a safe forum for the expression of ideas, was a strength of the study, as interactions between participants were able to be observed. Including a co-interviewer to manage the taping and ensure the discussion was focussed allowed interactions between the participants to be noted by the original interviewer/ researcher and facilitated a deeper level of questioning. Another strength of the study was the trust that was established between the researcher and participants prior to the research study commencing, facilitated a degree of openness by the participants that may not have occurred if an independent interviewer had been utilised.

Implications and Recommendations

Implications for nursing education and polytechnic administration can be drawn from the findings of this study. The difficulties the students experienced related to rural living, and as mature women with work and life commitments. These needed to be addressed more comprehensively prior to the students commencing the programme. Flexible and accessible support services and resources that meet the special requirements of these students would need to be developed if another programme is contemplated. This has financial implications for a small polytechnic already constrained within a tight budget and unable to offer a depth of resources and support services to students. Further research to evaluate the outcomes of the programme now needs to occur. It would be of value to assess the benefit of the programme to the community, although this would be difficult to measure accurately. It can be recognised however, that with these newly qualified registered nurses now working and acting as role models in their respective communities, other enrolled nurses may choose to enter tertiary education.

Lack of access and poor skills in information technology initially hindered the students' learning and placed demands on the teachers to find appropriate methods of developing the students' research skills. These skills were deemed a requirement for learning in the degree programme. The teachers faced a dilemma if they provided the students with the extra readings rather than persevering with developing the students' research skills, and implemented innovative teaching methods to meet the challenges. Identifying alternative methods of developing research skills has implications for nurse educators with students situated away from campus resources, who do not have ready access to computers.

Initially the lack of confidence in technology skills influenced the students' confidence in managing other aspects of the degree programme. Bandura (1986) described the concept of self-efficacy as the most important determinant in an individual attaining their goals, with self-esteem a major component in developing this self-efficacy. Although the majority of students claimed they would not have wanted the programme elongated by attending tertiary study

skills prior to the programme of study, educationally it is unsound to have students struggling with multiple new learning activities that may limit their success and impact on their self-esteem and confidence. The findings support the work on self-efficacy by Adamson (1997) and have implications for nurse educators to examine ways of developing tertiary study skills within a shortened programme. Integrating recognition of prior learning with individually negotiated learning contracts was one approach that was successful for a number of the students at the end of their second year, but this was limited to those students who were able to reduce other components of the programme.

The utilisation of relieving clinical teachers who were not totally cognizant with the polytechnic's degree programme has implications for future transition programmes. There is the recognition of the limited availability of expert degree prepared clinical nurses, able to work in a relieving capacity. Solutions need to be found however, that ensure that the foundations and framework of the conceptually based degree programme are integrated with enrolled nurses' previous experiences. A formal programme to develop the skills of preceptorship in clinical teachers would need to include strategies that enable the preceptor to assist the enrolled nurse to reframe current knowledge.

The findings related to horizontal violence in nursing are well supported by the literature and give reason for concern that this behaviour is still prevalent in New Zealand in 2002. It is recognised that the health reforms that have occurred over the last decade have been instrumental in diminishing the conditions and status of nursing in spite of the public's perception of the value of the profession. The lack of teaching support by clinical nurses reflects the conditions under which many clinical nurses are now working and has implications for the polytechnic in placing students in what may be perceived as unsafe clinical learning environments. With the current untenable workload of many clinical nurses it is unjust to expect them to be able to provide the required learning environment that students require. The study by Orchard (1999) has identified many of the issues surrounding the clinical education role of registered nurses. She noted that this role is 'erratic, problematic, ill defined and open to interpretation' (p. 145). From her study it is evident that there is not

a clear definition of the clinical education role and its associated responsibilities and as a consequence this role is being created in an ad hoc manner that may be detrimental to students. The utilisation of preceptors has been developed as one model for clinical teaching but this approach has not always been successful in clinical settings where staffing contains a high proportion of part-time workers. The provision of an appropriate model for clinical teaching has implications for service providers as well as education. These two groups need to accept joint responsibility for developing a clinical education model that benefits the students and registered nurses and results in optimal patient care. In the meantime the polytechnic needs to explore other methods of providing clinical teaching for students. These could include clinical/teacher dual appointments.

Current Political Changes

With the demise of enrolled nurse training in 1994, it could be presumed that the number of enrolled nurses wishing to transition to degree would diminish. This has been the situation at our polytechnic with fewer enrolled nurses requesting positions in the comprehensive programme in the last few years. However, in 1999 there was a change of government in New Zealand that led to a Labour-Alliance coalition. With this change the new Minister of Health, Annette King, in recognition of a shortage of registered nurses, decreed that enrolled nurse training would recommence, although not necessarily in the same format as previously. This decision, supported by the New Zealand Nurses Organisation (NZNO), has caused a large amount of controversy within the nursing profession and has drawn criticism from the College of Nurses Aotearoa (CONA), the Nurse Executives of New Zealand (NENZ), and the Nurse Educators in the Tertiary Sector (NETS) who all support a six month nationally standardised training programme for a second level health services assistant (CONA, 2000).

The Nursing Council of New Zealand has developed the programme's scope, competencies, and standards that will have the new enrolled nurse:

> *providing care for patients with predictable health outcomes in situations that did not call for complex nursing judgement. They will work in support roles as part of the healthcare team with patients who are relatively stable and in most cases living in supported community-based residential or home settings (NCNZ, 2001).*

This programme of study bears little resemblance to the previous enrolled nurse training which had these hospital based students gaining experience of practical nursing in a variety of settings including medical and surgical wards.

The students in this study undertaking the transition to the more conceptually based comprehensive programme, faced many challenges related to their old style of training which aimed to develop proficiency in basic skills and procedures. With the more limited enrolled nurse training envisaged with the new programme, educational institutions will be unlikely to offer shortened transition programmes for these enrolled nurses. With the title remaining as enrolled nurse this will also create some disparity and confusion between the new and the old, especially in the service areas. However, if a case is made for recognising any of the learning in the new programme, and special transition programmes offered to these new enrolled nurses, then the findings from this study may be of value when the programmes are developed.

Recommendations

From the findings a number of recommendations are made:

- Comprehensive assessment of students' prior learning, integrated with individual learning contracts to allow greater flexibility within a programme.
- Educational preparation of clinical teachers to develop strategies that would facilitate reframing and integration of enrolled nurse knowledge into the conceptual framework of comprehensive degree level nursing.
- Exploration of new models of clinical education that recognise the changing health environment and the financial constraints within this environment and within tertiary education.

- Recognition and development of support services appropriate for mature age female students entering tertiary education. For example, after hours student counselling/study support services with child-care facilities. Flexible lending criteria and distance access to library reference material for those students with limited access to information technology would also benefit the student.
- Include the cost of a computer within student fees to ensure all students have home access to information technology.
- Tertiary study skills programmes developed by the polytechnic and situated within local communities, for example local high schools, to meet the requirements of mature age students.
- Research to evaluate the benefits and costs of programmes delivered at a satellite campus.

Concluding Statement

It is a credit to the students that they were all successful in achieving both the Bachelor of Heath Science and their comprehensive registration in November 2000. At the time of writing the conclusion to this thesis it is a pleasure to note that all are working as registered nurses in their local communities. Four of the Maori nurses are working for a Maori health trust organization, spearheading new programmes and new modes of health care delivery, and all four have elected to continue into post-graduate study.

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Appendix 1

(Massey Letterhead)

Enrolled Nurses Adaptation to Degree Level Study

INFORMATION SHEET - STUDENTS

Principal Investigator: Judy Hylton, Senior Lecturer.....Polytechnic
Co-Interviewer: Lou Jurlina, Lecturer .....Polytechnic

Introduction
You are invited to take part in this research project which is to explore the major factors that have assisted or hindered enrolled nurses in adapting to degree level study. Your written consent will be requested two weeks after receiving this information sheet. You may wish to discuss this information sheet with others.

About this study
This study is in partial fulfilment of a Master of Arts degree at Massey University. The researcher is a senior lecturer at ....., where the study will take place. The study is supervised by Antoinette McCallin, PhD, Senior Lecturer at the School of Health Sciences, Massey University, Albany. The aim of the research is to identify the major factors that have assisted or hindered enrolled nurses in undertaking the transition to Bachelor of Health Science Nursing degree. Although the study may not benefit you directly it is hoped the study will provide information for the development of future transition programmes.
The study has been approved by the Massey University Human Ethics Committee and the ..... Polytechnic Research Committee. The study procedures involve no foreseeable harm to you, but ..... Polytechnic counsellors are available, if you wish to utilise their services. Lou Jurlina, in her role as cultural advisor will be available to discuss any cultural issues that may arise from the interviews. Your participation will involve 2 – 3 focus group interviews with other students in the course where questions will be asked on your perceptions of the course. These focus group interviews will take approximately one and a half hours each and will occur in November, December and possibly January, at a time convenient to the group. The interviews will be held in a room that is private and acceptable to the group. The interviews will be co-conducted by Judy Hylton and Lou Jurlina and will be tape recorded with the group's permission.

Anonymity and Confidentiality
Due to the fact that the Polytechnic is small it can be presumed that people will know you are involved in the study, but no material which could personally identify you will be used in any reports on this study. Pseudonyms will be used and data will be unable to be linked to your name. The tapes and transcripts will be held in a safe place at the principal researcher's home and copies kept in a locked file at .....Polytechnic for the duration of the research, the data will be destroyed three years after completion of the study. The data will be shared only with Lou Jurlina, the cultural safety teacher and my supervisor for the purpose of data analysis. The interviewer and transcriber will be required to sign confidentiality agreements.

Rights of Participants

Your participation in this study is voluntary, you are under no obligation to participate, and there will be no consequences to you should you decide not to participate. A signed consent form will indicate your willingness to participate. You have the right to withdraw at anytime, but data already collected may be used in the analysis.

A summary of the research findings will be available to you and held at the Polytechnic library. There may be articles published as a result of the research findings and the research may be used in seminar and conference presentations.

Focus Group Guidelines

Prior to commencing the focus group interviews, the group will discuss and negotiate agreement re the guidelines for the group process. Areas to be discussed and agreed to will include – confidentiality; withdrawal from the group; methods to ensure all members in the group have the chance to be heard; the choice to remain silent and not have to voice an opinion on any issues. There will be the opportunity prior to each group interview for all members to raise issues they wish to have negotiated.

Please contact me if you have any questions.

Judy Hylton
Ph. .....
Fax.....
Email: .....

Lou Jurlina
Ph. .....

Appendix 2

(Massey Letterhead)

Enrolled Nurses Adaptation to Degree Level Study

INFORMATION SHEET - TEACHERS

Principal Investigator: Judy Hylton, Senior Lecturer .....Polytechnic
Co-Interviewer: Lou Jurlina, Lecturer ..... Polytechnic.

Introduction
You are invited to take part in this research project which is to explore the major factors that have assisted or hindered enrolled nurses in adapting to degree level study. Your written consent will be requested two weeks after receiving this information sheet. You may wish to discuss this information sheet with others.

About this study
This study is in partial fulfilment of a Master of Arts degree at Massey University. The researcher is a senior lecturer at .....Polytechnic, where the study will take place. The study is supervised by Antoinette McCallin, PhD, Senior Lecturer at the School of Health Sciences, Massey University, Albany. The aim of the research is to identify the major factors that have assisted or hindered enrolled nurses in undertaking the transition to Bachelor of Health Science Nursing degree. Although the study may not benefit you directly it is hoped the study will provide information for the development of future transition programmes.
The study has been approved by the Massey University Human Ethics Committee and the .....Polytechnic Research Committee. The study procedures involve no foreseeable harm to you, but ..... Polytechnic counsellors are available, if you wish to utilise their services. Lou Jurlina, in her role as cultural advisor will be available to you to discuss cultural issues if they arise. Your participation will involve 2 – 3 focused group interviews with other teachers in the course where questions will be asked on your perceptions of the course. These focused group interviews will take approximately one and a half hours each and will occur in November, December and possibly February, at a time convenient to the group. The interviews will be held in a room that is private and acceptable to the group. The interviews will be co-conducted by Judy Hylton and Lou Jurlina and will be tape recorded with the group's permission.

Anonymity and Confidentiality
Due to the fact that the Polytechnic is small it can be presumed that people will know you are involved in the study, but no material which could personally identify you will be used in any reports on this study. Pseudonyms will be used and data will be unable to be linked to your name. The tapes and transcripts will be held in a safe place at the principal researcher's home and copies kept in a locked file at ..... Polytechnic for the duration of the research, the data will be destroyed three years after completion of the study. The data will be shared only with Lou Jurlina, the cultural safety teacher and my supervisor for the purpose of data analysis. The interviewer and transcriber will be required to sign confidentiality agreements.

Rights of Participants

Your participation in this study is voluntary, you are under no obligation to participate, and there will be no consequences to you if you decide not to participate. A signed consent form will indicate your willingness to participate. You have the right to withdraw at anytime, but data already collected may be used in the analysis.

A summary of the research findings will be available to you and held at the .....Polytechnic library. There may be articles published as a result of the research findings and the research may be used in seminar and conference presentations.

Focus Group Guidelines

Prior to commencing the focus group interviews, the group will discuss and negotiate agreement re the guidelines for the group process. Areas to be discussed and agreed to will include – confidentiality; withdrawal from the group; methods to ensure all members in the group have the chance to be heard; the choice to remain silent and not have to voice an opinion on any issues. There will be the opportunity prior to each group interview for all members to raise issues they wish to have negotiated.

Please contact me if you have any questions.

Judy Hylton
Faculty of Health and Science
..... Polytechnic
Ph.....
Fax.....
Email.....

Lou Jurlina
Faculty of Health and Science
..... Polytechnic
Ph.....

Appendix 3

(Massey Letterhead)

Enrolled Nurses adaptation to degree level study

PARTICIPANT CONSENT FORM

I have read the information sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask questions at any time.

I understand I have the right to withdraw from the study at any time and to decline to answer any particular questions, although any data contributed will remain with the study as it contributes to the collective process.

I understand my withdrawal from the study will not affect my future success in the programme or employment.

I agree to provide information to the researcher on the understanding that my name will not be used without my permission. The use of a pseudonym is acceptable to me. (This information will be used only in publication arising from this research).

I agree to stay within the guidelines for focus group interviews as negotiated by the group.

I agree to keep confidential any information that is discussed within the interviews and to maintain the confidentiality of the participants.

I agree/do not agree to the interview being audio taped.

If an interview is taped I understand that I have the right to ask for the audio tape to be turned off at any time during the interview.

I agree to participate in this study under the conditions set out in the information sheet.

Signed: _____

Name: _____

Date: _____

Appendix 4

[Massey letterhead]

DECLARATION OF CONFIDENTIALITY

The purpose of the research has been made clear to me and I understand the need to maintain confidentiality with regard to my role as an interviewer of the focus groups.

I_____ declare that I will not disclose any details of the identify of the research participants nor the content of the focus group interviews. I will not discuss information that arises from the group interviews that may in any way be detrimental to other group members.

I understand that any disclosure of information pertaining to this research by me will be in breach of the Privacy Act 1993.

Signature_____

Witness_____

Date:_____

Appendix 5

(Massey Letterhead)

DECLARATION OF CONFIDENTIALITY

The purpose of the research has been made clear to me and I understand the need to maintain confidentiality with regard to my role as transcriber of the data from the interviews.

I_____ declare that I will not disclose any details of the identify of the research participants nor the content of the focus group interviews. I will not discuss information that arises from the group interviews that may in any way be detrimental to other group members.

I understand that any disclosure of information pertaining to this research by me will be in breach of the Privacy Act 1993.

Signature_____

Witness_____

Date:_____