THE PROVING GROUND

The Lived World of Nursing Students in Their Pre-Registration Clinical Experience

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ABSTRACT

The purpose of this phenomenological study was to describe and interpret the lived world of twenty one senior Comprehensive Nursing Students in their pre-registration experience. The study set out to answer the question "What is the lived experience of Comprehensive Nursing students in their pre-registration experience ?" The pre-registration experience is a six to eight week block of clinical practice prior to sitting their State Registration Examination when the students work as soon-to-be staff nurses independent of close tutor contact. The study setting was in acute care clinical placements which included Emergency Departments, Theatre, Surgical, Medical, Paediatric wards and specialised Day Stay Clinics.

The study showed that students of nursing use an orientation period to gain confidence in a setting and engage willingly in their clinical practice. They use their theoretical knowledge to gain a "handle" on the demands of a nursing care situation, become involved in the client-nurse relationship which challenges their knowledge, skills and attitudes and opens new learning demands within the situation. They pursue specialised knowledge both directly and indirectly in order to function competently. Other registered nurses in the clinical setting are extremely important to facilitate the students learning and support the students in a host of ways from initiating opportunities to teaching specialised skills. The study re-iterates the importance of clinical experience to the gaining of nursing expertise.

A lack of job prospects was a dampening factor for the students but nevertheless, it did not inhibit their full engagement in their pre-registration experience.

The phenomenological method allows an experience to be captured in its wholeness to include the way the study participants thought, acted and engaged in nursing activities within a specific context. It is from the students' rich descriptions of their practice that this study gains its significance as it is the first phenomenological study of its kind in a New Zealand setting.

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TABLE OF CONTENTS

PAGE

Abstract ii

Acknowledgements iv

CHAPTER ONE: INTRODUCTION AND OVERVIEW 1

Background to the Study 3

Context of the study 6

Historical background 6

Nursing Education in New Zealand 6

Socio-political context 7

Economic considerations 8

Hospital Environments 9

The clinical environment 9

Educational values and orientations 9

Significance of the study 14

Structure of the thesis 16

CHAPTER TWO: LITERATURE REVIEW 18

Transfer of Nursing education to the general education system 20

Current relevant nursing literature New Zealand studies 21

Literature from other countries 27

Summary 32

CHAPTER THREE: STUDY DESIGN AND METHODOLOGY . . 34

The choice of Phenomenology as method for the study 34

The nature of Phenomenology 36

Assumptions of Phenomenological research . . . 38

Phenomenology as method 38
Interviewing 38
Relationship between researcher and participants 39
Research activities inherent in Hermeneutic Phenomenological method 39
Key Phenomenological concepts as used in this study 40
Hermeneutics 46
The Hermeneutical circle 47
Transformations in the interpretation of text 47
The research process 48
The importance of the method for Nursing scholarship 51
Summary 52

CHAPTER FOUR: THE RESEARCH PROCESS 53
Description of the study 53
Gaining the study participants 53
The participants 54
Table 1 55
Table 2 55
Study settings 56
Investigating the phenomenon - data collection methods 56
External ethical monitoring of the study 58
Risks to the participants 58
The choice of participants 59
Informed consent 59
Anonymity 59
Research ethics 60

Researcher's assumptions and beliefs about students' clinical experience 60
Adequacy of the study 61
Qualitative measures of trustworthiness 61
Triangulation 62
Summary 63

CHAPTER FIVE: THE PROVING GROUND 65
BEING AN OUTSIDER BECOMING AN INSIDER 66
SPATIALITY 66
Orientation 67
Outsider-insider 69
Becoming an insider 74
Acquiring local knowledge 77
Gaining a sense of predictability 79
Summary 87

CHAPTER SIX: DEVELOPING A SENSE OF WHAT IT MEANS TO BE A NURSE 88
INTENTIONALITY 88
Becoming connected with others 89
Working at relationships 90
Helpful and unhelpful experiences 101
Becoming entrusted 107
The giving over of responsibility 108
Freedom to embody nursing 110
Being part-student-part-nurse 112
Summary 113

CHAPTER SEVEN: DWELLING IN THE WORLD OF NURSING PRACTICE 115

BEING IN THE WORLD 'DASEIN' 115

Ensuring possibilities 116

Being able 124

Being in control of the self 126

Intuition 130

Problem facing 132

Caring ethical practice 133

Making clinical judgements 135

Recognising the moral demands in nursing practice 138

Being accountable 140

Being a competent practitioner 145

Summary 146

CHAPTER EIGHT: MAKING SENSE OF THE PAST - ANTICIPATING THE FUTURE 148

TEMPORALITY 148

Involvement 150

Foreground thinking and background thinking 150

Reviewing the past to make sense of the present 152

Value conflicts 153

Preparing for the State Examination 154

The situation as personally meaningful 155

Being aware of the self 156

Preparation for the future 158

Preparing for colleague Relationships 161

Clinical judgement that leads to advocacy . . . 162

Being a student and being a shift worker . . . 163
Losing a sense of the habitual body 164
Being a learner 165
Building confidence 167
Growth 168
Ready to take the plunge 168
Summary 171

CHAPTER NINE: DISCUSSION AND CONCLUSIONS 173
Overview and Summary 173
Limitations of the study 176
Findings 177
Discussion 182
The concept of involvement 184
Nursing Education - the value of clinical practice 186
Competence 188
Support from Similar Research 190
Significance of the findings 191
Implications 195
Suggestions for future research 195
Concluding Statement 196

REFERENCES: 197

APPENDICES: APPENDIX A 209
APPENDIX B 217
APPENDIX C 219
APPENDIX D 221

CHAPTER ONE

INTRODUCTION AND OVERVIEW

> To the world of practice I have come to the brink
> Is anyone interested in how I think
> Must I always be measured by what I can do
> For I can show you that I can think too.
>
> Rummel, 1992.

Clinical practice is at the heart of the discipline of nursing for students of nursing as much as for registered nurses. Throughout three years of educational preparation to register as Comprehensive Nurses, many students state that they enjoy their clinical practice more than classroom learning experiences. When involved in the delivery of client care in the clinical setting, they feel that they are 'doing nursing'.

This thesis has evolved out of my desire to make explicit the practice of students of nursing, how they think, feel and act as they go about their clinical practice. Nurses have been criticised in the past for being predominantly 'doers' rather than 'thinkers' (Moccia, 1986). This study will show that this assumption is not necessarily correct. As nurses 'do' - they also 'think'. It is the combination of the 'doing' and the 'thinking' that, for the student nurses in this study, constitutes a particular way of being that is informing, exciting, enriching, yet exhausting in their day to day experiences.

A phenomenological hermeneutical approach has been used to explore the lived experience of senior students assigned to acute care hospital settings. The study is focused on the weeks just prior to sitting their State Registration examination that will licence them to practice as Registered Nurses. The pre-

registration experience is the final clinical experience when the students feel that they will 'put it all together'. It is the culmination point of almost three years of study in a variety of clinical and classroom settings - a point at which they test their readiness to 'fly solo' as they anticipate post graduation practice as beginning practitioners.

Because of its methodology, this study relates to a specific population in a well defined area. The findings of this study gain significance only when they are seen within the context from which they have originated. The study cannot, and does not, claim to be definitive of the lived experiences of all senior nursing students as they near conclusion of their three year course. Nevertheless, the study can indicate likely patterns of responses by students of nursing who share similar educational experiences, given the particular historical, social, political and economic environmental conditions of the participants in the study.

This thesis then, is a report on the shared practices and common meanings conceptually derived from the lived experience of twenty one senior students of nursing during a period of six to eight weeks of clinical experience in acute care settings.

It is hoped that the insights gained from this research will stimulate further qualitative research to tell "inside out stories", that is, stories of nursing practice from the student's own perspective rather than "outside in" stories which reflect the perspectives of researchers or other observers (Diekelmann, 1992)[1].

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1 The reference "Diekelmann (1992)" refers to terms or expressions used by Professor Nancy Diekelmann in class to myself and others as part of an international study experience convened by her at the Nursing Institute for Heideggerian Hermeneutical Studies, June 1-12, 1992. This institute was held at the School of Nursing, University of Wisconsin, USA. Professor Nancy Diekelmann illuminated for me many of the deep nuances of M. Heidegger's writings thus assisting me greatly to understand and apply Heideggerian Hermeneutics as a methodology for this thesis. Whenever Diekelmann (1992) is used as a reference within the text of this thesis, this footnote will apply.

"Inside out" stories result when students narrate accounts from their experience that are usually uppermost in their minds because they are particularly meaningful to them. "Outside in" stories are the outcome of predetermined questions asked from a researcher's perspective that are initiated through hypothesis formulation and testing seeking the 'truth' of a phenomenon.

"Outside in stories" would suggest the creation of a 'still life' snapshot defining a single reality of a phenomenon under study. Studies conceived from such a perspective seek an objective view of the world and, when possible, control over events by being able to predict the future. On the other hand, "inside out" stories provide a kaleidoscope, a patterned but constantly changing picture, seeking to explain a shared reality that nevertheless has individual meaning for each of the actors involved.

From accounts of lived experience of nursing practice, shared meanings arise and understandings are enhanced for the clinicians, teachers and students. In this way, possibilities arise for nursing education to be better informed and perhaps, transformed.

BACKGROUND TO THE STUDY

The decision in 1973 to transfer nursing education in New Zealand from hospital based schools into the tertiary sector has been a controversial one. Although some of the difficulties that were experienced have been overcome, there are still those registered nurses, educated through a hospital based programme, who hold the view that the new breed of nurse is inferior to their earlier professional colleagues. Although the evidence does not support such a view (Taylor, Small, White, Hall & Fenwick, 1981), graduates and students from Diploma of Comprehensive Nursing courses, still carry the burden of this opinion. Successive generations of students feel that they must prove

themselves to be as able and as good as their predecessors - worthy to take their place within the nursing community.

Pre-registration experience is a period of time when the senior students in the Diploma of Comprehensive Nursing course, which is of three years duration, have reached the conclusion of clinical and theoretical teaching. At this point all classroom teaching is finished and their last clinical experience as a student is a period of six to eight weeks in a clinical setting of their choice. During this time, they work independently of tutors, except for an occasional visit to maintain as it were 'the umbilical cord' between the school of nursing and the clinical agency. It is a time when the soon-to-be-graduates seek to integrate theory and practice in a manner that they feel will carry them on into practice as registered nurses.

In this transitional time, senior students begin to identify more with their professional counterparts in the clinical setting, than with their clinical tutors (Perry, 1985a). For some, this is a time when their student status begins to become a source of frustration. There is a feeling of expectancy as they near the State Examination and the anticipation of a new status as registered nurses. It is also a time when the senior student feels vulnerable and feelings of self confidence need to be fostered.

Most students look forward to this time and see it as an opportunity to gain some idea of how they will practice in a work-setting in the future as a graduate.

For the most part, individual choice of clinical placement for pre-registration experience, rather than assignment to an area, suggests a personal interest in the type of work carried out in a particular setting. Motivation to become involved is therefore an expectation by the clinicians in the setting of choice,

as well as by the tutors who facilitate the placement through a system of negotiation, and by the students themselves.

At a personal level, attributes of the individual can make a difference. Some senior students are more confident than others and are able to be more assertive concerning their personal goals which have for most, determined their choice of clinical placement. This can facilitate a wider range of experience for them than for others who are less self assured. Interest kindles motivation which is outwardly expressed in the students' readiness to be involved in clinical practice.

There are limits placed upon the senior students in so far as performance of certain procedures is not legally permitted until they have their registration under the Nurses Act (1977). As well, they must practice under the supervision of a registered nurse. Therefore a paradoxical situation is created by the fact that personal autonomy, a value promoted by the Diploma of Comprehensive Nursing course, is constrained by how much they are legally allowed to do or are given to do in the clinical setting.

A pervasive theme throughout this study involved the feelings of frustration and hopelessness that the participants experienced in the light of the fact that, due to poor job prospects, very few of them, if any, would be employed at the conclusion of their course. This then is a dampening factor for the participants. Most realise that on graduation, few will get a chance to practice in New Zealand. It is salutary to note the fact that all of the study participants maintained a high degree of interest and motivation for their pre-registration experience. This was in spite of the knowledge that it was unlikely that any would find employment. It illustrates their enjoyment of their practice and the high level of commitment to client care that they hold.

Hope is a powerful motivator. If they achieve in their State Examination and successfully perform in their pre-registration clinical setting, a secret hope is that they may impress the Charge Nurse which could lead to future employment.

CONTEXT FOR THE STUDY

HISTORICAL BACKGROUND

Underlying the events of this study are a particular set of historical, political, social, cultural and economic factors that relate in a general sense to the lived experience of the study participants. They form an overlay of history that serves as a perceptual field through which the world of nursing practice is viewed. Most of the time we are unaware of this historical backdrop from which our taken for granted meanings and understandings spring.

The strength of the professional cultural background only becomes apparent when our awareness of it is heightened. To transport the reader into the "right region" (Diekelmann, 1992) and to gain a grasp of the situation, an examination of the background reveals that there are multidimensional influences that affect the study participants. As members of society and an international nursing community, the study participants were not isolated from the world around them but connected and interconnected with a host of unseen influences that impinged upon their day to day practice. These influences include history, socio-political and professional issues.

NURSING EDUCATION IN NEW ZEALAND

Nursing education in New Zealand has been shaped by an historical ideology which, to a greater or lesser extent, persists to this day. Education of nurses has mirrored the Nightingale model brought by Nightingale's proteges to the ninteenth century New Zealand, then a colony of Britain. This system of

training was based upon procedures learnt whilst providing service through an apprenticeship worked out in hospital wards. In this system, the way students learnt to become nurses was by observing those more senior than themselves. The nurse teachers were registered nurses who had come through the same system and therefore, taught as they had been taught. Doctors taught nurses subjects such as medicine and surgery and nurse teachers taught nursing. In this early era, an essential part of becoming a professional nurse was the internalization of the Victorian values of submission and obedience in which a good woman was expected to be a good nurse (Rodgers, 1985). These values were also mirrored by women's role in society generally, for historically nurses have been women (Reverby, 1987).

In 1971, a Canadian nurse, invited as a consultant by the New Zealand Government, recommended major changes in the preparation of nurses (Carpenter, 1971). The key outcome of Dr. Carpenter's report was the introduction, in 1973, of the three year Diploma in Comprehensive Nursing. The Diploma was to be taught within the tertiary education system rather than within hospital schools of nursing.

Many reasons were given at this time for the change. A significant reason was that hospital based nursing training was too narrow in focus, if the nursing profession was to meet its social obligations and the challenges of a changing world (Carpenter, 1971).

SOCIO-POLITICAL CONTEXT

Since the early 1970's, the Health Care System has undergone major restructuring with the aim of reducing government expenditure and making individuals more responsible for their own health. Health care institutions have had to become more accountable for how they spend the health dollar. The stated aim from political circles for the restructuring process is an

improved health care delivery service to the public of New Zealand (Upton, 1991). However, at the societal grass roots level, there is concern that the changes are being made more for economic reasons than for an improved health service.

Historically, as nurses finished their nurse training, there were jobs available in the hospitals where they were trained and it was not difficult to gain employment as a registered nurse. The situation today is that, due to the economic constraints placed upon health care agencies, nurse graduates are not guaranteed a job. In the last few years, decreasing numbers of positions have been available to newly registered nurses, certainly not enough for the numbers graduating throughout New Zealand each year. Prior to employing New Zealand nurses, overseas employing agencies usually require a minimum of one year post-registration experience. In the light of these conditions the graduates options are limited.

ECONOMIC CONSIDERATIONS

From a time when students were employed, and paid, by Hospital Boards, the students' financial situation has changed to create hardship for many. Today, students must pay high fees for their education. As well, students are expected to pay for transport to clinical placements at distant geographical locations and at odd hours when public transport may not be available. In the light of these costs, most students work at weekends or at night to fund their nursing education and many come out with a substantial debt at the end of the three years.

During the study, student participants worked in clinical settings for five days a week and on eight hour shifts which included night duty. At the same time, they were expected to study for the State Examinations. Many also had no choice but to continue with their part-time paid employment. This paid

employment was not only an essential source of income, but for some, their only prospect of employment after the completion of their nursing programme.

HOSPITAL ENVIRONMENTS

Over recent years, hospitals have become environments of much greater acuity of care. In a bid to reduce costs and meet the increasing demands for health care services, throughput of patients has been speeded up. In-patient services are focused on the acutely ill and there is an increased emphasis on early discharge. Follow-up care, rehabilitation, and longer-term care are increasingly managed through ambulatory clinics and community services.

THE CLINICAL ENVIRONMENT

At the organisational level, where the flow-on effects of the socio-political climate are felt, hospitals and hence all departments within, are operating with constrained resources. This is subsequently reflected in minimal staffing levels. Thus a paradox is created where the study participants, like other students of nursing, although theoretically supernumerary in order to be free to learn from their time with experienced clinicians, are faced with the reality of staff shortages. Often, clinical agencies expect senior students to assume case loads and thus help maintain nursing services, even though their contribution remains unpaid, and formally unacknowledged.

EDUCATIONAL VALUES AND ORIENTATIONS

Accompanying the many changes in health and education is a changing value system. Health, according to health professionals, policy makers, and health service managers, is to be seen as the responsibility of the individual, groups, and communities, rather than the responsibility of a Government funded health care system. For the nurse then, this means that at the nurse/client interface, the nurse's responsibility is not only to provide essential nursing care but a greater emphasis is placed upon information and teaching to enable

the client to take up self-responsibility for health. To function in this capacity, nurses require high levels of knowledge as well as excellent communication skills.

Nursing as a profession, has as its raison d'etre, a mandate to provide a service to society that is both necessary and valued (Watson, 1985). To realise the hopes of the Comprehensive Nursing education programme, and to meet the perceived health care needs of a bicultural, and increasingly multicultural nation, choices have been made by nurse educators for relevant education theory to guide the curriculum process.

At the curriculum level, humanistic educational values have taken a dominant place in the nursing education process. Principles of holism and caring have been central in order that upon graduation, nurses can provide services that are both respectful of, and have regard for, individual difference.

Emphasis has also been placed upon communication theory in order to prepare the students to communicate effectively. This is not only with their clients but also with the host of allied professionals with whom they will need to collaborate in the interests of their clients. This emphasis is not new, for a pioneering value of the profession of nursing is the quality of communication between the nurse and the client (Peplau, 1952; Orlando, 1961; Weidenbach, 1964; King, 1971; Travelbee, 1971; Paterson & Zderad, 1976; Orem, 1980; Watson, 1985; Parse, 1987).

Primary health care has also been emphasised within nursing programmes with the expectation that as they develop, nurses will take on the role of health promoter thus enabling self-responsibility for health to be taken up by individuals and communities. Primary health care is essential health care for individuals, families and communities. Within this perspective, greater

emphasis is placed upon the societal conditions that will best meet goals for a healthy and productive nation as well as on individual actions (Mahler, 1978).

Historically, nursing was conceived as a practice that was concerned with environmental problems, sanitation, nutrition, caring and counselling, as portrayed by Nightingale in her work in England with the urban poor. As an outcome of her work with wounded soldiers in the Crimean War, Nightingale linked disease with poverty, malnutrition, and squalor and in doing so became the first nurse epidemiologist. Thus primary health care is not a new concept but rather a turning back from an era of technologically driven health care focused on disease and hospitals, toward a renewed thrust for nursing that is focused on health of communities. The emphasis on primary health care within the students' educational preparation, sits uncomfortably with an emphasis on hospital based nursing that is seen as an essential prerequisite to gaining employment.

Criticism of the devaluing of humanistic beliefs and values and of a technical and rational form of knowledge that devalues practical experiential knowledge has provided the impetus for a call for a *curriculum revolution* in nursing education (Diekelmann, 1988). Others have suggested that nursing education curricula has lost the ability to capture the essence of nursing due to an over emphasis on science and a failure to value the art contained in expert nursing practice (Benner, 1984a; Benner & Wrubel, 1989). Exemplars of expert nursing practice presented by these authors, show that knowledge is not used in a linear step by step approach but rather is utilised as perceiving a situation as a whole. Salient features of a situation show up as meaningful to the expert nurse who draws on experience from similar situations in the past and on experientially generated knowledge, to guide action within particular practice situations.

The knowledge of expert practitioners that makes explicit the covered-over shared meanings and common understandings that are grasped best through narrative expressions and dialogue, can form the basis for curriculum that is meaningful to both the teacher and the learner as they share in a common culture of nursing practice. This thesis provides rich descriptions of how students think and act in their practice and how they use knowledge gained during their studies to guide their practice.

An increasing emphasis upon the ethico-legal dimension of health care has developed within clinical practice as the stresses of making choices in health care affect patients, families, and health professionals. Ethical dilemmas are almost a daily challenge not only for registered nurses, but at least through observation, for students also, as they meet with the realities and complexities of nursing practice.

Proponents of past changes within nursing education in New Zealand hoped that the 'new nurses' could and would be able to think more independently than their counterparts of yesteryear, that they would problem solve when faced with difficulties, be able to express themselves with confidence, and that they would question the status quo. It was hoped that educational experiences that encouraged these behaviours would produce a graduate that would change nursing practice. As time has gone on, however, this hope has dimmed. The apologists for this argument have suggested that the system was too strong, and the new graduates too few, to change the constraining structures and fulfil the dream (Perry, 1985a; Horsburgh, 1987,1989).

Others have suggested that by educating the student nurse to internalise a contemporary system of professional values supported by a strong self concept, the system could be made to change, and come to reflect an increased professionalism that would enhance nursing as a professional

discipline (Clifford, 1982; Dixon & Paterson, 1986). The present study bears witness to the fact that this hope was, for the most part, far too simplistic. The problem is complex and lies with the greater professional body of which the new graduate is the weakest member.

For the graduating Comprehensive Nurses in this study, there is yet another controversy looming concerning their educational preparation to be a registered comprehensive nurse. The Education Amendment Act 1990 has made way for institutes of technology and polytechnics to award degrees. An inter-professional debate has begun to examine the issues concerning the best possible nursing educational preparation to be a registered nurse (Horsburgh 1990/91; Chick 1991). Since 1973, Massey University has offered both extramural and locally based degree programmes to registered nurses allowing many nurses to gain degrees particularly through the extramural option. Victoria University has offered a locally based Bachelor of Nursing programme. Both these programmes have served New Zealand and a small number of Overseas students well. This new development has a two part thrust. First and foremost, it does not in any way demean the educational preparation of the currently graduating Comprehensive Nurses but rather, re-emphasises the need for a highly educated nurse who can combine an ability to be ethically compassionate with highly developed intellectual skills to meet the complex health needs of people in an advanced technological age. Secondly, New Zealand is seeking to follow a world-wide trend for a baccalaureate degree to be the appropriate preparatory education to enter practice as a registered comprehensive nurse.

There are many tensions and contradictions that the study participants faced as they realised that they must marry the ideals of their educational preparation with the realities of clinical practice. The ideology of individualistic holistic care had to be tempered with the reality that nursing

care must be prioritised to meet the needs of a number of persons and to meet work-place organisational goals within an eight hour time frame.

Procedures and technical skills although practiced in the classroom or learning laboratory, are much more involved when dealing with a variety of different clients, than just requiring technical dexterity. Technology proliferates throughout the health care setting and new machines and practices are encountered daily. That the tempo of working five days per week on a continuous basis can be exhausting, and that study for the State Examination has to be fitted around a daily pattern of going to work has already been mentioned. In addition, communication skills used by students have to be effective not only in the context of client care but also in the continuous context of collaboration with others in a dynamic, rapidly paced clinical milieu.

SIGNIFICANCE OF THE STUDY

It is the premise of this thesis that in order to understand better what it is to be a student nurse, there is a need not only for quantitative studies stemming from the empirico-analytic views of scientific inquiry, but also for qualitative interpretive studies that focus on subjective experiences and meanings that arise from them. Studies that allow students to report "how they come to think about and experience the complexities and incongruencies of nursing practice" (Diekelmann, 1990, p. 36) reveal that the nursing student is engaged in a world of nursing practice that is context specific, uncertain and demanding. The value of phenomenology as a method is that it permits the study of persons within the context of their everyday experience.

The purpose of this study was to gain insight into the experience of students as developing practitioners. A key assumption of phenomenological research is that meanings can only be appreciated in the context from which they arise,

in this case, the acute care settings in which students undertook their final period of clinical work.

Classroom teaching can provide simulated experiences that resemble reality but cannot replace the dynamic interplay of influences that take place in the real situation. By the time they became participants in the study, the students had two and one half years of working intermittently in a variety of clinical settings and would have learnt much about the day to day work that goes on in a hospital. Despite this, their growing expertise is not necessarily recognised either by their clinical teachers or by their professional colleagues.

Classroom teaching relies heavily upon theoretical concepts which cannot adequately prepare student nurses to cope with the many situations they will face in the clinical setting as the contexts where nurses practice are complex, fraught with difficulty, and require situation-specific decision-making.

Situations can arise where they must make clinical judgements and act immediately, particularly within an acute care context where nursing practice does not always proceed as expected.

The acquisition of experience-based skills is an essential prerequisite to developing clinical expertise (Benner, 1984a). Students need to value their own experiences and should be encouraged to reflect upon them. Their own practice is a rich source of personal knowledge which needs to become public knowledge to inform nurse educators and practitioners alike. Personal knowledge derived from experiences as the starting point for teaching/learning encounters, has the potential to transform the practice of nurse educators in their teaching.

Further, by making overt the competence of the potential new graduates, clinical agencies will be more sure of the expectations that they can realistically hold for their prospective employees.

It is anticipated that the study will lead to a greater understanding of what it is that senior students do in their practice and how they use their knowledge and skills to make clinical judgements in the delivery of nursing care as beginning practitioners.

It is also hoped that, as the result of this study, a dialogue will develop between educators and clinicians with a common language that each understands and thus gain greater appreciation of each others' contribution to students' learning and development.

STRUCTURE OF THE THESIS

This research report is presented in nine chapters.

In Chapter One, the background of the study has been outlined and the purpose of the research presented. Chapter Two contains a discussion and critique of relevant literature, with particular focus on the students' experience of clinical practice within nursing education programmes.

Chapter Three includes a discussion of the research methodology, in particular hermeneutical phenomenology which follows the work of Martin Heidegger (1962/1927). In Chapter Four, the way the research was conducted is described, including an outline of the study settings, the participants, ethical considerations and the methods used to obtain and analyse the data.

Chapters Five to Eight describe and interpret the research findings. The data analysis gave rise to four dominant phenomenological themes that entitle each

data chapter. Each chapter has a number of sub-themes which serve to embroider different shades into the tapestry of the lived experience of the twenty one study participants.

Chapter Nine contains a summary of the key findings of the study, discusses these in the light of current literature and addresses the implications and limitations of the study. A concluding statement completes the thesis.

CHAPTER TWO

LITERATURE REVIEW

Clinical practice makes up for half of the total learning experiences directed by nursing curricula in the Comprehensive Diploma in Nursing course in New Zealand (N.Z. Nursing Council Regulations, 1977 Nurses' Act). It is seen as an essential component of nursing education in the plethora of literature on nursing education, yet there is a paucity of reported research examining the contribution it makes to the development of the professional nurse.

In this chapter the focus is on an historical review of literature, in particular literature on nursing education in New Zealand since 1973 when a radical change occurred in how professional nurses were prepared. Carpenter (1971) recommended fundamental changes in nursing education which are discussed and literature evaluating the changes which followed is examined. The evolution of contemporary New Zealand nursing education is described and the influence of North American nursing publications and texts for nursing education considered. The chapter concludes with a brief overview of international research related to the focus of this study.

HISTORICAL PERSPECTIVE ON NURSING EDUCATION

The beginnings of New Zealand nursing were presented briefly in the first chapter; the emphasis here is on more recent developments.

In 1973, radical changes took place within the New Zealand nursing education scene. As a result of a Government directive, Dr. Helen Carpenter's review of nursing education initiated change from an apprentice styled nursing education to the present Comprehensive Nursing course. This initiative came about from both internal pressures for change from the New Zealand Nurses Association and external societal pressures as a result of Government

recognition that, in spite of pouring large sums of money into the health care system, there had been no concomitant improvement in the health status of the New Zealand people; in fact, when compared with other countries, there had been deterioration.

Among the reasons for change given from the New Zealand Nurses' Association, was a desire to utilise the advancing scientific body of nursing knowledge and to provide a professional nursing practice that was able to be delivered in any setting, not just within a hospital. Hospitals were said to provide a narrow disease-oriented preparation for nurses when nurses should be concerned with total patterns of health and illness in individuals and groups of people. Salmon (1983, p. 39) gives voice to the general view of the profession at the time by stating:

> ..If nurses are to fulfil their responsibilities in delivering a high standard of patient care in the future, they require an educational background comparable with that of other professional groups.

Carpenter (1971) stated that to compound the problem the existing nursing education system at the time was wasteful of resources, both human and monetary. Forty five per cent of the nurses dropped out during their training or within one year of completion. Another criticism was that the student nurse was removed from the main stream of the general education system and from the main stream of social life at the early age of eighteen years due to the nature of nursing education within a hospital setting. This was seen as an undesirable attribute of the then hospital schools of nursing and not conducive to continuing education, a necessary part of ongoing professional development throughout life (Salmon, 1968).

TRANSFER OF NURSING EDUCATION TO THE GENERAL EDUCATION SYSTEM

In response to increasing pressure by the nursing profession, the Government commissioned an enquiry by Dr. Helen Carpenter from the World Health Organisation in 1971. Following her investigation, Carpenter's recommendations to the New Zealand Government, initiated the transfer of nursing education from the hospital schools of nursing under the authority of the Department of Health, to place the educational preparation within the general education stream under the authority of the Department of Education. This move was based on the assumption that would-be nurses would become students of nursing primarily for educative purposes and not to meet service needs of the hospitals as had occurred since the turn of the century. A new relationship would be forged between the educational institute and the hospitals and other service agencies. Service agencies would provide a practice arena where theory taught in the classroom would be applied to practice, with the goal of gaining a better integration of theory with practice.

The nursing students of the Comprehensive Diploma in Nursing courses would be prepared for beginning practice in any setting, and thus replace the need for previously available registrations in General, Psychiatric, Psychopaedic and Obstetric Nursing. This was seen as the broad base of nursing education that would prepare the practitioner to meet health needs within a changing society. The new breed of nurse would be educated in order that she or he would be capable of independent thought and autonomous practice involving the provision of nursing care based on nursing judgements shaped through the learning and application of nursing science. Hopes were high that these new and different graduates would be change agents in the profession. In particular, these nurses "would be more likely to 'think nursing', from a nursing conceptual framework, and to value the attribute of

cognitive skill as a basis for practice, than did their predecessors" (Perry, 1985b, p. 35).

A further recommendation made by Carpenter, (1971), was that tutors should gain higher educational qualifications. Thus from 1973, there began an era in nursing education that removed nurse tutors from hospital schools of nursing to train them as educators in the broad system of Tutor Training, along with other tutors in the Technical Institutes. As an outgrowth of this move, tutors became fluent in the language of educational theory. This development mirrors North American nursing education changes that occurred forty years previously, as nurse tutors moved from hospital based schools for nursing education to Teachers Training colleges (Meleis, 1985).

Nursing began to develop as a science as North American nurse educators developed theories of nursing beginning with Peplau (1952) which continued through thirty years of theory generation to the present, the most recent being Watson (1985). Nursing theory taught in the classroom reflected the field of psychology, sociology and education with a nursing focus and has provided the content for nursing textbooks in New Zealand nursing education. Curricula was developed that adhered to strong educational principles based on a behavioural objective model developed by (Tyler, 1949) but a practice discipline must also provide opportunity for the neophyte nurse to gain practical skills. With the advent of Technical Institutes becoming the base for nursing education, Education Institutes interfaced with Health to meet the theoretical and practical requirements of a nursing curriculum (Brown, 1991).

CURRENT RELEVANT NURSING LITERATURE
NEW ZEALAND STUDIES

While research has been conducted to examine the post graduate socialisation processes to induct the Comprehensive graduate into the mainstream of the

profession, (Miller, 1978; Perry, 1985a; Horsburgh, 1987, 1989; Clare, 1991a) there has been little research conducted on how Comprehensive students perceive or experience their practice during, or at the conclusion of their course prior to graduation.

Miller (1978) used Levinson's Role theory in an exploratory study of problems experienced by graduates of comprehensive nursing programmes as they provided nursing care in general hospitals. From a possible 94 graduates throughout New Zealand, a sample of 25 students from the North Island responded to a questionnaire and were also interviewed. Miller's findings were that graduates who had been socialised into a professional role during their education, experience incongruity between their role conception and the role demands of the organisation once they entered the world of nursing practice. The author concluded that all graduates in her study demonstrated a significant degree of professional role deprivation.

She went on to suggest that both employing organisations and educational institutes should provide measures to lessen the inconsistency between the graduate's expectations and their actual work experience.

Similarly, Perry (1985a) investigated the experience of five nurse graduates as they entered their first year of professional practice as employees in a New Zealand hospital. Through a critical reflexive analysis of the perceptions of the five graduates, Perry argued that powerful social forces constrain personal and professional actions within both education and practice institutions. Her conclusions were that the induction of Comprehensive nurses into the profession of nursing is in part, a political process that occurs both during the course and across a number of practice contexts. The dominant cultural beliefs and values that are entrenched in the structures and activities of the dominant groups permeate all social relationships and serve to maintain

the dominant culture. She argued that such hegemony serves to suppress educational values of autonomy of practice and independent thought espoused within comprehensive nursing courses, and therefore succeeds in constraining both personal and professional actions of the neophyte nurse.

In a follow up study, Clare (1991a) worked with 11 tutors and 42 students in a third year comprehensive nursing program in one Polytechnic School of Nursing. The aim of the study was to investigate the socio-political forces that "constrain and shape personal and professional choices for action in the context of comprehensive nursing education" (Clare, 1991a, p. 206). Of prime concern in this study, was the 'hidden curricula' seen as a pervasive influence that serves to maintain the dominant ideology. From the in depth data collection and critical analysis involved in this study, Clare pointed to the "extent to which hegemonic conditions of both education and practice limit opportunities to develop a dialogic relationship between tutor and student in the comprehensive nursing course" (ibid, p. 198).

Using a descriptive survey, Walton (1989) undertook an extensive study of the nature and organisation of nursing practice in New Zealand hospitals. A total of 633 valid completed questionnaires, providing both quantitative and qualitative data, yielded a comprehensive picture of the nursing workforce and their practice.

Of relevance to the present study is that in Walton's research, only 105 of the 633 respondents were Registered Comprehensive Nurses. The remaining 528 were either "hospital trained" Registered Nurses or Enrolled Nurses. While only 19.7% (180) of Registered Nurses reported student supervision as part of their work, 35% (41) of Enrolled Nurses reported supervising students - a finding that may be rather surprising as well as of concern to nurse educators.

A significant finding of Walton's (1989) survey was that while nurses felt generally positive within their work situation, they also experienced a number of frustrations, related in the most part to being unable to always give the best possible care to clients. The main problem areas identified related to short staffing, time pressures, nursing colleagues, management and personal health.

During the data collection phase of Walton's survey, New Zealand underwent widespread social change including radical health reforms. One outcome of the latter, was the first national nursing strike. Walton noted that there were some angry survey respondents who were keen to have their opinions heard. It is within this context, that Comprehensive students in the present study have undertaken their nursing education and the residue of unrest persists as they move toward registration and practice as qualified nurses.

Three studies have been undertaken in order to evaluate the comprehensive nursing courses in New Zealand, (Small, Taylor, & White, 1979; Taylor, Small, White, Hall & Fenwick, 1981; Street, 1982). These studies showed that the expected outcomes of the comprehensive courses were being achieved but they did not explore the students' experience of nursing education nor their experiences in clinical contexts. These studies have not been replicated with more recent cohort groups.

Although focusing on registered comprehensive nurses in their first year of practice, Perry's (1986) survey provides some information about the clinical work settings which is of relevance to the present study. A profile of the graduate emerged as part of a three phase study which commenced in 1986. In 1988, a report was published on phase two of the survey. Data was collected from 255 comprehensive graduates as they took up their first clinical practice position. The survey was a follow up of the original third year comprehensive nursing students who took part in the first survey as well as

others who were willing to be included. The final group included 34% of all 1986 comprehensive graduates.

Significant events in the first week of graduate practice related to patient care. From the responses received 26.6% (25) of the graduates stated that they felt the sudden responsibility, 17% (16) said that they were the only staff nurse on the ward and therefore carried heavy workloads and 14.9% (14) said that they experienced problems with staff and felt unsupported in their new position.

For the graduates in their first week of practice, a considerable learning curve was undertaken as they developed personal knowledge. Significant events were stated as; "20.3% (15) learning about hospital/ward procedures, 17.6% (13) feelings of inadequacy and incompetence, 13.5% (10) expectations for a high standard of performance was expected by the staff" (Perry, 1988, pp. 20-21).

Among the responses concerning organisational knowledge was that 23.4% (15) of the graduates said that learning new skills was a challenge, they felt the responsibility for procedures and techniques 28.1% (18), but there was a lack of support by staff 20.3% (13).

High on the list of factors considered very important for achieving personal satisfaction in their post graduate experience was emotional satisfaction 67.9% (171). Other factors given very important prominence were "strengthening and developing skills 61.8% (155), involvement with people 57.3% (145), conditions of work 56.0% (141) and acquiring knowledge 53.0% (133)" (opcit: 27).

The graduates rated the self as mainly clinically competent on a scale that spanned "very competent" "competent" "reasonably competent" and "not competent".

The areas rated related in particular to functioning as a member of the health team and the application of the nursing process to meet individual health care needs (ibid, pp. 27-28).

The conclusions of the survey drawn by Perry (1988) was that it was of concern that one third of the graduates were not interviewed for their first position, and those who were, were not asked about their interests or their goals for their career. This latter point was of particular concern as the graduates had shown a high commitment to furthering their nursing education and to ongoing career development. The graduates were moved frequently in their first post graduate clinical experience which required them to be adaptable and flexible.

She also stated that it would be desirable to establish at what level the practice occurred and the effects a rapidly changing work environment had on the individual and the organisation (Perry, 1988).

The majority of the thirty participants who were interviewed in the final phase of the three phase study, reported feelings of not being welcome in hospital wards, of needing to 'prove themselves to other nurses', of needing to be careful and selective in approaching more experienced nurses when they needed help, and feeling burdened by heavy workloads.

A study by Horsburgh (1987), also focusing on first year staff nurses, paints a similar picture of a mismatch beween what graduates from comprehensive nursing programmes expect, and the reality of the practice world. Horsburgh

lays the blame squarely on the employing institutions, claiming that their bureaucratic management systems fail to facilitate and support the development of professional nursing practice in New Zealand hospitals.

A somewhat different study was undertaken by Paterson (1989) using a phenomenological approach to describe the lived experience within the practice world of a small group of registered nurses working in an acute care hospital in New Zealand. Using Benner's (1984a) study as a framework, Paterson described the difference that experienced nurses make to clients' health outcomes. Paterson made a plea to nurses to "explicate the knowledge embedded in clinical practice if the significance of nursing practice is to be fully appreciated and continually developed, particularly in times when the humanitarian nature of nursing is threatened through economic stringency" (Paterson, ibid, p. 91). While Paterson's study involved only registered nurses, student nurses too, if they are to develop clinical expertise, need to make sound clinical judgements and must learn to reflect upon their practice during their clinical placements if they are to develop the personal competence required of a professional.

LITERATURE FROM OTHER COUNTRIES

While there is a serious lack of New Zealand research literature relating to clinical experiences of nursing students, studies from other countries are not numerous either. In a bid to better understand the clinical experience of senior nursing students in United States of America, Windsor (1987) studied nine such students' perceptions of clinical experience in their final semester. Windsor's findings were that the students clearly identified the importance of the practice of nursing skills as the major learning goal of clinical experience. They identified assessment skills, psychomotor skills and therapeutic communication as particularly important and stated that a considerable amount of their time was taken up consulting their text books in order to facilitate

their learning and practice. Time management was identified as a source of frustration and even though they tried to organise themselves ahead, they found that "many things change when you actually get to clinical, you have to learn to think on your feet" (Windsor, 1987, p. 151). The author identified three distinct phases within the students' experience of clinical placement. The initial phase was overshadowed by anxiety and fear as students focused on the rules of task performance. The second phase was a transition period during which students moved toward closer identification with the role of the nurse. In the final phase, students moved toward greater independence by expanding their role and performing tasks more independently. During this final period, students identified more closely with clinical nurses than with their instructors.

In an Australian study, Higgins (1989) became concerned that the concept of nursing promulgated through the media was at variance with the nurse that nursing education programmes were seeking to produce. Higgins investigated students' perceptions of priorities in nurse education and compared these with perceptions of staff (nurse and non-nurse) responsible for implementing a college-based nurse education programme. To do this he used a Ratings of Objectives questionnaire consisting of 26 items, each making a statement of a possible objective for a basic nurse education programme accompanied by a "degree of importance" scale ranging from "extremely important" rated with (1), "very important" (2) "important" (3), "not very important" (4) through to "unimportant" rated as (5).

Higgins' (ibid) study showed that students and staff had different sets of priorities in terms of what students needed to learn and be able to do. For example, the students saw as most important their need to develop the ability to work effectively as nurses in acute care hospitals and to be able to perform selected medical procedures in an emergency. They also gave priority to

being able to provide appropriate and effective care to patients to meet health needs and to be able to report observations accurately and fully.

Nurse educators, on the other hand, had somewhat different priorities. They saw as most important students' ability to use the nursing process effectively, to communicate appropriately with patients and staff, and to maintain professionalism by keeping up to date with nursing knowledge. Ability to work effectively in acute care hospitals and to be able to assist doctors with commonly performed clinical procedures was seen as least important by the nurse teachers. The potential for such disparate views between clinicians within hospital settings where students practice is an ever present source of tension which may hinder students' learning and confidence in clinical settings. There were marked differences between the groups in relation to the importance ascribed to various objectives, in particular, between the students and the nursing staff.

From a general picture which emerged from the group of studies carried out by Higgins (1989) it was apparent that nursing students graduating from nursing programmes were ambivalent toward many of the stated objectives and priorities of their educational programmes. He postulated that the origins of the ambivalence appear to reside both in a restricted view of the nurse's role held by the students, and in doubt and fear about their level of clinical competence; a situation that should be of concern to nurse educators.

Higgins (1989) further points out that expectations for students entering the nursing profession are influenced by the media and the image of nursing portrayed in the community at large, which at the time of Higgins' report were considered to be conservative and unlikely to meet the aspirations of reform in nursing education to develop the profession of nursing.

Some researchers have questioned the value of clinical placements for students' learning. In an American study, Monahan (1991) explored two potential learning outcomes of clinical experience - the ability to make sound clinical judgements, and the development of professional identity. A quasi-experimental design involving sixteen Baccalaureate students where eight were assigned to the experimental group and eight to the control group was used. The experimental group undertook a defined period of clinical practice while those in the control group had their clinical assignment delayed until after the completion of the study.

The results of this study showed that clinical experience did not contribute to greater accuracy of clinical nursing judgements or to the development of professional identity. In the same study, Monahan makes the point that although clinical practice is seen as an essential component of the preparation of a registered nurse and therefore an essential ingredient as part of nursing education, there is little reported research examining the contribution it makes to prepare the graduate. As well, there has not been any clinically identified competencies that a new graduate should possess only those that have been rooted in tradition. Monahan questions the emphasis placed upon clinical experience for student nurses without demonstrable learning outcomes. Of concern in Monahan's study is the limited size of her research population. Her findings, although relevant to this study, are reported with caution.

Nurse educators spend considerable energy creating simulations both in written scenarios and in practical mock situations. The objective in this activity is to assist students of nursing to gain the intellectual skills required to process complex patterns of information in readiness for their clinical practice, yet there has been very little research related to teaching clinical judgement, and less on how students cope with accessing and abstracting their knowledge to apply it in their practice (Corcoran & Tanner, 1988).

Tanner (1987) has undertaken research into clinical judgement most of which has concerned registered nurses in an American setting. One study by Tanner, Padrick, Westfall, & Putzier, (1987) however, included student nurses. The findings showed that student nurses, as well as experienced nurses, undertook the same intellectual diagnostic reasoning processes to formulate hypotheses at an early point in simulated clinical problem solving as they tested out probable solutions. Differences between the students and registered nurses were in cue recognition, systematic information gathering and accuracy in diagnoses. An outcome of this study was that the authors questioned the model based on information theory, upon which the research rested. The authors made a plea to undertake further studies in clinical reasoning using naturalistic enquiry rather than empirico-analytic methods to study this phenomenon.

Kolb (1984) and Burnard (1987) have undertaken considerable research into experiential learning which includes clinical practice for students of nursing. Experiential learning is seen as learning by doing, is personal, and involves reflection. Personal knowledge has been described by Heron (1981) and Burnard (ibid) and is cited by Carper (1978) as one of four sources of knowledge that constitutes Nursing knowledge. Personal knowledge is for the most part hidden because as suggested by Polanyi (1958), we know more than we can tell.

Burnard (ibid) however, makes the point that reflection is necessary following learning activity if we are to learn from it. The present study involves narratives from students who relay their lived experience through language and thus have reflected to some extent upon their actions in order to share with another. There is interpretation (Van Manen, 1990) as a person makes meaning of their experience to tell another and thus the experience as it is related to another has undergone a first transformation (Reinharz, 1983).

Thus experience has the potential to enlighten through increased understanding post-facto.

This study would be incomplete without giving recognition to the vanguard work of Patricia Benner (1984a) who identified, using the Dreyfus model of skill acquisition, five stages of knowledge development based upon observations of nurses at their work. These were the novice, the advanced beginner, competent, proficient and the expert nurse. The novice was seen to use theoretical concepts that were concrete and static as a guide to practice whereas the advanced beginner was able to grasp recurring situational components and use principles to guide action but were not able to discern priorities. Competent nurses saw their actions in terms of long-range goals and could prioritise accordingly. Proficient nurses used maxims to guide their practice and perceive situations as wholes and plan and modify plans in the light of changing circumstances. The expert nurse has a clear understanding of the whole, can assess a clinical situation rapidly, can recognise salient events, and can use appropriate theoretical frameworks flexibly to guide action in different situations.

Current nursing theory and research has a lack of the rich practical knowledge embedded in expert clinical practice which nurse practitioners perceive as knowledge that is most meaningful. Benner's work, (Benner 1984a; Benner & Wrubel, 1989) has given impetus to researchers turning their attention to methodologies that hold greater promise in uncovering the knowledge that is hidden within a practice discipline.

SUMMARY

What the review of published research shows is a clear lack of studies that have examined, from the students' perspective, their experience of clinical

practice and the way this experience influences their learning. The present study is thus an important move toward redressing this situation.

The focus in the next chapter is on the phenomenological hermeneutical method used in the present study to describe and interpret how the study participants viewed and experienced their practice in acute care settings.

CHAPTER 3

STUDY DESIGN AND METHODOLOGY

This methodology is divided into two chapters. Chapter Three focuses on the researcher's choice of method, nature of phenomenological investigation, assumptions related to phenomenology, its application as method to the study of lived experience and why it is important for nursing scholarship. In Chapter Four, a description of the study and study participants is given and the settings for the study are outlined. The chapter concludes with considerations of ethical issues related to the conduct of the study as well as issues of reliability and validity in qualitative research.

THE CHOICE OF PHENOMENOLOGY AS METHOD FOR THE STUDY

Why choose phenomenology ? As a nurse educator who is interested in clinical practice as the context within which a practice discipline's knowledge is developed and applied, I have been impressed with senior students' knowledge and skills as I have observed them at their practice. Yet, so little of this knowledge and ability seems to show up in formal evaluation tools. Visiting students on pre-registration clinical assignment once or twice per week, I had noted that students often felt very nervous at the outset, but as time progressed they appeared to find new confidence in themselves. The questions that arose for me were:

What is it that makes the difference to their knowledge and confidence ? What do they learn from a lengthier period of uninterrupted practice ? What meaning has the experience for them ? What is the lived experience of senior student nurses within acute care settings and how do they use their knowledge and skills to make clinical judgements in their practice ?

As a Master's student aware of a variety of research methods, I considered the phenomenological approach as particularly suitable for a study focusing

on understanding human experience. Nursing's concern for suffering of those we nurse gains greater significance if we can appreciate the personal lived experience of those who are ill or distressed. By the same token, insights gained from personal accounts of practice by student nurses, particularly at the end of their programme of study, give greater understanding of how students experience their practice and prepare for later work as registered nurses.

Hermeneutical phenomenology provides a method that allows a researcher to both describe and interpret what it is like for senior student nurses to work through their final clinical assignment. According to Van Manen (1990, p. 181):

> Hermeneutic phenomenology tries to be attentive to both terms of its methodology: it is a *descriptive* (phenomenological) methodology because it wants to be attentive to how things appear, it wants to let things speak for themselves; it is an *interpretive* (hermeneutic) methodology because it claims that there are no such things as uninterpreted phenomena. The implied contradiction may be resolved if one acknowledges that the (phenomenological) "facts" of lived experience are always already meaningfully (hermeneutically) experienced. Moreover, even the "facts" of lived experience need to be captured in language (the human science text) and this is inevitably an interpretive process.

For me then, phenomenology is a methodology that would allow the lived experience of senior comprehensive nursing students to move from a position of concealment to a position of revelation. Dreyfus (1991, p. 32) suggests that "the subject of phenomenology must be something that does not show itself but can be made to show itself". In this case, the aim has been to obtain an "inside-out" view of the everyday, taken-for-granted experience of student

nurses, in order to discover the meaning of that experience in the context in which it occurs.

THE NATURE OF PHENOMENOLOGY.

Phenomenology is a philosophy, a science and a method (Munhall & Oiler, 1986). Phenomenology as a human science "begins in lived experience and eventually turns back to it" (Van Manen, 1990, p. 35). Merleau Ponty (1956) cited in Munhall & Oiler (1986, p.49) takes a philosophical position on phenomenology to explain it as the study of 'essences' and as a way of describing experience as it is lived without questioning how it came to be the way it is.

Munhall & Oiler (1986) state:

> All acts of consciousness-remembering, judging, dreaming, and so on are possible because we are present within the world. This is a critical consideration in Merleau Ponty's phenomenology. It recognizes consciousness as simultaneous contact with the world and with oneself. The idea of a subjective and an objective world is eliminated in this conception (p. 49).

Consciousness links the subjective experience of the person to the objective physical experience through bodily contact with the world around him or her, coined by Merleau Ponty (1962) as 'embodiment'. Our bodies in contact with the world around us through sensation, sexuality, language and speech become the channel through which we create and store knowledge.

Knowledge is not only stored in memory but also by our bodies. Our bodies become 'knowers'. This is particularly relevant in practice disciplines and is useful to explain the difference between a novice and a skilled practitioner's performance. The novice is gaining experience and is building up a repertoire of skills, for example the fine motor movements involved in the dressing of

soft tissue injuries. On the other hand, the skilled practitioner who has worked for some time in a specialist area utilises skilled 'know how' in approach, touch, and dexterity when accomplishing skilled performance in complex wound dressings (Benner, 1984a). For Merleau Ponty (1962) then, the person as an embodied being comes to know the world through their bodily contact within it. "We are our bodies" (Munhall & Oiler, 1986, p. 52). We live our bodies.

Merleau Ponty (1962) further explains the particular perspective one takes up in the world and terms it one's "gaze". "Gaze" refers to the particular lens through which we view our world shaped by one's biography, past experience and knowledge of the world, and a desire to achieve one's purposes or intentions. The lens through which we view our world determines our 'comportment' within it. Comportment here refers to a general posturing or a stance in the way we embody our world.

Phenomenology as a science has developed as a qualitative methodology that utilises rigorous methods to capture experience as it is perceived by those individuals or groups who live the experience.

Phenomenology begins in the lifeworld which has been described by Husserl (1859-1938), the father of phenomenology, as the original, pre-reflective, pre-theoretical attitude that we naturally adopt as we live within the world of everyday life. The present study adheres to a Heideggerian hermeneutical view of phenomenology which describes and explains the human way of being.

ASSUMPTIONS OF PHENOMENOLOGICAL RESEARCH

The major assumption of phenomenological research is that knowledge of phenomena can be obtained from making explicit accounts of experiences from those who live them (Munhall & Oiler, 1986; Madjar, 1991).

The phenomenologist accepts experience as it is described by the actor and relayed to the researcher.

This study rests on the acceptance of this assumption as a beginning point to acquiring a deeper understanding of what the lived experience is for senior Comprehensive Nursing students in their pre-registration clinical practice.

A second assumption of phenomenological research, is that in most instances, people are able to communicate an account of their lived experience in an intelligible manner and as honestly as they have experienced it. One cannot experience another's life - each person's is unique, therefore I accepted the phenomenological assertion that each person's experience is legitimate for them and they are the experts on their history (Swanson-Kauffman & Schonwald, 1988; Van Manen, 1990).

PHENOMENOLOGY AS METHOD

Phenomenology as a method relies heavily on the willingness of the participants to articulate their experience. Being able to bring to speech (Dreyfus, 1991) and relay this fully to a researcher is an essential part of the skills required by the participant.

INTERVIEWING

In hermeneutic phenomenological research, the main datum collection is carried out by interview which serves a specific purpose. In the first instance, it is used to gather narrative accounts of lived experience which then serve as

a resource for developing deeper understanding of a human phenomenon. In the second instance, the interview may be used as a way of developing a conversational partnership to come to understand the meaning of an experience (Van Manen, 1990, p. 66).

The interview is focused by the research question which, in the case of this research, was "What is the lived experience of senior Comprehensive students in their pre-registration clinical experience in acute care settings?" The question focuses the interview but it is important to gain narrative accounts which are not punctuated by a lot of questions and answers. When the participant is relating meaningful material, then the accounts flow as in a story. Questioning in phenomenology is used for clarification or probing, but also, reflecting through paraphrasing can initiate a story. It is better to commence an interview with an opening phrase, for example "Tell me about your experience this week in the Ward". In this way a narrative is initiated rather than a series of questions and answers that serve to break up a whole experience as it has been stored in the mind of the participant. We live as self interpreting beings and make meaning in wholes and not in parts.

RELATIONSHIP BETWEEN RESEARCHER AND PARTICIPANT

Phenomenology also rests strongly on the strength of the participant researcher relationship. The development of a trusting relationhip between the researcher and the participant is an essential part of the research methodology. Without this, it is unlikely that participants would be likely to share their experience. Part of the skills required by the researcher is an ability to communicate effectively and to listen.

RESEARCH ACTIVITIES INHERENT IN HERMENEUTIC PHENOMENOLOGICAL METHOD

Van Manen (1990, p. 31) identifies six research activities inherent in the hermeneutic phenomenological method.

These are:-

1. turning to a phenomenon which seriously interests us and commits us to the world;
2. investigating experience as we live it rather than as we conceptualize it;
3. reflecting on the essential themes which characterize the phenomenon;
4. describing the phenomenon through the art of writing and rewriting;
5. maintaining a strong and oriented pedagogical relation to the phenomenon;
6. balancing the research context by considering parts and whole.

These guiding steps have been used in this study in the following way:-

1. the phenomenon of interest is the lived experience of senior Comprehensive students in their pre-registration experience in acute care settings;
2. exploring the experience of students in its entirety as it was lived by them;
3. thoughtful reflection to bring to speech that which constitutes the nature of the students experience. This includes bringing to speech that which would normally be hidden;
4. writing the essential nature and interpretation of the students' experience in order to reveal its richness publicly;
5. maintaining the truth of the experience as it was lived and related by the students to me as the researcher in the written research report;
6. identifying the parts while maintaining a view of the whole in seeking to discover the essence of the experience. This required an engaged dialogue with the text to discover what the essence of the experience was and what were the parts that constituted the whole.

KEY PHENOMENOLOGICAL CONCEPTS AS USED IN THIS STUDY

Key phenomenological concepts as introduced by Martin Heidegger (1962/1927) and interpreted by Benner (1984a), Benner & Wrubel (1989) and Dreyfus (1991) are therefore outlined. *Being-in-the-world or "Dasein"* (Heidegger, 1962/1927) may be translated as "being" as every day existence,

or as "being there". For Heidegger, *dasein* is the beginning point of human existence and experience and can refer to "ways of being" not only for individuals, but also the broader concept of "Being". *"Being-in-the-world* in Heideggerian terms describes how people are involved in situations through concerns, skills and practical activity" (Benner & Wrubel, 1989, p. 407).

An assumption of phenomenological research is that we must first 'be' before we can know anything. We live in the world as self interpreting beings as we experience the world directly in terms of its meaning for the self. As we interact with the world around us, so we become part of that world and the world becomes part of us. In growing up as members of a culture we internalise the norms of social life, and so our living for the most part, is effortless. We understand ourselves in a non-reflective way because we constitute and are constituted by experience. We come to know who we are, only in relation to the "how" of "being". That is, how we comport ourselves and are involved in the host of experiences that we encounter as members of the human group during the course of living a life (Benner & Wrubel, 1989).

Phenomenal Body refers to the way we experience ourselves in the world. This can relate to our size, shape and physical characteristics as a person and how as a 'self' we experience the impact of the 'self' in the world about us. The *phenomenal body* is a holistic self. For example, in this study, the senior students brought to the clinical setting not only their personal attributes as a person, their gender, education, nursing knowledge, skills, beliefs, values and attitudes about being a person and being a nurse, but an expressed collective feeling of lack of confidence in the idea of being a graduate nurse. The way that each individual related to others in the setting of choice, is expressed in their phenomenal body.

Embodiment refers, in this study, to the way the senior students *embodied* being a nurse. A feature of the study was that the participants did not yet *feel* a "nurse". The term one participant used was "part student-part nurse" (Anne, 2:13, p111) to describe the experience of being in transition between a student and a nurse within the context of this study. This contrasts with empirico-analytical studies on role theory (Merton, 1968). In the latter view, students of nursing gaining clinical experience in the role of the nurse are perceived as being 'nurses'. They wear a uniform of a nurse and are carrying out the actions of a nurse, all be it as a student nurse, therefore they are a 'nurse'. In this view, they become the role.

In phenomenology, by contrast, the term *embodiment* means much more. Thoughts, feelings, expectations, styles and habits of being a 'nurse' are experienced, that is they are *embodied*. When the experience denies the perceived expectations of the conception of being a 'nurse' by the person, then one is not yet a nurse. Merleau Ponty (1962) when referring to the concept of *embodiment* believed that we come to know a skill or events through not only an intellectual process but through the body. The body is seen as a 'knower'. This concept can be understood in relation to a skill such as venipuncture in nursing. It is the tension or resistance that the nurse gets as they puncture the skin and feel the resistance of the vein wall that becomes familiar with experience. The depth of the needle as it passes through the skin to accurately access the vein, and the actual puncturing process along with the swift movement that accomplishes this, so that the person feels little discomfort, or ill effects throughout the process, is accomplished by an expert effortlessly. Over time, an expert can think about other things during the process of undertaking a venipuncture because mastery is not only intellectual but also from bodily knowledge of feeling and accuracy. It is this knowledge that is said to be embodied knowledge.

The habitual, skilled body also relates to the term *embodiment*. It refers to the way all socially acquired behaviours such as gestures, customs and ways of conducting the self that have been learned confine the way we are in a situation. The term also relates to the way we learn to use bodily skills (Benner & Wrubel, 1989). For example, in this study the senior students were learning ways of being a nurse in context with other registered nurses but they were also learning specific technical skills not only by observing others but 'experiencing' particular skills, in many situations, for the first time.

Embodied intelligence refers to the fact that the body itself is a knower. Embodied intelligence comes into play in all expert skills. Sensations, tensions and feelings involved in fine-motor movement necessary in the performance of skilled activities involve this type of embodied knowledge.

The phenomenological concept of *situation* (Benner & Wrubel, 1989) refers to the influences that are operating within any given context at any given time. For example how we act within a situation will be influenced by our concerns, the information available to us, the issues involved and constraining influences that will restrict our actions and determine experience within a specific situation. This concept, although similar to "environment" goes much further. "Environment" in conventional science refers to a physical boundary, for example the internal organs of the body contained within the skin may be referred to as "the internal environment". In phenomenological terms, *situation* takes into account that we experience our world as an *embodied* person situated within contexts which help give meaning to our experiences.

Variations include *situated freedom* which relates to the way person(s) have of being in situations with others in a network of relationships. In this instance, some choices for action are more possible, as well as being potentially more pleasing, than others. *Situated possibility* refers to potential

opportunities that arise for a person(s) when involved in situations with others through concern (Benner and Wrubel, (1989, p. 412), (Dreyfus, 1991, p. 191).

Heidegger uses the term *comportment* as a way of explaining how human beings relate to people and things within the world around us. "Comportments have the structure of directing-oneself-toward, of being-directed-toward" (Heidegger, 1962/1927, cited in Dreyfus (1991, p. 51). The term *comportment* is used interchangeably with the phenomenological term *intentionality*. Van Manen (1990, p. 181) refers to *intentionality* as a way of describing the "inseparable connectedness of the human being to the world".

These two terms explain the 'how' of being in a situation. We become involved in situations out of our concerns. Our concerns direct our thoughts, emotions, and actions within situations toward people or things. For example, within this study, senior students of nursing adopted a particular comportment within situations out of their concerns to provide safe, client-centred nursing care to meet specific health needs. *Comportment* also refers to the way that we experience our *phenomenal* bodies within situations.

Temporality refers to the way a person experiences the passage of time. In phenomenological terms, time is seen not as a linear sequence of chronological hours, or years, but through history. The past is part of the present and points the way to the future. For example, for the senior students in this study, the past two and one half years is made meaningful by the realisation that the present pre-registration experience is the last clinical practice that they will have as a student nurse. How they comport themselves within the experience is made meaningful by projecting themselves (in their imagination) into the future as registered nurses.

The concept of *concern* when used within phenomenology refers to the things that matter to a person within a situation born out of a deep respect and care for people and the world which we inhabit. It is concern that motivates and guides intentional activity within a situation (Benner & Wrubel, 1989).

In using these concepts within the study, my aim is to provide a description and interpretation of the participants' experience in a way that recognises their situations, their concerns, and the life-world of their clinical practice.

With reference to knowledge that is used to guide everyday activity Heidegger (1962/1927, p. 60,[36]) makes a distinction between discovered and undiscovered knowledge[2]. This he refers to as "covered-up-ness" which he believes to be the 'counter-concept to 'phenomenon'. Undiscovered knowledge is neither known nor unknown, simply because it is as yet undiscovered. Undiscovered knowledge then can relate to a form of "covered-up-ness" to the background of everyday practices in nursing which are hidden. To make visible undiscovered knowledge as it relates to the everyday practice world of senior comprehensive nursing students is therefore my quest as a phenomenological researcher.

The second dimension of undiscovered knowedge refers to things that have been "covered-over" or "buried over". In the latter situation, "covered-up-ness" may be either partial or complete. In the process of discovering knowledge through phenomenological methods, the rationale that underlies ordinary every day practices that has often become obscured can be revealed through speech and therefore, scrutinised and questioned.

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2 Reference : Heidegger (1962, p. 60, [36] - p. 60 refers to the standard English translation of Being and Time (1962) whereas the bracketed [36] refers to a page of the standard German.

Partial or complete covered-up-ness can be the basis of ritualistic background knowledge carried on simply because no one questions the way things are. Phenomenology allows knowledge that is hidden to be revealed through the everyday speech of practitioners through their narratives of their practice. In revealing knowledge that has been hidden in some way, a new appreciation of the importance of specific practices can be gained.

Heidegger (1962/1927, p. 60) also claims that a more sinister form of "covered-up-ness" can exist where knowledge that is known is kept concealed. He calls this "disguise" suggesting that it has its roots in persons not wanting to see the truth.

HERMENEUTICS

Dreyfus (1991, p. 34) has this to say concerning Heideggerian hermeneutics:

> For Heidegger, hermeneutics begins at home in an interpretation of the structure of everydayness in which Dasein (being) dwells... Hermeneutics is the "art of understanding rightly another man's language" and broadened in the appropriate sense [hermeneutics] can mean the theory and methodology for every kind of interpretation. Hermeneutical phenomenology, then is an interpretation of human beings as essentially self-interpreting, thereby showing that interpretation is the proper method for studying human beings.

Hermeneutic phenomenology as a research approach is committed to clear understanding. For this reason, Heideggerian hermeneutics may seem commonsensical, deceptively at-home and simple at times. Hermeneutics is an engaged, profound way of listening where we actively seek to understand. It is listening and seeking an inside-out understanding to shape our interpretation of what is happening.' We dwell in the world hermeneutically, that is, as self-interpreting beings. Our everyday world is captured in our language directly as we live out our day to day lives within situations and as

we interpret our experience in the light of our temporal intentions and concerns.

THE HERMENEUTICAL CIRCLE

The hermeneutical circle is the method used to interpret the text produced from collected data. This is a process where the whole is interpreted and understood in relation to its parts and the parts are interpreted and understood with reference to the whole. The interpretation process is one of constant motion between the whole (for example whole interviews or experiences) and the parts (for example specific statements or events) in an ever returning circle (Heidegger, 1962/1927; Schleiermacher (1977) cited in Reeder (1988, p.207). The aim is to ensure understanding in context and in as much depth as possible.

TRANSFORMATIONS IN THE INTERPRETATION OF TEXT

Reinharz (1983, p. 79) discusses the phenomenological method as a five step series of transformations. These are:-

1. A person's experience is transformed into actions and language that becomes available to him or her by virtue of a special interaction she or he has with another person(s). In this case the other is a phenomenological researcher who creates a situation or context in which the person's inchoate lived experience becomes available to him or her in language. That's the first transformation.

2. The researcher transforms what she or he sees or hears into an understanding of the original experience. Because we can never experience another person's experience, we rely on data which participants produce about their experience, and we produce from that our own understanding. That is the second transformation.

3. The researcher transforms this understanding into clarifying conceptual categories which he or she believes are the essence of the original experience. Without doing that, one is simply recording, and recording is not enough to produce understanding.

4. The researcher transforms those conceptual categories that exist in his or her mind into some sort of written document which captures the essential meaning of specific experiences. That is another transformation. In all these transformations, something can be lost and something gained.

5. The researcher's audience transforms the report into something that is meaningful to them. Phenomenological understanding throws new light on existing knowledge and may confirm it or lead to an appreciation of the world previously taken for granted.

RESEARCH PROCESS

The process was undertaken in seven sequential steps as outlined by Spiegelberg (1976). These were as follows:

1. Investigating the particular phenomenon,
2. Investigating general essences,
3. Apprehending the essential relationships among the essences,
4. Watching modes of appearing,
5. Watching the constitution of phenomena in consciousness,
6. Suspending belief in the existence of the phenomena,
7. Interpreting the meaning of the phenomena.

The use of Spiegelberg's steps guided the research activity in the following way.

1. The study participants' descriptions of their experience were read and reread many times to gain a sense of the whole. This included the process of 'bracketing' (Schutz, 1973 in Oiler, 1986, p. 73) where the reader holds prior knowledge and experience concerning the phenomenon at bay rather than projecting one's own view into the interpretation. Bracketing involves peeling back the layers of interpretation so that the experience can be seen as it is and not as reflected through a researchers pre-conceptions. By peeling back the

layers of meaning, what is left is the perceived world prior to interpretation and explanation. This process brings the experience into clearer focus.

2. Analysis of data included reading each transcript in its entirety to identify particular themes, and then, to seek both similar and contrasting themes in all transcripts through a process of reading and re-reading.

3. Patterns of text using particular words, concepts or phrases that appeared to be related to the particular theme were isolated from the text through a line by line analysis. The outcome of this process was to create constitutive themes. Whenever possible, participants' own words that seemed to be descriptive of the theme were used to entitle it. This was done to stay close to the experience as it is lived and described by the participants (Van Manen, 1990).

4. As relational themes were created from common experiences they formed the overall structure of the experience. As themes emerged, they were then considered in terms of their meaning to the participants in the study. This meant asking and repeatedly asking the question: "But what does it mean to this participant and what does it mean within this context ? Are there others who share this experience and meaning ? It was the raising of questions and the returning to the transcripts that formed the dialogical process between the researcher and the data. This too-ing and fro-ing between the questioning and the answering within the text, forms the workings of the hermeneutical circle in the analysis process (Van Manen, 1990).

6. Relational themes were then looked at closely again through a questioning process to find the structure of the theme. These became the constitutive themes that related to the whole.

7. The overal themes portray the experience in terms of meanings and not just a sequence of events. To just record and report events would not result in understanding (Leininger, 1985). It is the interpretation of the text that lays bare the hidden knowledge that is embedded within it and it is this that results in enlightenment, shared new meanings and understanding. This was both a time consuming and difficult experience. Finally, the essence of the combined experience of all participants was written to form the substantive research report.

8. The essence of the experience "the proving ground" emerged as the central theme and was therefore used as the title of the thesis.

9. A final process of returning to the participants to validate the description and interpretation of the experience was undertaken. A venue for a group presentation of the research report was arranged. The overall thematic scheme of the interpreted experience was shared with the group. The group agreed that the data had been interpreted correctly to reflect the pre-registration experience as they remembered their experience of it. The group became excited as they listened to the presentation and the reflections on their experience created spontaneous discussion and insights were shared among the group. This activity confirmed for me, the researcher, the beneficial outcome that can be gained from hermeneutical Heideggerian phenomenology.

THE IMPORTANCE OF THE METHOD FOR NURSING SCHOLARSHIP

The phenomenological method sets out to reveal the systematic concealings that have occurred due to a dominance of research that has treated student nurses as 'objects' rather than 'subjects'. Treating student nurses as objects rather than subjects ignores the many nuances from being situated in a world that is self interpreted and that gives meaning to the way the students comport themselves within the world of nursing practice.

Nurse scholars have pointed out that the dominant received view in science which has underpinned the medical model for health care and empirical knowledge, has failed to adequately serve nursing as an evolving discipline (Paterson & Zderad, 1976; Donaldson & Crowley, 1978; Benner, 1984a; Meleis, 1985; Leininger, 1978, 1985; Watson, 1985; Munhall & Oiler, 1986; Chenitz & Swanson, 1986; Benner & Wrubel, 1989). Nursing as a practice discipline whose very nature is bound in a social context, lends itself to holistic methods of enquiry to reveal the knowledge that is concealed in practical activity (Benner, ibid; Benner & Wrubel, ibid).

This thesis is concerned with the phenomenological hermeneutical tradition which, it is argued, can bring a unique dimension to the meaning and understanding of clinical experience as part of the total educational experience for the senior student nurse. Knowledge generated through studies using this method of enquiry has the potential to transform educational practices for nursing students. Teachers, clinicians and students alike become excited as they recognise the power that comes from "inside out stories" as they reveal the knowledge that is uniquely welded into a whole by the practitioner, in the practice of the science and art of nursing.

SUMMARY

In this chapter, the study design and methodology has been outlined and the reasons for phenomenology as a choice of method has been explained. Key phenomenological concepts have been defined as used within this thesis and Hermeneutics and the Hermeneutical interpretive process has been described. Transformations that occur as an outcome of the research process as well as the research process itself is explained and the chapter concludes with a statement of the importance of the phenomenological method to nursing scholarship. Chapter Four follows with a description of the study and study participants, settings for the study, ethical considerations in qualitative research concluding with issues of trustworthiness of the study.

CHAPTER FOUR

THE RESEARCH PROCESS

DESCRIPTION OF STUDY

The aim of this study was to explore the lived experience of senior student nurses in the Diploma of Comprehensive Nursing Programme as they worked through their concluding clinical practice in acute care settings, prior to sitting their State Registration Examination. The aim was not only to come to know what it is they do in their practice at this time, but also to elucidate how they perceive their clinical practice from their point of view. Furthermore, I wanted to find out how students use their knowledge and skills to make clinical judgements as they interact with clients in acute care settings in the delivery of safe nursing care.

GAINING THE STUDY PARTICIPANTS

Two group presentations were made by the researcher to introduce the study to third year Comprehensive Nursing Students in two large metropolitan Polytechnics in New Zealand.

The students interested in participating, were given an overview of the proposed study and asked if they would be willing to be involved in the study. The students were asked to contact the researcher privately so as to remain anonymous to the wider group.

Twenty one participants volunteered to be in the study. One participant withdrew after the first interview owing to illness but gave permission for the transcript to be included in the study. Their ages ranged between twenty and forty five years. Twenty were female and one was male. All had concluded the theoretical component of their course and were engaged in a final period of clinical practice within acute care settings.

To meet the criterion for inclusion in the study, students needed to be engaged in clinical practice in an acute care setting. Acute care is defined as the provision of nursing care to those persons that require episodic and time limited measures which are delivered from a health care agency that offers such a service. This would take into account those persons who would enter a hospital for example as a result of an accident. The definition in this study also extends to those who require life sustaining nursing care for example within a haemodialysis unit. Some of the participants in this study had two placements within their pre-registration experience but one of these, was within an acute care setting.

THE PARTICIPANTS

As way of background to the study and to provide the reader with an appreciation of the breadth of the student study participants' experience, a broad description of the clinical setting is provided.

Sixteen of the student participants worked in large acute general hospitals that provide medical, surgical, maternal and child, and psychiatric services to the general public. Three of the students worked in private hospitals and five of the students worked in a mix of public and private agencies. The latter group had pre-registration experience in more than one agency.

The students place of work is shown in the following tables:

TABLE 1

Accident and Emergency Department	6 students	(Private and Public Agencies)
Intensive Care Unit	1 student	
Psychiatric setting	1 student	
Specialist outpatient clinics	2 students	
Paediatric setting	2 students	
Postnatal setting	1 student	
Medical setting	2 students	
Surgical setting	5 students	
Surgical setting and Theatre	1 student	

General biographical data related to the study participants is contained in Table two.

TABLE 2

Mature students	6 students	(commencing nursing education after the age of twenty years)
With adolescent children	2 students	
With young children	2 students	
Previous enrolled nurse experience	1 student	
School leavers		
(Six Form Certificate with grades totalling 18 or less Seventh Form A or B Bursary)	10 students	

Each setting has its own work culture with a variety of work practices and protocols specific to the area. The mode of delivery for nursing services is within teams or individual patient assignment. Student participants were 'buddied' because legally, they must work under the supervision of a Registered Nurse as they are not yet licensed to practice autonomously.

STUDY SETTINGS

The study participants were found in both private and public health care agencies. The settings to which they were assigned included general medical and surgical wards, and specialist wards, Accident and Emergency Departments, Intensive Care Unit and Operating Theatre. Two of the students spent time in outpatient clinics.

INVESTIGATING THE PHENOMENON - DATA COLLECTION METHODS

1. Interviews of approximately one hour duration were conducted with twenty volunteer participants on three separate occasions during the six to eight week period they spent in clinical practice.

2. Interview data were collected by audio-tape and were then transcribed by a confidential typist. A total of sixty-one interviews were conducted and transcribed to form the text for analysis and interpretation.

3. In addition, all participants kept a diary of their experience for a period of between seven to ten days. This diary could be kept at any stage of their pre-registration experience but most kept it within the first two to three weeks. Since writing is thinking (Diekelmann, 1992) it was beneficial to have access to the participants' experience through their own semi-structured, although in many cases thoughtful, written accounts. Significant experiences shared within interviews, also appeared as significant in their diaries. These different sources allowed for some triangulation of data (Kimchi, Polivka, & Sabol Stevenson, 1991) and enabled me, as the researcher, to gain a rich picture of the events and issues as they entered the participants' experience.

4. Between interviews, the researcher would read the previous transcript and any points of clarification or points that needed elaboration were sought. New questions arising from the transcript would be probed at this time in terms of meaning of experience to the participant. It was also at this time, as far as was possible, that previous transcripts were shared and where necessary, corrected by the participants.

5. All interviews were undertaken at a place and time of convenience for the participants. Most were undertaken in their own places of residence with one being conducted in the researcher's home.

6. The interview process began with an open question such as "tell me about your week. What has it been like for you to be working in the ward this week?" Interviews proceeded in a dialogical manner with questions arising to probe the experience to greater depths as the participants described their everyday practices.

7. As the rapport between the researcher and participants improved, so did the flow and quality of the information. When the participants spoke of meaningful events, the flow of the description was powerful and engaging. To reiterate the point, Diekelmann (1992) refers to this uninterrupted narrative of meaningful events in the data collection process as "being in the right region". That is, the researcher has achieved an environment where the participant feels free to relay significant experiences to the researcher because of the meaningfulness of them to the participant.

An example of thematic analysis is included in Appendix D.

EXTERNAL ETHICAL MONITORING OF THE STUDY

As the study involved human subjects, adequate protection of their integrity had to be assured over and above the quest for knowledge. The research proposal was submitted to the Ethics Committee at Massey University. As well, copies of the proposal were sent to the Heads of the two Schools of Nursing from which the participants were drawn (at this time, neither had an Ethics Committee).

RISKS TO THE PARTICIPANTS

In the sense that the study was conducted at the conclusion of their course and close to their final examinations it was a time when it could be perceived as being one of increased vulnerability for the students. Emotional stress begins to mount on two accounts. The first is from the students' longer period of working in the clinical setting on different shifts and without the supportive presence of their teachers, and second, from their pending examinations.

This was recognised by the researcher and all interviews were concluded at least a month prior to the study participants sitting their examinations. Rapport was developed with each participant and a friendly relationship was maintained throughout. In a few cases, when learning needs were identified by the participants, these were discussed and assistance given at the conclusion of the taped interview.

Some of the study participants were known to me as I had been their teacher. From the outset a new relationship was established with the known participants as I had withdrawn from my teaching position temporarily to undertake the collection of data. In this regard, I had no responsibility or involvement in their assignment or supervision while in the clinical setting nor in any further teaching or assessment. This then created the necessary

environment for a different relationship to emerge; that of a researcher and participants engaged in a research process.

THE CHOICE OF PARTICIPANTS

Risk was considered, and measures taken to minimise it, in so far as the study participants were informed at a large group presentation of the intended research and volunteers were asked to contact the researcher privately if they were interested to participate.

This was not only to maintain their anonymity but also, to ensure that no coercion to participate was perceived by any of the potential participants.

INFORMED CONSENT

In addition to the public presentation to inform students of the study and to gain participation, each volunteer was given a written consent form outlining the study and what it entailed for them as participants (See Appendix C). The study was discussed and questions answered before participants gave consent to be involved in the study.

ANONYMITY

To conceal the identity of the participants and maintain anonymity a pseudonym was chosen by each participant. From this point on, the pseudonym was used in all taped interviews, in all interpretation and in all conversations.

As voice is a distinguishing characteristic of a person, all tapes were stored in the researcher's home until the end of the study. Tapes were replayed during the data analysis by the researcher, if there was a need to check the transcript. The tapes were transcribed by a confidential typist and the typist and myself as the researcher, were the only ones to have access to them. They will be erased at the conclusion of the study.

RESEARCHER ETHICS - TRUSTWORTHINESS OF THE STUDY

In phenomenological research, the researcher and the participants are co-participants in the research process. Each relates to the other in a discourse from which comes the research data. The potential for researcher bias in the interpretations of the text is high and the researcher needs to acknowledge and as far as possible, bracket assumptions and beliefs that could lead to interpretations based on pre-conceived ideas rather than being grounded in the data of the study.

RESEARCHER ASSUMPTIONS AND BELIEFS ABOUT STUDENTS' CLINICAL EXPERIENCE

As a teacher of students' of nursing, I have preconceived ideas as to what constitutes good learning contexts in both the classroom and in the clinical setting. These are:

1. The teaching of theory is essential for students to learn the scientific basis to nursing practice.
2. Clinical practice is the setting where the science and art of nursing come together in a unique way as expressed personally and professionally by the nurse in the client-nurse relationship. Experiential learning is essential for the student to integrate theoretical knowledge with the practical knowledge and see the relevance of both for clinical practice.
3. The essence of nursing is expressed in the client-nurse relationship.
4. The richness of clinical practice and the knowledge that is embedded within it is, for the most part, uncharted and therefore invisible.
5. Students of nursing learn a great deal more from their clinical practice than what shows up in traditional clinical evaluation tools used in nursing education curricula.

By acknowledging preconceived biases, I was alerted to these in an overt way in order to assist me to focus on my role as a researcher rather than a teacher and to maintain focus only on the text as expressed by the student participants.

ADEQUACY OF THE STUDY

To ensure that the interpretation of the text would accurately reflect the experience and its meaning for the participants, adequacy is achieved through several different ways. The many quotes from the participants used throughout the research report will assist a reader to appreciate the interpretations made by the researcher and thus be part of the validation process.

Adequacy is also achieved by validating the interpreted text with the study participants as to its accuracy and clarity of meaning as interpreted by the researcher. In this study, the study participants were exposed to the interpreted thematic outcome at the conclusion of the study as well as the interpretive process outcomes at stages along the way. There was general agreement that the study findings were an accurate portrayal of their common experience.

QUALITATIVE MEASURES OF TRUSTWORTHINESS

To establish the trustworthiness of the study, (Lincoln & Guba (1985) and Sandelowski (1986)) provide four criteria that are used as measures for this to occur. These are *credibility, transferability, dependability* and *confirmability*.

Credibility is achieved when the study participants agree upon the findings and interpretations of the text as a true construction of their reality as it was lived.

Also that the findings and interpretations can be appreciated by other researchers who judge the interpretations as being true to the data.

Transferability refers to the researcher giving sufficient detail of the methodology so that another can take the study design and transfer it to a similar situation and come to similar conclusions. This is a difficult criterion to meet as meanings are context specific and often idiosyncratic but, nevertheless, it should be possible for another researcher to study the lived experience of clinical practice of senior nursing students and find similarities with the findings of this study.

The *dependability* of the study is established through an enquiry audit. At points throughout the study, I have met with my supervisor who has read some transcripts and has guided me through the early conceptualisations of this study and the writing of the research report. She has conducted research using the phenomenological method and has a clear understanding of the methodology.

Confirmability is established by way of an audit trail that provides sufficient evidence in the body of the research report to allow the reader to confirm the findings identified by the researcher. Relational themes are illustrated throughout the report by exerpts from the participants' transcripts accompanied by the researcher's interpretations. In this way, the interpretive process can be confirmed by another reader as has been accomplished by a small group of the participants at a researcher presentation of the research report.

TRIANGULATION

Triangulation is concerned with the use of multiple data sources similarly focused to obtain different views about a topic for the purpose of validation.

Denzin (1989) has listed three types of data triangulation, time, space and person. Two of these were used in the study to a limited extent. Triangulation by time was established by having three interviews investigating the same phenomenon at different points within the same experience. Space triangulation refers to collection of data about the same phenomenon at different sites. In this study, the participants came from two Polytechnics and worked in a variety of clinical settings during the study.

SUMMARY

In this chapter, a description of the study, the study participants and the settings where the study took place are presented. Data collection methods are explained and ethics related to the study are discussed. Within the human sciences, phenomenology being one, scientific rigor is achieved in a variety of ways. The trustworthiness of study is achieved through four criteria that have been outlined by Lincoln & Guba (1985) and Sandelowski (1986). Van Manen (1990) emphasises that the research report should stay close to the participants own expressions, hence the use of exemplars throughout this thesis to illustrate the interpretive process.

Benner (1984b, 1985) emphasises that there is a need to limit the number of possible interpretations in order to allow the reader to participate in the process of consensual validation.

The overall study design has been described and methods of data collection, analysis and interpretation have been discussed. By making public the activities related to the research process I am able, as the researcher, to demonstrate that the descriptions given to me by the participants stay close to the lived experience (Van Manen, 1990) and an interested reader can audit the "decision trail" throughout the study (Lincoln & Guba, 1985;

Sandelowski, 1986). Ethical considerations as they relate to human science research have been outlined.

The twenty one participants who shared their experiences with me have contributed to my own appreciation of the lived experience for students of nursing. Their descriptions of their day to day lives have enriched my own understanding of the nursing education process and my practice as a teacher. In describing and interpreting the lived experience of the students I have endeavoured to bring to speech the day to day reality of their clinical practice at the conclusion of their educational preparation to be a nurse. The next four chapters present the findings and the thesis that has been formulated from them, inviting the reader to share in the creative epistemological transformation process as the outcome of the phenomenological hermeneutical method. In doing this the interested reader shares in the validation process which is an essential part of the research process.

CHAPTER FIVE

THE PROVING GROUND

The Proving Ground is the central theme that captures the essential quality of the students' experience of clinical practice. It evolved out of the participants' experience in trying to prove to themselves and to their registered nurse colleagues that they were capable of providing client-centred caring and effective nursing care. This idea has germinated from the many statements which the twenty-one study participants made concerning 'proving' themselves, and their ability to engage in nursing practice.

The attachment of the word 'ground' is particularly appropriate within phenomenological research since it is a term of particular significance in phenomenology. Heidegger (1962/1927) believed that the ultimate 'ground' or foundation for understanding is simply shared practices (Dreyfus, 1991, p. 157).

The idea of 'proving' denotes ongoing action. The study participants dialogue with the researcher began with the raw data from their experiences which were action oriented. The concept of 'proving ground' has a phenomenological theoretical significance as well as an historical one. Both of these perspectives are used to provide the reader with a sense of salience that overarches the entire study. The reader is invited to share in the events that have lead to the constitutive themes and sub-themes that create a rich interpretive description of the gestalt called ***'the proving ground'***. This chapter presents one main theme and four sub-themes which characterize the study, particularly experiences during the pre-registration clinical practice which they came to think of as a 'proving ground'.

BEING AN OUTSIDER - BECOMING AN INSIDER

The over-riding theme for this chapter is ***being an outsider-becoming an insider***. Feelings of being outside the work group initially were expressed by the study participants and the process of entering the work group was described as 'work'. Sub-themes to be discussed in this chapter include first, the ***orientation*** for the students as they entered the practice setting where they would work during their pre-registration experience. The second sub-theme relates to feelings of ***being buddied*** which was part of the process of being an outsider and becoming an insider. The third sub-theme is related to ***acquiring local knowledge***. This sub-theme has two parts; the first is related to ***getting to know routines*** and the second related to ***acquiring additional knowledge*** in order for them to make comprehensible their experience in the setting.

SPATIALITY

Phenomenologically, this chapter can be interpreted within the concept of ***spatiality***. Space here relates to 'Dasein' or a way of being-in the -world for the students on two accounts. In the first instance, the study participants entered a public space, that of a clinical setting, which Heidegger (1962/1927, p. 136-137) points out exists independently of the location of people. In the second instance, 'spatiality' refers to the way the students experienced themselves in the setting in the early stage of settling in (Heidegger, ibid, p. 138). In the latter instance, spatiality refers to the way the study participants concerned themselves with gaining the knowledge, customs, and practices to allow them to function within the setting. An alternative explanation for the latter point could be the Gestalt concept of 'figure-ground'. The students could be said to be constantly turning their attention to the things that appeared most purposeful at any given moment whether it be routines, protocols or language. In this way, what seemed to the students to be most

important took priority over other things engaging both their attention and their energy, in order for them to function adequately as quickly as possible.

The chapter concludes with a brief summary of the significance of these sub-themes to clinical experience as ***the proving ground*** for the study participants.

THE ORIENTATION

It has been customary for students to be given an orientation to a new clinical setting throughout their previous practice. During their course, the tutor usually initiates the orientation for students who are required to become familiar with unit layout, where emergency equipment is kept, and who key people are. It is a time which allows them to "survey" the area and gauge what expectations clinical staff are likely to have of them. The study participants therefore have come to expect that an orientation to a new setting is the 'norm' as they 'find their feet'.

As the study participants entered their pre-registration clinical areas, their first encounters with clinical staff had considerable impact upon them. Student expectation for orientation to the area was not always met. Sometimes they felt welcomed which augured well for a 'good' experience. However, if the student felt that the clinical setting had not given too much thought to their arrival, they were left with feelings of being incidental to the running of the department - a feeling they were very familiar with in their student status.

In defence of the clinicians, students come and go constantly from areas where the central focus is providing nursing care for clients. While such contextual constraints are recognised, at the same time, students appreciated being expected and being made to feel welcome. Being welcomed meant that the students felt that some planning and preparation had been undertaken for their arrival into the practice setting. When staff were expecting them it was

more likely that there would be a reciprocal give and take in the relationships between student and staff within the area.

It was particularly significant when the Charge Nurse was expecting students. Anne tells of her first encounter with the Charge Nurse in a pediatric ward and the welcome she received.

> The first week, a new ward, I had never worked on it before, /../ I found it really good because the Charge Nurse /../ she took us like on this orientation Day - none of the other wards - I don't think had that. She showed us everything - like a real tour - and she showed us videos on CPR and videos on asthma. We got to know the staff - we got to know little things like where the emergency equipment was kept, things like that, which I found really good - and we left probably an hour early - our day was quite short and then the next day we started in to a normal shift.
>
> Anne: 1,1.

When expectations for an orientation were not met, feelings of disjointedness resulted. Disjointedness occurred when the students felt they were not expected in an area and when the Charge Nurse and/or the staff were not prepared for the student's arrival. In these situations, students experienced feelings of being unconnected to the work group they were joining and they had to take responsibility for their own orientation as Patricia explains:

> I felt very disjointed, (it was) not a good time to arrive on a new ward, as people were at lunch and there was no time to give even a little orientation. It was a matter of having to instigate this on my own. Don't think I felt one hundred per cent happy about this, but understand why.....Spent the afternoon orientating to (the) ward.
>
> Patricia: Diary, Day 1.

Part of the work for the student was to engage themselves in moving from a position of ***being an outsider*** in the work group to a position of ***becoming an insider***. Becoming involved in the work that took place in the practice setting is referred to by Heidegger (1962/1927) as modes of engagement. The engagement process for the study participants took time and considerable energy. Study participants spoke of 'work' in terms of energy expenditure, effort, or 'getting my brain into gear'.

OUTSIDER-INSIDER

Initially, students felt and were seen by others as outsiders. Feelings included being unfamiliar with the work place in so far as situation specific knowledge is concerned. The latter included where equipment is kept, the work culture and how it operates, key people and their particular position within the group, important communication points and procedures, and the general routines that are important to the functioning of the work setting. Students explained ***being an outsider*** as a feeling of self consciousness of their 'newness' in the work setting. They were uncertain of the expectations registered nurses had of them. Students spoke of feelings such as nervousness, uncertainty, apprehension, being frightened and scared, being "thrown in" and being name-less. These feelings reflect a comportment that is not easy or comfortable in the context of the established work group.

For instance:

> I felt quite nervous when I entered the double doors of the Emergency Department in the busy "City" Hospital.
>
> Alison: Diary 1.

> I felt a bit 'thrown in' and one of the nurses commented that she didn't think it was very fair for me..
>
> Kit: 1,19.

> None of the staff included me in any individual's treatment and they didn't know my name, or couldn't care who I was or what I was doing there.
>
> Karen: 1,1.

These feelings were compounded when entering a specialist area which was known to be stressful. The specialist focus of the work group made the work even more difficult. Students were very aware of their lack of practical knowledge and what they were able to do. Colleen illustrates her feelings as follows:

> The first day is always frightening because you don't know the staff, and you don't know the routine and because it is a specialised area, you feel very scared and think you are going to do something wrong. It always takes a little while to settle in and to get to know the staff and for them to get to know you and what you can do. It seems to be taking longer in the Emergency Department than other places because I think with the sort of nursing they are doing they [the staff] are very stressed,it's really hard going.
>
> Colleen: 1,1.

An easier entrance to the work group was experienced by Rachael who was working in a mental health specialist team. She was the only participant who felt she did not have to 'prove' herself. Rachael shares her experiences:

> (Researcher and Rachael in dialogue:)
>
> (How have you felt yourself being in that team ? Like you felt at the beginning they were accepting people. Do you think its a process you have to go through, being accepted ?)
>
> Well, I had struck that in other areas in the hospital but not at all here. I'm aware that that goes on and in that respect its been really neat to be in the team because

> you don't have to prove yourself. You just have to be enthusiastic and willing and that's the only criteria that they expect.
>
> Rachael: 3,1.

The team is a multidisciplinary group of experts who work together focused upon mental health. The nature of their work is bounded by specialised knowledge and skills. To compare this group with a ward group that provides a general service for patients requiring a larger staff who in the latter situation, work on rotating shifts, there is less opportunity for the same people to work together day in and day out. Therefore the latter group is less likely to be as cohesive than a group who constantly work with one another over a long period of time as is the case with the specialist group. As well, the mental health team recognise that the student will not develop the specialised skills required to function effectively in counselling in a short space of time, as was the case in the pre-registration phase. It is significant that Rachael did not expect to gain expertise in a short space of time. She recognised inexperience as her main difficulty and was satisfied with her own progress as she reports:

> Without the experience I wouldn't know how to deal with some of the things that came up..//.. its really just inexperience and not the fact that I am a student, if you see what I mean.
>
> Rachael: 3,8.

Rachael points out the importance of experience to hone skills but also recognised that experiences need to be within context. Experience is an important contributor to the study participants' quest to **prove** themselves.

All study participants entered the world of nursing aware of the responsibility that would soon be theirs. They showed a keen sense of awareness that the

most important criterion that they would be judged upon was their safety to practice. This would be constantly tested as they worked within clinical settings and would also be tested in written form in their State Examinations. This then became part of their comportment within the setting. A self-consciousness was evident as the study participants began to embody the 'safety' of professional nursing practice.

Each ward setting or specialist unit created a possibility for a student who was unfamiliar and nervous in the setting to 'do something wrong'. Such an incident could be disastrous for the soon-to-be-registered nurses who appreciated that the pre-registration experience offered both excitement and fear for their future as nurses. Anne thinks about what could happen:

> I'm so scared of doing anything wrong, I'm always checking over and over again with my drugs..//..any little mistake could keep me out of being a nurse forever, giving a drug out that I'm not supposed to or doing something wrong like that so I'm always double checking..
>
> Anne: 2,3.

Connotations of being an outsider extended beyond the immediate work group, to take on a deeper meaning. It included the students' fear that they could be excluded from the profession of nursing. On the brink of entering the profession, a foolish mistake from either not being sufficiently aware or careful, or being guilty of unsafe practice that jeopardised a client's safety, could result in being an outsider to the profession of nursing. To be a registered nurse and join the community of registered nurses was the goal the study participants had strived for in the past two and half years and they were aware of the importance of being careful and responsible.

Buddying is one of the strategies that helps students in the process of ***becoming an insider.*** In this context, a 'buddy' is a registered nurse from the work group who guides and assists the neophyte nurse in his or her initial encounter with the practice setting. 'Buddying' was a short, transitional process which lasted from two days to two weeks depending on protocols within areas and individual preferences of Charge Nurses.

For Marie, her buddied experience lasted two weeks. It was a 'loose' arrangement providing support to the student yet encouraging her to be independent. This kept the self in tact while she tried herself out in the context. Marie describes her experience of being buddied:

> There were two students there, and both sort of buddied with one nurse for the first week and the second week you were put with separate nurses. We are given freedom, that goes with third year students. Probably they do have a bit of guidance which is good..I felt that we were free to look after somebody.
>
> Marie: 1,1.

One study participant was not given a 'buddy'. This is a deliberate management strategy used by some Charge Nurses to encourage the independence of the student. When this occurred, the study participant felt that she had missed out on something. Patricia states:

> I kind of think that I would like to have been buddied..//..I think I would have liked that but this way we've just been included as part of the ward staff and get on with it.
>
> Patricia: 1,2.

Patricia elaborates on the responsibility she feels towards her clients' wellbeing and her feelings of some uncertainty about her ability to maintain their welfare without the support of a 'buddy':

> Even though all the knowledge that we have been learning over the three years is coming together and you think, "Oh yes, I know why I'm doing that now," there's still that thing in the back of your head saying you're accountable and are you doing the right thing, and you are really very aware at the moment that people's health and welfare depends on what you do. You always have this at the back of your mind that if you do the wrong thing you are affecting somebody else's health.
>
> Patricia: 1,2.

The greatest value of having a 'buddy' is that the registered nurse becomes a personal referee. The study participants felt free to approach their 'buddy' on any doubtful issue. They saw their 'buddy' as someone who would support them as they gained independence.

BECOMING AN INSIDER

"Finding my way" (Kit: 1,19) is how one student expressed becoming used to the clinical setting, getting to know routines and developing confidence in their own abilities which all assisted the study participants to move forward.

Feelings that illustrated this transition were identified as a familiarity with specific local knowledge and practice parameters and a willingness to find these things out for yourself.

Anne illustrates this point:

> As a student I found it really hard because you're like an OUTSIDER..//..I was always asking about keys and

> things, but now I know where the Keys are kept where the little things are kept -I know what I'm allowed to do..//..I think it is more you have got to do it yourself if you want to learn.
>
> Anne: 1,26.

To ***become an insider*** there had to be a willingness on the part of both the students and nurses in clinical practice to begin to relate to each other and connect with each other. The students described feelings of being included, being supported, being 'settled in' and being appreciated which were all part of this transition.

> Surprisingly, I'm just about included as part of the team. It's just been fantastic..//....On my second day there, the Charge Nurse came up to the other girl and I and said, "you're doing well, we're pleased with your work" and I can't remember ever anyone saying that to me and feeling that I can now go on with what I've been doing without thinking "Oh, am I doing it right?" On Monday of my second week, the Principal Nurse called us all into her office and asked us how we were finding it, whether there was anything we'd like to ask and told us that they were all pleased with our work and it just makes such a difference.
> If they say things like they're pleased with your work, well they've made me feel part of a team.
>
> Katherine: 1,9.

Katherine's comments illustrate how important it was to her to have some feedback as to how she was faring in the work setting. To receive praise and to feel appreciated were the motivating forces that freed her to continue to practice in the setting with a new found confidence. As she became reassured of her competence, anxiety was reduced and energy was freed up which was then used in providing client-centred care.

It took time and energy to enter the work group as well as familiarity with the staff and a knowledge of the routine. In areas of high specialisation it was more difficult than in some other areas due to specific protocols with which a student needed to become aware. As well, the 'hi-tech' equipment could be unnerving. Kerry who was working in the Intensive Care Unit described the effort involved in this process as 'work' and implies that it was 'hard' work:

> At this stage, I'm still working at being an integrated member of the team. You have to ask, push in, which is OK if it is done tactfully. But having to work at it all the time is hard.
>
> Kerry: Diary, Day 2

As the students gained greater access to the shared world of the insiders, confidence increased.

'Confidence' was a term used frequently by the study participants. Self-confidence in one's abilities and judgements is a pre-requisite to professional practice and, for the study participants, it was extremely fragile. Successive experiences would demonstrate the tentative and fragile nature of the students' confidence in clinical practice. Kerry expresses the concept of confidence as a 'growing' quality:

> It's now half way through my 2nd week. Things are getting better every day. I get to know more staff, get more familiar with the routine and generally confidence grows more and more every day.
>
> Kerry: Diary, Day 1

As an ***insider*** there were multiple ways of being in the practice setting for the study participants. All students had in common that they were keen to extend themselves to their maximum, to 'try themselves out' in preparation for their

post graduate status when they would be expected to work as a full team member of a work group. Being in a position of choice is acknowledged by Anne:

> I sort of think I will try it. I am going to get a work load I'm going to get four patients, I am going to do this and I am going to do that.
>
> Anne: 1,26

The effort had to be made by the students to enter into the work group which they appreciated and did so, for the most part, enthusiastically. A willingness to accept a work load, to participate in the functioning of the work group and an enthusiasm to learn, was a particular way of comporting themselves within a situation that would be an important ingredient in the proving process. An added competence also required of them was being knowledgeable about the local setting where they were working.

ACQUIRING LOCAL KNOWLEDGE

For the study participants, being knowledgeable took place on several levels. The first level was the acquiring of a ***local knowledge*** in order to function effectively in the setting. Local knowledge referred to specific routines and practices carried out that related to a specific setting, for example the routine checks that were done at the beginning of each shift to check emergency equipment in the Intensive Care Unit. The second level was to acquire a ***specialised knowledge*** in order to practice safely in the setting. For example, in a surgical ward, knowing the special requirements for clients who were admitted regularly to have Total Hip Joint Replacements (THJR). In the latter situation, specific practices and procedures related to pre-operative and post-operative care for clients undergoing this surgery were standard protocols agreed upon by the nurses, doctors and physiotherapists. To have this standard knowledge made a person's hospital stay a reasonably predictable

one; facts well known to the permanent workgroup. As an outcome of being informed, staff could share with the client how long they would be in hospital and what they could expect as an outcome of their surgery. This is an important factor for the client who can then arrange their every-day life concerns around their hospitalisation. But for the study participants, this specific knowledge had to be acquired and once they had, it generated the feeling of ***being an insider***.

An example of the effort involved for study participants to acquire knowledge and to be knowledgeable in order to provide a high quality nursing care to clients is given by Alana:

> I'm much more used to the ward now. I sort of know how things run a lot better than before and I feel more confident because I have gone out and read books and actually know what I'm doing and why.
>
> Alana: 1,1.

Alana demonstrates how she has sought out specialised knowledge related to her practice that she felt she needed to care for clients safely within her situation. This was an important part of becoming familiar with the context where the students were working. Students found too, that there was specialised jargon that they needed to come to terms with if they were to communicate effectively as part of the team of nurses and understand how the clinical context operated.

On another level, Alana illustrates an important principal related to self-responsibility for her own learning. Self-responsibility in learning encourages a learner to access resources through self motivation in the quest for acquiring knowledge. For Alana, having to care for clients safely within the ward context has sparked a need 'to know'.

GAINING A SENSE OF PREDICTABILITY

As each study participant was situated in a specific setting be it Intensive Care Unit, Emergency Unit, Ward Operating Theatre or Clinic they became acquainted with local knowledge through involvement. Part of the 'finding out' process was done through the safe guise of 'routines'.

Collins Dictionary defines 'routines' as those activities that are acquired and have grown familiar by mere force of repetition' 'done by rule'. As routines usually involve skills that the study participants were well versed in, students could be independent and work with minimal supervision but as well, they provided both structure and predictability in an often, unpredictable environment. Such routines became part of the lived experience of the study participants. A common routine was the handover.

The hand-over at each shift change, or within a shift, if a patient was being transferred from one unit to another, is a familiar routine to nurses. The handover has connotations of both relinquishing and the taking up of responsibility that is transferred to another in a personal caring way. The hand-over is a time when all relevant information concerning clients, their medical diagnosis, their current health status, interventions that have been done for them and interventions that are to be continued, are passed on to the succeeding staff in an oral report. The handover is an important organisational communication system and requires concentration to avoid missing important information.

It is a time when what work has been accomplished by the preceding staff, is reassessed to ensure completion and the ongoing continuity of nursing care assured for clients through the careful transmission of information. It has also been identified as a time when staff secretly survey who they will be working with and the known competencies of each (Paterson, 1989).

For the students, the handover was a time when they could feel most vulnerable. It was a time when they were visible as students for they wore a different uniform to the staff and they felt that their student status was emphasised. As a student they felt they had less status than the permanent members of the staff. They felt like visitors at first in the context but later, as time progressed, some study participants were able to assert themselves. A few of the study participants felt that they had little status as a student and expressed this.

As the students sought to prove themselves, it was important to them to demonstrate good work organisation habits to show their capability of managing their workload. The handover was also used to put in place their personal systems of work organisation as Therese illustrates:

> If you are not used to the routine, you take notes so I make little notes when I take report - I write in red pen, things I have to do - like he has got a bad wound - so O.K. check wound - dressings - I write all that in red pen and then through the day, before I go to morning tea, I grab the list. I have a look - so right, I have done that, so I cross it off. So you keep tabs.
>
> Theresa: 1,8.

The routine handover provided an important opportunity for students to see who were important spokespeople and noted managerial styles of charge nurses and senior staff nurses. The handover was often a platform for teaching, particularly by the Charge Nurse. In discussing the need for specific disease related knowledge, Patricia points out how her Charge Nurse was able to meet this need as a function of the handover and how effective she found this practice:

> To be able to assess different disease processes, because there were a lot of different ones actually on that ward,

> it would be prudent to have a fairly good knowledge. For example, we all did quite a bit at Tech. about Rheumatic Fever so we pretty well knew what to expect from that but then, you would get something that was quite obscure, you would have to go away and read and look up about it. Our Charge Nurse was actually very good in that if anything came along like that, he gave us a talk about it, at ward report each day. If anything else came up about it, he would get the students and his own staff and get us involved. That was one thing that I thought was really good.
>
> Patricia: 3,15.

The routine handover is the place where work is divided out among the staff for the shift. For the more self confident of the study participants, quite early in their experience, they were keen to gain independence for their own practice. Kiri explains how she used the handover as a way of negotiating an independent workload.

> Ward meeting handover, fairly relaxed. Charge Nurse wants us buddied again, as only second night. Although considerate of her, I find the idea very frustrating, as the ward isn't busy. My buddy and I end up with six patients. As my buddy is also the team leader, I asked her if I could get on with the five patients I knew, and come to her if stuck - she agrees to this. I find it much easier to get stuck in and organise myself if I know what I am doing.
>
> Kiri: Diary, Day 1.

Kiri draws attention to the importance of 'knowing the patient' (Benner, 1984a; Benner & Wrubel, 1989). By knowing five patients, she feels that she can manage their nursing care for herself and she has set up a communication system between her team leader and herself that can ensure client safety. By acknowledging that she may require assistance, her registered nurse team leader also shows confidence in the student and allowed her to have some

autonomy in the situation. This freedom gave Kiri a chance not only to prove to herself how she will manage the nursing care required for her clients, but also how effective were her organisational skills. She also illustrates a desire for independence and a willingness to assume responsibility for her practice.

Routines in specialised areas such as the Intensive Care Unit were far more complex when compared with ward environments where routines can be more predictable. Intensive Care Unit routines required knowledge of technical equipment and specialised skills that could not be mastered in a brief period of time. For Kerry, in the Intensive Care Unit his learning included appreciating the importance of specific routines such as checking monitors, oxygen and suctioning systems. In the highly technological environment of the Unit where a client's condition is both critical and unstable, the need to be able to act quickly in the interests of safe client nursing care is essential.

Kerry asserts both the necessity of being prepared for the unexpected and the value of familiarity with a client. What is different about the unit is that a Doctor is readily available and present at all times due to the critical nature of the work undertaken. Kerry outlines the complexity of the routine checks undertaken in this area and the difference that is noted in having a Doctor close at hand.

> The day starts with report and then people get assigned a patient and they try and follow through with someone they have had before and then its hand over which is quite an in depth one because they have to go through everything in the chart and the nurse has to be confident that she understands every instruction that has been passed on because things do change within the hour you know, quite quickly.....There is always a Doctor in the Department so if anything goes wrong or anything needs to be changed you don't have to hunt for doctors which is different to other wards. Then we do our checks and you go through and you check your machines, you

> calibrate them, making sure your systems are working, you've got oxygen flowing, you've got everything, you have an Intubation tray....because when you need it you need it in a hurry so it is all set out.
>
> Kerry: 1,1.

Routines served an important time-management function which included drug rounds, washes for clients, dressings at four hourly intervals, handover times, and documentation as previously described by Paterson (1989) when referring to registered nurses in the New Zealand work context. Like the nurses in Paterson's study, the students used these sign posts as a way to gauge their time management and had personal systems of organising their work to fit time slots.

Alana's Diary illustrates how she makes sense of her day.

> report
> recordings
> drugs checked and handed out
> regular recordings on two post-op clients
> 2 hrly BMs on unstable client post-op
> 1 post-op client nauseated, vomited twice,
> stayed with them for reassurance.
> Washes
> more recordings & drugs
> CWSM checks [colour, warmth, sensation, movement]
> report (written)
>
> Alana: Diary, Day 2

In ward environments, routines provided not only predictability but, once mastered, less personal effort and energy expenditure.

Alana states:

> If you work in a ward for a long time things become routine, you just do them without thinking about it.
>
> Alana: 2,7.

Routines provided an opportunity to use initiative, and to show usefulness and helpfulness and provided some autonomy important in developing independence. Alison shows how a routine practice assists her feelings of independence which was an important part of the proving process:

> I restocked the ENT trolley and theatre using the appropriate list. This was able to give me some autonomy and I could get on and do it without too much bother.
>
> Alison: Diary, Day 3.

Knowing the routine assisted the study participants to have a sense of purpose and gave them some control over themselves in unfamiliar territory. In this way, they felt included as students, and began to merge with the work group. A visible barrier that almost all of the study participants commented upon was that of wearing a student's uniform. The student uniform acted as a constant reminder that they were different to the permanent members of the work group.

The repetitive nature of doing the same things brought with it a sense of security, predictability and feelings of familiarity. Once routines were grasped the students felt some control over the self and a sense of belonging. This meant that the study participants could relax a little in their clinical setting. The demands of the work organisation took precedence over the ideal of working with one person exclusively in a person-centred relationship. That is doing things with and for people when it suits the person. Working with a

number of client's and working with others in a team situation taught the study participants that demands in their everyday practice require some order to the day to be maintained.

The ***essence*** of Chapter Five is that the study participants gained a sense of some predictability in a constantly changing environment. Routines served a greater purpose other than providing structure and process of each day. Once a routine was learnt it gave the study participants a new found security and freedom. Freedom from feeling less useful in the situation than their registered nurse colleagues, but also freedom to choose the 'how' of their comportment within the situation. Knowing the routines provided the possibility for them to create their own routines. Their routine was self-initiated and therefore became more meaningful to them. It was a 'thinking' way of organising the self, born out of a desire to prove themselves competent in coping with the demands of the work place but also, their concerns for being in their situation. The students chose a particular way of ordering their practice that grew from a beginning awareness of their own capabilities and the desire to provide continuous care within an ongoing client and nurse relationship. Jenny shows this stance:

> I'm prepared to take on a bigger workload because I feel more comfortable and more confident. But basically when we have our report and we find out what's wrong with everybody and what everyone needs and I just go back to the previous day's work and I see if there is somebody that I have been nursing from the previous day and often I'll pick one that I've already had because I like to be constant, and clients like that. They like to have the same nurses each day.
>
> I pick my workload and its something that you can deal with during the whole of your shift so that you are not getting everything all at once.
>
> Jenny: 1,5.

The importance of placing a person within a work schedule is emphasised by Jenny. She says she likes to nurse the same person and they like it too. She is not unaware that she has to organise her work but she has learnt to pace herself. She states "I pick my workload and its something that you can deal with during the whole of your shift" (Jenny: 1,5). Jenny has gained personal insight as to the 'how' to manage her practice but she does so with her clients in mind.

The essence of being accepted into the group, becoming familiar with the routines and meeting expectations of the staff in the setting in terms of meaning to the self was that the study participants were able to feel that they had some independence within the situation.

As self interpreting beings in the shared world of nursing practice and having been educated to become autonomous practitioners within their programme, the students were keen to try themselves out as decision-makers and self governing practitioners within the legal limits of their situation.

Sally captures this essence in her statement as follows:-

> The more familiar with the expectations and routines,
> the more decisive you can be.
>
> Sally: 3,7.

It was important for the study participants to feel independent yet they recognised that they were interdependent as they began to identify with their registered nurse colleagues. Their registered nurse colleagues were important supporters as they accessed the path to the proving ground.

SUMMARY

This chapter has focused upon the themes that conceptualised the feelings of the way the study participants entered the work culture. They had experienced these feelings in the past as they had moved from setting to setting throughout their course, but this time, it took on a more purposeful quality for it was crucial to gaining access to the proving ground. This was the ground where they would prove to themselves that they could nurse. This was what they had both aspired to and had been prepared for through their education. In proving to themselves that they were capable, they also proved themselves to others.

The process required 'work' on the part of the student and they were aware of this energy consumption which, when included as part of the many pressures they were facing, could be considerable.

A hallmark of this study is the willingness of the students to be involved in the many experiences offered to them. In this way a situation was created in the context for new understandings and new possibilities for their learning and thinking to show up.

Finally to gain a sense of routine assisted the study participants to gain a sense of connection, usefulness and security in an uncertain world. It was through the repetitiveness and predictability of routines that the study participants began to develop some confidence in themselves but this was not the only factor. Knowing how the local setting functioned gave them some control over themselves. They could become more decisive in 'how' they were in the setting. There were many other factors that would extend the margins of their growing confidence. Chapter six focuses upon these factors.

CHAPTER SIX

DEVELOPING A SENSE OF WHAT IT MEANS TO BE A NURSE

This chapter continues to unfold the process and adds another dimension to what it meant for the study participants to be in their pre-registration experience as they sought to prove themselves to the self and others, to show that they were capable of being the nurse that they aspired to. The central focus of the chapter is developing a sense of what it means to be a nurse.

There are six sub themes related to developing a sense of being a nurse. The first focuses on the meaning of ***becoming connected with others*** in a world of relationships and being constituted by the work group, the second addresses the significance of ***being given responsibility***, the third ***helpful and unhelpful experiences*** and what this meant to the study participants in their practice. The fourth sub theme is ***becoming entrusted*** with the care of clients which then led into the fifth sub theme, a ***freedom to embody nursing practice.*** The sixth and final sub theme in this chapter is the experience of ***being part-student-part-nurse***.

INTENTIONALITY

The phenomenological term 'intentionality' refers to the way we "are directed towards" or relate to others in a shared world of relationships and human activity (Dreyfus 1991, P. 51). This world that we all live in is a relational one, dominated by people. For the study participants, those with whom the developing professional self required that they negotiate relationships, included other nurses, doctors, patients and allied health workers. The study participants learnt about themselves and in turn, others learnt about them as they became more in tune with the work that was carried on in their clinical settings and became familiar with the staff and the common routines of day to day practice. It was through the day to day encounter and the familiarity

with what constitutes the meaning of being a nurse that the students became constituted and in turn constituted by the work group where they were situated. As they worked with others they became connected to the workgroup.

Becoming Connected with others

Benner & Wrubel (1989, p. 408) define the phenomenological term 'constitutive' as "descriptive of the way people become involved in situations so that what they experience in those situations, changes them and their personal meanings." The study participants worked in the shared world of clients, clinicians, doctors and other health care workers, and in doing so, they defined the situation for themselves in terms of meaning for the self. Their central concern was to gain a sense of belonging in the work group, in order to seek opportunities for caring for clients. A process of involving and engaging the self was undertaken to accomplish what was most meaningful for them.

In most situations the students worked within a team concept. The team has been defined as a group of nurses both male and female, registered nurses and enrolled nurses who were responsible for a number of patients reporting to the Charge Nurse and the Medical Staff, the latter having the ultimate responsibility for the health status of the patient. There may or may not be a team leader, but generally the group work together in a co-operative fashion to achieve the goals of providing nursing care for a number of clients.

Within the team the students sought independence both to prove themselves in the situation and to prepare to be a professional person. However, they were constrained by two factors. The first was that there were legal constraints on their practice for as yet, they were not licensed practitioners. Second, they were dependent upon the group for opportunities that would

allow independence to develop. A careful strategic pathway needed to be worked out between the students and the staff for them to gain access to clients in order to care for them on an individual basis. This privilege had to be earnt.

Working at relationships

The work of becoming a team member was purposively negotiated as the study participants recognised the need for the support of their Registered Nurse counterparts if they were to achieve their own goals. They therefore put energy into personal relationships first. This is expressed by Theresa.

> I talk more - try to be more amicable, I want to get more out of this.
>
> Theresa: 1,19.

Feeling part of the team brought feelings of enjoyment, an air of relaxation and an opportunity to be oneself. Colleen states:

> I suppose you can sort of see yourself as you become more comfortable in the area you are working in. You can carry out the work much easier. You know what to do and it gives you a feeling of satisfaction after you have finished the day that you have accomplished something. It sort of feels like you are doing real work, like you've done a day's work in the sense of your profession, like a professional person.
>
> (What do you think has brought that about, that feeling that you are doing real work ?)
>
> Well you do things with more independence and see what needs to be done and go and do it..//..You are making a few jokes and you are chatting to the other staff and you know, more relaxed in that manner so you

> can bring out more of your own personality in your work and with patients as well.
>
> Colleen: 3,1.

The organisation of work in terms of workload and time management, was an issue with the study participants as they wanted to prove that they were capable of making a positive contribution to the work of the team. Patricia expresses the importance of time management recognising that it is through her registered colleagues that she gets the chance to try herself out.

> When it came to work loads on the ward, I felt for me, it was important to have as heavy a work load as I was able in that ward setting, just to show me where my time management was, and how I was at coping with a full work load. And the staff really trusted us - trusted me enough to let me do that, as well as all the cares for people within that ward.
>
> Patricia: 3,2.

Although there was a willingness on the part of the students to take a full workload, the situation did not always allow this to happen. Patricia continues...

> I think I coped with the work load quite well, but there were times when it was quite slow in the ward.... It wasn't as heavy at times as possibly I would have liked, so I think that my time management skills weren't put to a totally honest test, because the maximum patient - pretty well any of us had, even the staff nurses was about four or five at a time. The load depended on the disabilities of those people.
>
> Patricia: 3,2.

For Patricia, as she sought to try herself out with what she had hoped would be a full work-load, her intentions were unable to be realised because of the

situation that she found herself in. The demands of client care in the context were less than she had hoped for and therefore felt denied of the opportunity to challenge the self. Patricia is becoming aware as a developing nurse of the importance of being able to assess clients' abilities to self care and their degree of independence is an important factor when allocating work load. A staff nurse may have few clients' to care for but the intensity of that care determines the workload rather than simply a numbers game.

Being a team member meant that the study participants could gain a sense of being part of a whole, experience feelings of being connected to others, to feel and experience the culture of nursing and share in the work to be done. Alana who is working in a general surgical ward expresses the way she works within a team:

> We do work as a team together for certain patients and everything is sort of shared, the workload, which works out quite well...
>
> It gives you time management because you have to work around other people and everything is worked out on times, like drug rounds and recordings, so you work around those things. Things like lunches and breakfast and ward rounds and that gives you time management as well, plus you have got a lot more patients to look after because you are really looking after nine patients, (usually between three people) but you are just getting a bit of help. And then you also have other people that you can sort of ask for help. You are directing people to do things as well...you have to know what you are talking about.
>
> Alana: 2,1.

Alana reiterates the thoughts of Heidegger (1962/1927) who claims the ultimate ground for being-in-the world are 'shared practices'. Alana referred

to shared practices as a means of learning how to be a nurse. For Alana being a member of a team taught her that she had to consider not only her patients but also her fellow nurses and their clients needs also. This meant sharing the care of certain patients and working in an organised pattern so as she could co-ordinate with others in a way that was recognised by them as acceptable practice. It also taught her that it was acceptable practice to call on others for help if necessary and at times one becomes a manager of situations. To be an acceptable team member, she needed to be conversant not only with patients and their diagnoses and the care that each required, but also with the normal pattern of working to a time oriented system of nursing care delivery. As well, Alana needed to acquire the language of the nursing group if she was to communicate effectively within it.

Language is a distinguishing feature of a culture and is the vehicle through which a culture is transmitted.

Language referred to here is not the specialised language that has been referred to in the previous chapter acquired to make their experience comprehensible, but a working language in order to meaningfully communicate as a member of the nursing group. That professions have a specialised jargon is a characteristic of their specialist preparation. Nursing and medicine have their own language and although the students have accumulated a certain working knowledge of this jargon to date, there were still many medical, technical and medication terms with which they were unfamiliar. Because of their involvement in the work of the group, language was something which they needed to grasp. For the opportunity to prove yourself to others one needed to be able to communicate meaningfully within the context. Amanda who worked in a general surgical ward where a common surgical procedure for male clients was a Transurethral resection of the prostate gland illustrates this point:

> One of the things has been finding out what the abbreviations mean, and another thing is learning the cares around, the through and through. They call them through and through. (Surgical procedure). I like being busy but also to learn because when they (clients) come back from theatre, like the different bags they have up and where they go, its all so different and it would be good to learn how to work around those, so to learn and keep busy I guess.
>
> Amanda 2: 1-2.

The term 'through and through' was an oversimplistic term that hid for Amanda the complexity of a nurse's work in caring for a client post transurethral prostatectomy. Amanda identified the need to be familiar with a procedural language called 'through and through' but she recognised that language is only part of the whole. She also recognised 'through and through' was a complex surgical post-operative irrigation method for maintaining an unobstructed urinary passage. Amanda links the language to busyness. The study participants needed to know the language so that they could 'do' what was expected of them. They have also learnt that one must 'do' if you are to be appreciated as a nurse. She states that 'it is all so different' identifying the struggle she had to learn to think and to act simultaneously as the meaning of 'through and through' became a lived reality as she translated its meaning into nursing care.

In specialised areas, common procedures and equipment were labelled by acronyms. For permanent registered staff in an area, acronyms become common place but for a student entering a specialised area, the language could be mystifying. Kerry shows how he learns the language as he became involved in the work of the Intensive Care Unit.

> Depending on how many arterial lines there are, they always have this line with this bag of saline and its

attached to a bag, a bag which is pumped up to 300 pounds or something, I'm not sure what the measurement is, and its always tucked up and I thought that was really quite freaky but when you thought about it, its not really, so that was one piece of equipment that was no problem after the second day, I got used to those...//..because this guy, he's having the CAVH..

(What's the CAVH ?)

Don't ask me that - continuous something.

(It is not CAPD)

It is not CAPD, its not, it is different, it is different all together, its continuous aortic venous something. I'll look it up and tell you.//..they have got a big profile on it because it must happen a lot, they must do it often and its, its gone out of my head.

Kerry: 2,9

The ability to speak a language lags behind comprehension. Kerry shows he partially understands the procedure for what the letters stand for and can discriminate between one procedure and another but he has not yet grasped the correct understanding of what the letters stand for. He also states that he will 'look it up' for the researcher rather than ask. As thought and language are closely linked, and a specialised jargon distinguishes one group from another, to ask is to identify oneself as the new chum to the group. At this particular time, when one is most vulnerable as one jostles for position in the group, to 'look it up' protects him from the eyes and ears of the group members and does not draw attention to his newness. It is also risky, since he may not find or adequately understand written information, or learn about specific aspects of the condition as managed in this particular setting.

Kiri shows how she has acquired the language of the medical speciality that organised her way of being in a surgical ward:

> The majority of patients are elderly because of the community..// there's a lot of Gyney [Gynaecological] type work and, they do a lot of TURP'S [transurethral resection of the prostate gland] here.
>
> Kiri: 1,2.

Acquiring the language used in the area of work meant the study participants could communicate meaningfully in a world of shared meanings and understandings which facilitated their connection to it but also so that they can be a 'doer' within it.

"Doing" provided experience and therefore was of value to the self for increasing competence but also it was an overt expression of one's worth in contributing to the total work load of the ward. If one was a 'doer' one was more popular with team members therefore more acceptable to them. From this position, opportunities for experience were offered to them by the registered nurses. On accepting opportunities as they were offered, a wider range of experiences were opened up for the study participants which in turn, brought increasing confidence for them in their own abilities.

Alana illustrated how she perceived quiet times in her ward as opportunities:

> If there is nothing to do, you help the others, I might even swap teams if I feel that one nurse has too much work and you don't.
>
> (How would you gauge if a team's work load was light ?)
>
> Well, you might ask around if there is anything to do..mainly to see if anyone needs help..//.. You are

> learning a lot more because you are not just with the same patient on and on, you have got a bit of a variety.
>
> Alana: 2,2

Variation meant that one could learn a lot more from being helpful to others in the team when work loads were uneven. Alana demonstrated a need to extend her learning about clients both in their medical conditions and their nursing care. As a student, Alana's approach to being in the clinical setting was a place for 'gathering knowledge and skills', whereas full involvement as a nurse (yet to come) would require that she appreciate a person's individual needs for different levels of professional care.

Working in a team with regular staff members, students both gave and received help, recognised that others had expectations of them, but also learnt that help was proportionately given and that one needed to be selective about whom one could approach for help. A number of the students talked about the pressure they felt from staff who expected too much from them. A position such as this arises out of unclear expectations from both the registered nurses and the student for each other. Alana discusses staff relationships:

> The staff are generally very helpful... but, they seem to expect you to be able to do everything. If you feel that you can't do something you ask. They will help you once and the second time they might look at you a bit funny because they sort of expect you to pick it up straight away. Some nurses just let you get to it, put you in the deep end sometimes, and you feel you can't ask them again. You might sort of go to another nurse that is not even on your team. ..// If you know that you get along with a nurse, then you will go back to her and ask her. There are some nurses that put you off, that expect too much of you.
>
> Alana: 2,5.

Differing relationships with staff were related not only to the personalities in the group but also in the type of work that was going on in the situation. Busy critical care units such as Intensive Care and Emergency Departments, meant that the study participants appreciated that the focus for staff in these areas was first on sustaining life and as students, they must take second place. They accepted this but also knew that if they were to prove themselves in the situation, they must assert themselves albeit diplomatically, just to let the staff know that they were about.

Alison discusses her perception of this process:

> I think you had to keep on making them aware of your presence because they are in such a highly skilled area - and it is busy - and sometimes they tend to forget that you are there -
>
> Alison: 3,11.

> In the beginning I was probably kind of - not pushing myself to do things - a bit reserved - in what I could do or couldn't do - but by the middle of it, I was starting to push my way into different situations and to get involved and to learn new skills - and I think that is what made me feel good about myself - and helped in my relationships with staff and clients.
>
> Alison: 3,6.

Alison points out that as a student in the Emergency area with life and death encounters by staff a part of every day practice, that she does not expect to be the main focus. She is also aware that she has her own learning goals to achieve and that she must be self assertive to meet her own goals. Over time she recognised that unless she herself makes an effort, it was unlikely that her learning needs would be met. Becoming involved is what made a difference to her in her relationships with self and others. Her self esteem was enhanced

and from then on the way she comported herself within the situation changed her way of being in the situation. This in turn brought about a reciprocal change in others.

Early in the experience, the staff directed the study participants to do tasks, and they felt that they were just an extra pair of hands. Most did not comment upon this but some did. Colleen called this 'just doing things', she states:

> The staff say can you do this or do that, he's busy, who needs help, you are just doing things - doing heaps of running around - ..//.. I'm doing things that somebody else has told me to do. You know, that sort of struck me the other day, that's what we are doing mostly - its things we have been directed to do.
>
> Colleen: 1,11

Colleen is questioning the way she is in this situation because her intention is, as a student in her final clinical experience, to pursue her need to show to herself and others that she can nurse. Being directed by others to meet the needs of the practice area rather than her own practice needs made her realise that her own needs were secondary within the situation. This has the outcome of her becoming aware of herself and to the 'how' of her being in the situation. With self awareness, Colleen was later able to understand the meaning of her feelings as expressed in the following extract:

> [At the beginning] You feel very unsure of yourself, like feeling unconfident with what you do. I suppose it is like getting to know someone, getting to know another person, getting to know what you are meant to be doing in your role and where you fit in and what you have got to do and feeling that you're not going to make a big blue or do something terribly wrong. So that

> feeling of just being much more relaxed and being able to do things well.
>
> Colleen: 3,1.

Colleen reflected on her earlier feelings and recognised her uncertainty in the situation was partially due to her being unfamiliar with what was expected of her from others but also from what she can expect of herself. This resulted in a feeling of being 'unconfident'. As time progressed both issues were resolved as can be seen in the following extract:

> I've got to know the staff a lot better and they know me. They seem to be interested in me more than just the job sort of thing which in turn helps you to show your own individuality within the job and how much you can get out of it. I enjoyed it so much more last week and this week, much more than I have before.
>
> Colleen: 3,1.

Colleen shows the true meaning of feeling relaxed within the situation because she feels valued first as a person, and then, as a nurse. The result was that energy that had been drained through uncertainty was freed in order for Colleen to be open to possibilities that did arise within the situation. Recognition by the staff were important ingredients in the proving process which, for the students, resulted in feelings of greater independence. Colleen continues:

> Last week, on afternoons, I had a lot of feedback from the staff for things for my duty, like at the end of my duty, "thanks a lot for your help, you've been really great" and that's like from the nurse I worked with and they've told the Charge Nurse that was on. When I left, she said something about "you know you've done really well tonight", and I felt like I'd proved myself so therefore I could go on and act more independently and

> instigate cares rather than just taking from their direction.
>
> Colleen: 3,2.

Helpful and unhelpful experiences were experienced by the students within their situations and it was the staff relationships that made the difference. An helpful experience was seen by the study participants as one where they were given responsibility for client care and although uncertain about their own capabilities, were keen to meet the challenge. They saw these experiences as important parts of their developing competence but recognised that they needed registered nurse support. Certain staff members were seen as key facilitators in this process and were highly valued in the study participants eyes. Helpful staff contributed to feelings of self confidence and being appreciated. Kerry who is working in the Intensive Care Unit, states feelings related to staff being supportive and the difference that it made.

> There are three staff who I get on with well and give me the enthusiasm to participate and they make the shift an enjoyable one..
>
> Kerry: Diary, Day 3

> I enjoy working with them - there was teamwork - good communication, they give me responsibility and I was able to make decisions on my own and that was great. I was doing my own assessing and interventions for what I was able to do and then if I was still in doubt, I called them. They made me feel more than just a student for a change. But that only happens with some staff - not all...When the staff are helpful for us to learn- its great.
>
> Kerry: Diary, Day 10.

Enjoyable days were days when the students felt that they had achieved something meaningful to them. Conditions that contributed to these feelings

related to caring for a patient with whom they were familiar, having a degree of autonomy in their practice and working with supportive registered staff. Kerry continues:

> Again looking after the same patient. I was a lot more confident today because an ICU staff nurse was in the same room and so it was easier to obtain help. I seemed to take a more active role in the doctors' round today.. Because I was familiar with my patient, it was a lot easier to follow care. I felt I could give drugs etc. safely. I felt more confident. Sometimes my planning went out the door and things got behind and some minor problems arose, but the staff never seemed concerned so in turn I didn't get too worried if I forgot something at the right time - as long as it was done and documented.
>
> I enjoyed my day - I felt I achieved a lot again.
>
> Kerry: Diary, Day 5.

Kerry also relates feelings concerning unhelpful staff:

> I felt my staff nurse was not happy to do that tonight [be helpful] and if I have a choice, I may not work with her again.
>
> Kerry: Diary, Day 3.

Helpful staff appeared to have a quality recognised by the study participants. Kerry continues:

> [What are the things do you think that make the difference with those staff that you enjoy working with ?]
>
> I think it is the fact that they are comfortable with their own level of knowledge and their skills and so if they are comfortable with those skills then they are confident to let you carry on.

> They let you do your own things, make your own decisions and do your own evaluating,that's basically it. If they are uncomfortable with their own skills then they are unwilling to give you any responsibility..//..
>
> Kerry: 2,11-12.

Kerry points out characteristics of staff who appear to be best suited to be the 'teachers' as clinicians. They have qualities that show that they are secure in their own knowledge and skill and because this is so, they are willing to delegate responsibility that is carefully considered to students. In turn, the responsibility when delegated is accepted by the student but it was recognised that he or she was not alone and can call for assistance if needed. The autonomy of practice that developed out of this situation for the student was highly valued and was the means for a student to 'fly solo' in safe conditions. It was this experience for Kerry which was the most meaningful.

It also demonstrated that Kerry sought the conditions in his practice that he was most used to as a student, that is, learning opportunities by way of supportive teachers in a safe environment. It was also an indicator of being not yet ready to 'fly solo' as an independent practitioner particularly in the highly specialised area where he was situated.

Unhelpful experiences were also relayed by the students and had the effect of creating feelings of being undervalued and powerless to express their concerns. The study participants cited several occasions where they felt they were "put upon", that is, asked to do things simply because it was not a pleasant task and their registered nurse counterparts did not want to do it. The students knew that this was a game playing situation, but as students, felt no right of redress. Being placed in the situation, they had to use their initiative to get through it. These feelings were illustrated by Theresa on one such occasion:

> I was at the desk, and the Charge Nurse was asking me to do something, and then another Staff Nurse interrupted and asked me to take his client to the toilet, and I said sure because he was obviously busy, I thought - and I walked into the room and there was faeces from one end to the other - this gentleman was confused - and I had to get him up myself onto the chair into the toilet - and then the Staff Nurse that was looking after him didn't want me to shower him - but I said I am going to because he is a mess, it was just everywhere. So I put him in the shower, showered him all up - fixed him all up and then went back to his room, fixed up all his bed because that was left - the person that was looking after him had seen the mess, but just walked away from it.
>
> Theresa: 1,20.

The Staff member displayed a stance of being uninvolved with the care of his client and used Theresa as the student to attend to his client because of the unpleasant nature of the task to be done. Theresa, as a student, was perceived by him as having no status or power to refuse his order. Benner & Wrubel (1989) would say that this is an uncaring action not only for his client but also toward Theresa. Theresa showed that she was concerned for the client out of respect for his humanity more than having an unpleasant task delegated from another Staff member. The difference between the two staff members is the way a person is perceived by the nurse. The staff nurse saw a task that was not a pleasant one, Theresa saw a person who was experiencing the indignity of being covered with excreta and recognised that if the client was not confused, he would be extremely upset and embarrassed. Theresa's caring action is born from the latter.

Theresa continues:

> I agree with team nursing and I will do anything for anyone if they are busy - but I don't particularly like it

> if they are aware of that situation and they just palm it off, because they are too lazy and they can't be bothered or they don't like doing that - but I mean I didn't mind. At least, the client got a good shower - I am sure he felt better.
>
> Theresa: 1,21.

Students lived and worked in a world with others and were connected to others in the context of their practice. Being a student in that world also meant that one had to prove themselves to others. The proof of ones capability was related to what "you could do" as portrayed by Colleen:

> You have to show what you can do before you are given any responsibility.
>
> Colleen: 2,1

Part of a trust that would develop between the students and the staff as they intermingled with each other in the work group came from the students having passed 'the test' with the staff. Fundamentally, this test was 'safety to practice'. Testing took place as a covert activity by registered nurses and was portrayed by Patricia as 'watching':

> When they [the staff] realised we were 3rd year students there was probably one or two, who were not testing, but were watching, probably to see how we reacted in given situations and once they realised that we were safe their attitudes seemed to change and they included us and it was really good. They have been really supportive.
>
> Patricia: 2,2.

Patricia states that once the staff were convinced that she was safe, attitudes changed and she became included in the work team. The registered nurses in the group would not be happy to entrust their clients to any student

particularly when they had the overall responsibility for the student and the client.

Normal group behaviour as new members enter an established group, is the assessment of a person's strengths and weaknesses, but in nursing, where the stakes are much higher due to the nature of a nurse's work with human life, it becomes more important to assess a new member's capability in the interests of safe nursing practice.

The significance of getting to know the staff, accepting responsibility, and being accepted into the work group was that the students sought and gained through the opportunities opened to them by the staff, their own clients to care for. This was an important factor for the students in the proving process. It was within the client nurse interaction that they could prove to themselves and to others that they could provide client-centred safe nursing care and be the nurse that they aspired to become. Opportunities were more readily available for some students than others and part of the reason for this was that staff in the work group were still undergoing the assessment of the student's capabilities. Theresa showed not only that it had taken time for her to gain opportunities to care for her 'own patients', but how she created her opportunity:

> I hassle them, what can I do ? Will you let me do something ? I am always showing them that I am keen to do whatever they want me to do. Over the course of the weeks they have just started letting me do a lot more now, so I have got my own patients and do everything.
>
> Theresa: 1,1

The willingness that Theresa showed in the context was an important part of being given opportunity to prove the self within the situation.

The importance to the students of being given their own patients was that they knew that they were trusted by the staff. Sally called this process ***becoming entrusted***.

Becoming entrusted was more than just having responsibility given over to her. It was a covert expression by other team members that was interpreted as a positive sign that the student was meeting unspoken expectations. It had a connotation of competency and a feeling of being a colleague. Being entrusted meant that the student was given a certain number of patients to care for and that the standard of nursing care provided by the student was acceptable to other team members.

Being entrusted acted as a morale booster, for it not only confirmed to Sally that she was meeting expectations of the team but also, it meant that she was able to extend her boundaries of her practice wider by being given more patients to care for. The meaning of these acts were that they contributed to a growing self confidence. Sally illustrates the theme of being entrusted:

> I think having been allocated certain patients, to care for, I have sort of been entrusted with them really and no-one has challenged that trust, or checked up whatever. It seems to have been accepted that I am capable of looking after those people. Obviously people would have come on behind me on the next shift and would have been aware had they not been adequately cared for so it is quietly morale boosting, to know the next day that you have been given the same patients or more patients to care for in the same manner. I have been assured by many of the staff, that I would certainly have heard had I not done what I was expected to do. I think that in itself gives you confidence.
>
> Sally: 3,7

Being entrusted was a three-way experience, that is, it included the registered nurse, the student and the client. Fundamentally, it was the client's well-being that was the valued entity which was being entrusted. Things that are not valued may be ignored, left unattended, given away carelessly or discarded. Only things of value are entrusted or placed in the trust of another. To have clients entrusted to Sally for her nursing care meant that she could feel that she was not only meeting expectations but she was also valued for her contribution as a member of the team.

Being entrusted also meant that the study participants were given responsibility dependent upon the setting they were working in and the appropriateness of the delegation. For example, legal limitations upon practice meant that responsibility delegated to the students by registered nurses was carefully balanced.

Rachel who is working in a specialist Mental Health team expresses her feelings as an outcome of being given responsibility.

> I feel content within the team and I also feel that the two Consultants are willing to put responsibility on me. They've seen that I have responded well in those situations and so each time I'm with them, they give me more responsibility which is really good and that built me up and made me feel really good.
>
> Rachel: 2,14.

The giving over of responsibility by the staff and the taking up of responsibility by the student, created a reciprocal relationship between nurse and nurse. This meant that being 'the student' began to lessen and the nurse could begin to emerge in preparation for the staff nurse that they would soon become.

Not all the students felt that they were ready to take up the responsibility of acting in the staff nurse capacity albeit prematurely, nor did they appear to be thought to be ready, by the registered nurses with whom they worked.

The students themselves perceived this lack of readiness. The insecurity they felt in themselves showed in the way that they acted within the setting. One of the difficulties for Mere was the interplay between theory and practice. Mere states:

> One of my major weak areas is transitioning [applying] knowledge to practice in the clinical area. This is my goal for the remaining weeks, is to apply this.
>
> Mere: Diary, Day 1

Mere experienced feelings of being challenged by her day to day practice and recognised that she needed to be able to draw upon relevant cognitive and practical knowledge quickly and in context if she was to care for her clients safely. Mere called this process 'transitioning knowledge' drawing attention to the difficulty that a novice nurse can have 'putting it all together'. That is, drawing upon relevant theoretical knowledge, discriminating between what is relevant and not relevant, then making a clinical judgement for a course of action before undertaking that action. Expert nurses have refined their theoretical and practical knowledge through their experience of many similar situations that have taught them to view their practice as wholes (Benner, 1984a; Benner & Wrubel, 1989). This taken for granted way that experts work appears effortless to a bystander who would fail to appreciate the intellectual processes and the skills involved but nevertheless, it is the hallmark of professional practice.

Mere, by bringing to speech her struggle, drew attention to the complexity of the process of uniting theoretical and practical knowledge as it is called forth

in nursing practice. That is a nurse dwells in the world of nursing practice 'thinkingly'.

Freedom to embody nursing:

Students given responsibility by staff to take care of clients, responded by grasping the opportunity opened to them. The responsibility provided an opportunity to express a developing newly found freedom that had come from the lessening of the restraining effects of anxiety. Freedom from focusing intently on the self and ***freedom to embody nursing*** in practice. The freedom that came from knowing that they were trusted and had clients entrusted to their care, however, created a situation of ambiguity for them. On the one hand, they were keen to grasp the opportunity opened to them and on the other hand, they were uncertain in their capacity to measure up to the trust that was placed in them. These feelings needed to be worked through.

In dialogue, Anne speaks of this process:

> [Have you felt the responsibility ?]
>
> Yes,I have actually because you are assigned that patient, you haven't got a nurse, they are actually your patients and you are actually on the board, I've got my name on the board who are my patients. I don't actually have a nurse ..//.. - I can choose any staff nurse that I want. They are your patients and if anything happens, you are the one that is responsible for them and you are the one that should have got help.
>
> [and that responsibility has been sort of allocated to you and you have found that you were ready to take that ?]
>
> Yes, well you should be, because you are going to be a staff nurse in a few months. You have got the responsibility. I don't feel at all rude to ask another nurse if I need help - that's BEING PART STUDENT, PART NURSE. I sort of think that I'd better get some responsibilities before next year when I am a staff nurse - or if I am. You haven't got that person that you can

ask but you are the one that is responsible and you have got people under you that will be asking, like students will be asking you. I sort of think well, far out, that will be a bit more.[responsibility].

[That idea of accepting responsibility and accountability for your practice, has that developed more in this experience than any other time?]

Yes definitely.

[how do you think that has actually been taking place ?]

I think it is more so in the third year, but more so at the end of your third year because you are coming close to your registration and becoming a staff nurse, it seems more realistic and because you're there for a much longer period of time. The first say week or two they often assign you a staff nurse, so you work with a staff nurse rather than on your own, like I am at the moment. I've never really been in a place more than 2 or 3 weeks, only a couple of places I've been to.

2 weeks you don't even get to go on your own, you've got no responsibility really and they come and check on you all the time, I don't know whether they trust you but I suppose it is that they are responsible for you and their job. But that's what's good about being here for the longer period of time.

Anne: 2,13.

It is a fine line for Registered Staff to know just how much responsibility to give a student but it is only through being entrusted with client care that the student or the staff will be able to gauge the appropriateness of that delegation.

Anne captures the essence of what it means to be in the clinical setting learning to be a nurse. Clinicians in the setting need to trust the student if the student is to 'go on their own' but there is a time when this should occur.

Anne states that she feels that towards the end of the third year when she is close to becoming a staff nurse is an appropriate time. Anne also states that she needs to be in the setting for a long enough period of time for trust to have been built between the student and the staff before being entrusted with client care. But with that trust comes responsibility and accountability for one's own practice. She identifies a particular way of being in the situation as 'part-student-part-nurse' and in so doing captures the transition process for the soon-to-be-graduate in the pre-registration experience.

Being Part-Student-Part-Nurse:

The lived experience of being a student in the pre-registration experience meant that the study participants felt they were neither one thing nor the other. Anne 2,13 explained the feeling as that of being 'part-student-part-nurse'. They were aware however, that they would soon be expected to practice safely alone as a registered nurse. For them to be able to meet the expectations of registered nurses as a post graduate, they needed to try themselves out prior to becoming registered.

For this to occur, staff in the clinical setting needed to know and trust the student for them to gain an opportunity to prove that they were capable of providing safe nursing care for clients. What made a difference was becoming connected to a supportive staff and becoming involved in the shared world of nursing practice. As self confidence grew from being given responsibility and being accountable for that responsibility, the student, began to diminish and the shadow of the staff nurse began to emerge. This came about gradually as the participants accepted increasing responsibility for their practice and as they worked through the proving process.

SUMMARY

As the students became connected to others and experienced being accepted into the work group, they underwent feelings of being tested out and being watched. Becoming entrusted with the care of clients and being given responsibility, meant that they gathered that they were proving themselves to date within the context although no words were ever spoken to this effect. The registered nurses in the context made covert judgements and gave greater freedom to those whom they were satisfied, could practice safely.

This judgement included the knowledge by the registered nurses that the students would seek help if they needed to and they could trust them to do this.

This freedom allowed the students to work alone, to accept challenges to their knowledge and skills in the delivery of client care, which in turn opened to them possibilities for diverse experiences. This in turn increased their self confidence and feelings of self-worth, which in turn contributed to a lessening of their anxiety. A more relaxed stance meant that their personality could emerge as they assumed a way of being as part-student-part-nurse and they could begin to enjoy the interdependence of the professional community. The culmination of the experience resulted in the impetus to move forward thus allowing the 'nurse' to emerge and the 'student' to lessen.

As the study participants worked in their setting, they unconsciously were taking up the demeanour of the nurse in that their thinking and action became more like their registered nurse colleagues. This would lead them into becoming increasingly independent in their practice.

ONGOING SUMMARY

Chapter Five was linked to the phenomenological concept of ***'spatiality'*** as a function of how the students concerns shaped the way they comported themselves in the clinical context. They worked to become 'insiders' to the registered nurse work group in the clinical setting where they were found. They could be part of the human group in a physical, social and emotional sense, but as students, in a professional sense, they could not yet be fully 'insiders' to the group.

Chapter Six was linked to the phenomenological concept of ***'intentionality'*** as a way of describing the students way of being among and connected by the clinical work group. They recognised that "trust" preceded being given responsibility for client care, but as students, although their intentions were to work as registered nurses, their way of being was part-student-part-nurse, and as such, full responsibility and accountability for practice could not occur.

Chapter seven focuses upon the study participants and the way they ***embodied*** being a nurse and how they **dwelt in the world of nursing practice**. In this chapter the full meaning of the ***proving ground*** is revealed.

CHAPTER SEVEN

DWELLING IN THE WORLD OF NURSING PRACTICE

This chapter focuses upon how the study participants ***embodied*** being a nurse and how they dwelt in the ***proving ground*** of nursing practice. This chapter relates to the phenomenological concept of '***Dasein***' or '***being-in-the-world***'. For the students, their way of being in the world of nursing practice was to dwell completely. They were totally involved in so far as their thoughts, words and actions were attuned to the everyday affairs in the clinical context and their concern was their nursing practice. In this way, they ***embodied*** being a nurse.

The students as part of the proving process accepted responsibility and accountability for their own practice within the context and expected themselves to act as if they were staff nurses. The meaning of the experience was that they wished to gain the competence that they knew would be important to them both in the immediacy of the present and in their future as graduate staff nurses. This chapter shows how the study participants interpreted their practice to make their experience meaningful to themselves.

The over-riding theme of **DWELLING IN THE WORLD OF NURSING PRACTICE** showed that the study participants dwelt in a particular way of being - that of 'learners'.

Dwelling in the world of nursing practice is supported by three main sub themes. The first is ***ensuring possibilities. Ensuring possibilities*** was a two way push pull process involving on the one hand, the study participants being pushy but there was also an inferred corresponding pulling by the registered nurses in the setting as they opened up possibilities for the students to ensure practice was gained.

This theme includes the notion of ***turning away*** from being a student ***toward being*** a nurse. The students practiced with ***intentionality*** as they experienced skills which had been learnt. As well, they acquired new skills which they believed were the hallmark of professional nursing practice.

The second main sub-theme is ***being able*** which included a whole range of skills that nurses use in the practice of nursing. Skills identified included ***intuition, caring practice, making clinical judgements, being accountable, and being a competent practitioner.***

The third main theme refers to the way the study participants ***embodied being a nurse*** as they worked out a philosophy of nursing practice that they believed epitomised being a professional nurse.

ENSURING POSSIBILITIES

Difficulties can arise for registered nurses when students, regardless of their level of seniority, take care of clients yet without this responsibility, their practice would not develop. Legally the students could not be held responsible for their practice because they were as yet not registered nurses. As they endeavoured to prove themselves in the context of their pre-registration experience, they actively sought opportunity to practice independently and accepted willingly the responsibility and accountablility for their practice in readiness for when they would be staff nurses.

A challenge for the registered nurses in the context was to allow the students to practice nursing independently. There is a fine line between what is too much responsibility and what is insufficient for a student to gauge the success of their performance as a would-be-staff nurse for as yet, they were too uncertain of their competence. The registered nurses in the context were not

unaware of this and made a professional judgement as to what and how much a student should or should not do.

Turning away from being a student ***toward being*** a nurse included a display of initiative on the part of the student which was a signal to the registered nurses in the setting that the student was 'ready' to try themselves out. One such initiative was 'being pushy'. Being pushy to gain experience was an assertive attempt by the student to ensure that they would have opportunity to work with clients in the context. 'Being pushy' was a precursor to the student gaining a wide range of experiences.

Intentionality embraced the quest to prove themselves and to practice as they had been taught in a meaningful way by being responsible and accountable for client care. They chose to be in the situation as nurses who valued and practiced holistic individualised nursing care for clients. They had already begun to realise that there were many facets to the professional nurse's practice and they sought to experience the full range of possibilities. The way this was accomplished could be seen as a push-pull process. The student was 'pushy' but there was an inferred 'pulling' by the staff in the context as Carrie illustrated:

> It depends on how pushy you can kind of get in there and say,"Well, I would like to look after so and so today because I need the experience with giving blood or something like that", and depending on how I approach it during the day, is how, the experience that you will get and I've been trying to do that, I've been trying to take things on that I normally would not have as a student, doing my other jobs and that, because I realise that things like ordering from the pharmacy, allotting the work out for the morning, I've had a couple of mornings where the staff have said well you

> plan who is going to have what room and how, who's going to go to tea and that. I've had to do that twice.
>
> Carrie: 1,1.

Carrie pushed in to gain experience but she also showed a willingness to take on extra in readiness for her soon-to-be staff nurse role. She illustrated an awareness of the need to extend herself to the maximum but is careful first to do her normal work. To avoid criticism she knew she must prove herself as capable for caring for clients safely but was able to perceive possibilities within the situation. The perception of possibility included grasping opportunity as well as creating opportunity. With opportunity offered, she took on 'other jobs that she would not normally do as a student'. Carrie is ***turning away*** from being a student ***toward being*** a nurse in anticipation of her staff nurse role.

She was keen to try new skills as she recognised that very soon she would be expected to perform these. This was an ideal time for her to gain specific experiences that she knew she would need to have. The students recognised that as students there was a certain freedom for experimentation that was unlikely to occur on a frequent basis as graduates. They also knew and acted upon the knowledge that as a student, the staff were supportive toward them and would assist them in their quest for learning. As a registered nurse, their peers would expect them to be able to practice as an equal and meet the requirements of the work place. Therefore opportunity must be grasped if they were to become competent practitioners.

The trusting partnership between the registered nurses and the student in the setting made the difference between good clinical learning and poor clinical learning in clinical practice. The process of gaining meaningful experiences was not done in isolation. It took initiative both on the students part and on

the part of the staff. The staff had to be willing to take a risk with the student and this came after trust had been established. Nevertheless, at times the staff had to be persuaded to let the student practice independently. In the following dialogue, Anne illustrated the trusting partnership through her willingness to accept the challenge of caring for a critically ill infant. The complexity of her thinking and the skills that were required to manage her infant safely is shown in her dialogue:

> I was quite lucky - they [the registered nurses] didn't actually want me at first to look after it- but the other nurse said it was a good experience because the baby is really sick and because, I suppose I'm a student they sort of give me a bit less than what they normally do - not always...//..they let me look after this baby because if anything is wrong I would get one [a staff nurse] anyway so they left me in this room. It's really challenging because this baby keeps on having apnoea episodes and you have to keep an eye on it. It has got to be close to the Emergency Station and it needs suctioning all the time - which I have never suctioned a baby before, I mean I have never suctioned anyone out before which was good learning. I use one of those Yanker suctions. I have just got to be prepared really every time I get it fed I turn on the suctioning for about an hour afterwards. ...sometimes I use one of the other ones that goes down into the throat.
>
> Anne: 1,7.

A staff nurse persuaded her colleagues that the experience Anne sought to care for a critically ill infant was what constituted 'good experience'. Anne in her bid to gain competence accepted the challenge and the responsibility for looking after the sick baby and described the process as 'good learning'. She acknowledged the seriousness of the situation by stating that she would need to 'keep a close eye' on the baby and assessed the skills and the commitment required from herself in the situation.

The registered nurses knew that to care for the baby safely would require Anne to be fully committed to the care of the infant and adjusted her workload accordingly. Anne recognised the concession in her remark that as a student, they gave her a 'bit less'. Anne took a defensive stance by stating that this was 'not always' the case should I, as the researcher, think that she was being privileged.

The challenge of the situation required her to perform many new skills which she had not practiced 'for real' before. For example, Anne had a theoretical knowledge of suctioning as a procedure but she had not applied her theoretical knowledge in practice. Although she knew how to go about it, she is now required to perform the skill and under tense conditions. Thus for Anne, she is challenged to experiment with what she thinks she knows and what she must do. The feelings this engendered in Anne were for her 'scary'. To Anne, there is a great deal resting on her being able to manage the situation successfully for the infant's safety. She did so successfully and through the confidence gained from her success, she learnt to vary the procedure to meet the needs of her infant not only in the situation, but in successive situations. The toll of the total experience on Anne is captured in the statement that it was 'pretty scary'. Anne continued the dialogue:

> (Do you have to do that at all ?)
>
> Yes once - that was scary.
>
> (Why did you find it scary ?)
>
> Just because the baby looks so little - it looks more scared - I suppose the first time I thought it might just go down the wrong hole or something into the stomach - but no, I think it got there. Especially if it is to do

> with breathing and it could die - it's pretty scary - ..
> //...
>
> Anne: 1,7.

Anne identified the 'scary' aspect of her practice and her fear that accompanied an awareness of the life and death nature of nursing practice and the responsibility that accompanied it. The acuity of her infant client required Anne to be totally involved in a minute by minute vigil. It required her to perform invasive procedures into body orifices which she understood theoretically as 'holes'. But the skill required included touch, freedom, resistance, softness, and dexterity in the 'feel' of passing a tube into a body orifice which she could not trace visually in its passage. Anne infers the proximity anatomically of the oesophagus and the trachea recognising that she needs to clear the breathing passages to maintain the infant's life and anticipates a potential to 'go down the wrong hole'.

Anne gave voice to a mostly unspoken stress faced by nurses frequently as they sustain life under difficult circumstances. Anne could determine her success only through the response of her infant in that it could breathe comfortably. The body sensations that Anne acquired in the process of suctioning her infant successfully enabled her to develop an embodied knowledge that included a host of feelings which will develop a personal way of knowing in that her hands will become knowers as well as her head. A knowing 'how' to suction will form part of her repertoire of embodied knowledge that accompanies being a nurse.

Anne continued:

> The first day I had it, I was pretty scared - I fed it at 5:00 and it only drunk (sic) about 60 mls - not much - and then I had to suction it for about an hour after its

feed - not continuous suction - but it was all frothing - like after it would cough and splutter and then go quite red - and I'd start suctioning - and I left for tea at about 6.00 - and when I got back at 6.30 I was still going - I was thinking gosh, every time I feed him - because he only drunk 50 or 60 mls - I would have to feed him again and didn't want to because it was going to be 2 and half hours by the time I had finished and I was saying no - but he was alright the next time.

As Anne reflected on her practice she showed the intensity of her involvement in the care of her baby. As she came to know her infant and gained confidence in the situation from success with suctioning her infant's airway effectively, her anxiety is lessened. The outcome is a freedom in the situation to focus on her infant and her practice rather than herself. What followed is focused energy for the accurate assessment of her infant. She posed two problems that she needed to overcome. The first was the time taken to feed her infant and the second was that of frequent inadequate feeding. To assist Anne to reflect on her practice and learn from it I continued the dialogue:

(What do you think you have done differently now that he requires less suctioning?)

I don't know - I suppose I have been feeding him better - I need to feed him every 3 hours instead of every half hour because you just don't have time.

(In what way do you think you are feeding him better ?)

Probably sitting there with more time - I am not holding him any differently - I am burping him more frequently after every drink - 30mls...

(Does he bring up any milk when you do that ?)

Yes - very frothy...he has got so much mucous in there - so much.

(Do you suction then - at that point when he burped it up - frothy ?)

Yes - I wipe it up around his mouth and just put the suction on to suction - because normally it's his mouth that gets it all in - not really down the back of his throat ?

Anne: 1,7.

As Anne is prompted to reflect on her practice she demonstrated her analytical process of thinking through her involvement in the situation in order to arrive at how she gained a better management plan for feeding her infant. Anne had learnt more about her baby as she had worked with him for she recognised that the mucus collects more in the mouth than in the back of the throat. Through a combination of knowing her infant client, lessened anxiety in the situation as a result of successfully caring for her infant safely through the mastery of necessary skills, problem posing and problem solving, Anne was enabled to continue the care of her infant from a stronger personal and professional position. Anne concluded her narrative by emphasising the importance of continuous care of the same client:

The first time when you have a patient you are not really sure what their routine is and things - you ask around - they [the staff] sort of tell you about what they have been doing - and then you have the 2nd day - you get a bit better - then the third day - that's why I try and keep my patients the same - because you know what they like and you get to know them - and I think it is good if you try to keep the same patient like that. Three hour feeding and then if you feed him good every three hours he will go down well otherwise he cries and he is not settled - but if you burp him well and then you can leave him for say 2 hours - and it is just much more organised.

Anne: 1,10

Anne illustrated the depth and the richness of her learning from being in the situation. Benner (1991) likens the experiences that Anne illustrated to those of 'skilled involvement'. Anne valued continuity of care for the same client and getting to know the client and their likes and dislikes. She mastered the skills she needed in her practice to provide effective nursing care and she also valued being a member of the team of nurses as part of a skilled community as they share their experiences in order to facilitate better client care. A deeper meaning for Anne is that she has gained a sense of personal satisfaction in being able to meet the challenge of nursing practice and has achieved in the situation.

The students in the study related many instances of independent practice similar to the experience that Anne related. As they acted as a staff nurse accepting responsibility and were accountable for their practice, confidence began to emerge in the self as a practitioner of nursing.

Nursing practice requires a configuration of knowledge that involves intellectual activity, attitude, and practical skill uniquely mixed in the delivery of nursing care to clients but the combination is difficult to portray overtly. Ultimately it was within the unique patient/nurse encounter that thinking and doing united for the study participants. As the students continued to gain confidence in themselves, they recognised that they did have a considerable body of knowledge which was constantly being expanded. They also began to increasingly rely upon their own judgment.

BEING ABLE

Being able was a theme that was prevalent in the study transcripts as the study participants recognised the need to be able to perform technical skills competently. There were two reasons given for why being able to perform skills was valued. One was related to a desire to be able to "do things" to

appear competent in the clinical situation which would give them a reputation of being a competent student nurse among the registered nurses in the context; an important factor when jobs are scarce and graduate practice was just over the horizon. The second was to be competent in their own eyes in order to perform competently and safely the activities of a nurse regardless of the setting. Also they knew sooner or later they would be expected to manage alone. Alana illustrated the quest to gain technical skills:

> I wanted to get as much experience as I could get because there's been a lot of things that I haven't done before and I wanted to see a lot of things..I've taken the opportunity to have a look. Like putting in catheters - I'm next on the list I've seen two - it looks so easy really. I don't know - it may be hard.
>
> Alana: 1,7

Alana alludes to the knowledge that can only be gained from experience that is - skills look easy but when undertaken, may be hard. Alana inferred that there is more involved in a skill than what meets the eye. She refers to a host of feelings that come from working with a person and their body, which builds an embodied knowledge that an experienced nurse has learnt and takes for granted.

As a way of preparing students of nursing to perform technical skills safely, simulated experiences are provided in the demonstration room. The students recognised the limitations of this practice when comparing it to the real situation. Alana addressed this issue:

> The dummy is all wrong.. You forget what you do at Tech, when you actually do it. You know the reasons for doing it and you can read up on it because you've just done it and you can often relate to it. I find that I

did remember the theory at Tech when we did it but it is totally different when it is for real.

Alana: 1,8.

Alana in anticipation of her first catheterisation experience portrays her feelings of an inadequate preparation for undertaking the procedure on a real person. She inferred that skills involve so much more than having theoretical knowledge and an ability to work with equipment. She has the expectation that catheterisation is a skill that she needs to be able to practice, but in the real situation if she is to be a nurse. Certain skills were so important to her that she had prioritised them as a 'must do' before the conclusion of her pre-registration experience and was prepared to 'queue' to ensure opportunity was given to her.

Being in control of the self when being confronted with clients who had experienced severe trauma was a theme within the interviews by the study participants. Being with a person in phenomenology means a total presencing. Being with clients meant that the students would spend time with clients often because they were either assisting a staff nurse or a doctor with a procedure or because they were given the responsibility for ongoing monitoring of a client's health status as part of their responsibility within the situation.

Alison recounts a major incident that she became involved with in the Accident and Emergency Department.

By ***presencing*** herself she was able to be with the patient in a different way to other staff who were directly involved in the resuscitative process. Alison was able to disclose to the Doctors important information that had been overlooked and in so doing, was able to act as an advocate for an unborn baby.

There was a 24 year old woman came in on a road traffic crash. She was conscious and had facial lacerations to the left side of the face and part of her head and there was quite a lot of blood loss and the temple artery was actually severed so immediate transfusion was required with Haemocel. I wasn't involved when she came into the resuscitation room but made myself known and asked if I could assist in any way. Then I took the initial recordings of Temperature, Pulse and Respiration and Blood Pressure which was challenging in itself having the person lying there all covered in blood and blood spurting out and just looking a real mess. Just being able to cope with that and being able to channel my thoughts onto right, I have to do blood pressure and take her temperature and then the other nurse asked if I could get the Haemocel out so I did that as I helped check the equipment in the room, so I knew where everything was located and all that so that helped and once the Haemocel was in place the doctors were coming and assessing the wound for it required suturing. The wound stopped bleeding that seemed to be the main priority because of the risk of Hypovolaemic shock. We had to move the patient to another room with better lighting so I went in and removed the theatre bed to make room and set up with gauze, pads, adrenalin and just sort of things like that..//..

(How did they sound the recordings ? Did you find them easy to listen to ?)

Her pulse was kind of faint, not bounding, blood pressure was going down, going down because of the blood loss and it was good to be able to take it again after the bleeding was stopped and see it rise.

..//..Another thing that I found out, talking to the person, she was also pregnant so that of course was a concern as well and I felt good at being able to have gathered that information from her and I felt I had contributed a bit more just to be able to talk, just briefly because it was really hard to know just what to say because she's lying there, it is difficult to find words...//She was concerned about the well being of the baby.

(What were your immediate concerns when you found out that information ?)

Oh! my goodness! Was anyone aware of this - and my responsibilities in passing on this information her concerns about the baby - and then finding out that she had a scan the day before - twins were supposedly there, the risk of foetal death or threatened abortion.

(you said that her recordings were very faint at first - her blood pressure was right down - can you remember what the reading was ?)

It was something over 40.

..//By looking at her, the way she was - you would expect it to be quite low - she was pale and had lost a lot of blood - and her pulse was really slow.

Alison demonstrated how her theoretical knowledge is used as a basis for her actions within the situation and how her observations of her client reinforced a blood pressure reading that is dangerously low. She also illustrated the important information that she gained by being with her client. She expressed her feelings of inadequacy in the situation thinking that she would not be able to significantly contribute to the overall outcome but on the contrary, finds out very important information through presencing herself with her client. The dialogue continued:

(How did you feel in that situation?)

Initially I was seeing this person laying there, blood everywhere, it was an initial shocker. Oh my goodness, because that was the first major trauma that I had seen and my pulse rate I think, increased rapidly. But then I channelled into what I was going to do and did it effectively and being pleased that I didn't end up fainting. It was an objective that I set at the beginning

> of my experience and started to accomplish that in itself, I felt really good.
>
> Alison: 2, 1-2.

Alison demonstrated how she struggled with the personal self as a concerned human being that is naturally horrified with the sight of the person covered with blood. Alison was able to call forth 'the nurse' in herself and draw upon the professional self to apply her knowledge in a step-like, yet effective, manner to monitor her client's health status. By presencing herself and being with her patient, she was not only able to act effectively as a developing professional nurse but also was able to glean information that may have been overlooked and in this way, be an advocate for the unborn twins. So often student nurses, are perceived as having not much to contribute but in fact, because of their person-centred approach, they remain with clients who in turn find their presence valuable and therapeutic. While other skilled staff are involved in life sustaining activities, the student maintains an ethic of caring in the situation which is of primacy to healing (Benner & Wrubel, 1989).

At the conclusion of this experience, Alison on being asked what the situation meant to her she replied:

> It boosted my confidence immensely- in BEING ABLE to cope with such a situation - after at first wondering how I would react - and just being able to communicate with somebody who had trauma effectively - and being able to listen effectively - and to pick up on important aspects of care that is required and be able to communicate with the family - and to competently use skills that I have learnt, to appropriately get the information required - just generally boosted my confidence immensely.
>
> Alison: 3,4.

Alison had put herself to the test because she was not sure of ***being able*** to manage herself in a situation where she was confronted with sights and smells, from which, if she was not a nurse, she would recoil. She learnt about herself in this situation and learnt that she was able maintain her own integrity in the situation, to act competently and safely, calling forth her knowledge and skills as a nurse and to use them in a responsible manner. Alison discussed how her new found personal knowledge had boosted her confidence and infers the satisfaction she has gained from knowing how she will react within similar situations. Next time she is confronted with a similar situation, she will feel more sure of herself within it.

It was being challenged with situations, accepting the challenge and working through responsibly that displayed the study participants abilities to their registered nurse colleagues. Each successful encounter contributed to the proving process. The study participants not only proved themselves to others, but in so doing they also proved themselves to the self. Heidegger (1962/1927) calls this a reciprocal process of being constituted by and in turn constituting the situation.

Intuition played a part in the students' practice. Although not highly developed, an idea that something was not quite right was sufficient for students to pursue feelings that would lead to a change in diagnosis for a client or a change in the established care plan. Kit who was practising in a medical ward shared her intuitive feelings concerning one of her clients.

> An elderly gentleman had a brain stem CVA [Cerebral Vascular Accident] and was not expected to live but he's come around really quite wonderfully. He's quite interesting actually because one of the nurses was saying how wonderful he was on Sunday night and I found him quite inappropriate but I couldn't actually link what it was - but I knew something was up so I went and got

> one of the nurses and went through why he would be confused - what possible causes there were and we discovered that he was dehydrated.

Kit stated that she knew something wasn't quite right but she could not isolate what was wrong. Her registered nurse colleague in the context assisted her by helping her to think why her client might be confused. This was a typical finding in the study where registered nurses in the context actively questioned the students to assist them to identify relevant theoretical knowledge to apply in their practice. Kit continued:

> If the nurse wasn't there it would have been quite difficult because she just said -"Let's think what causes confusion ?" ..//.. so we just went through what the causes were and in the end I took his temperature because he looked really hot and we cooled him down. I think we took all of his vital signs..//.. he wasn't eating and when we got him up to walk he was like a drunken sailor and I was quite scared he was going to fall over ..//..he wasn't actually making any sense- he was talking about nothing really - ..//..it was very much a learning thing for me. At Tech. you learn to assess things but sometimes it's difficult to actually pinpoint the causes even though you can actually assess that there is something going wrong - It was pointed out to me that I should perhaps remove myself from a situation for a couple of seconds and have a quick think about what causes these things...We had a long list but it was just a case of looking at his input and output - that pin-pointed the problem. We called the doctor and he agreed. He was on Intravenous fluids for two days before he came right.
>
> Kit: 2,14.

Kit draws on the registered nurse's experience to inform theoretical knowledge but also illustrated the value to her client of acting upon intuition. ***Being able*** to stand back in a situation and reflect upon it was the means of identifying the source of the difficulty but it was the intuitive grasp that

something was wrong that initiated appropriate nursing and medical intervention. Within this exemplar Kit also demonstrated the registered nurse who acts as the 'coach' (Benner, 1984a) to the developing practitioner. It was through the registered nurse's probing of Kit's theoretical knowledge concerning 'confusion' that the reasoned diagnosis was eventually pin-pointed and appropriate medical intervention initiated. The registered nurse in the situation does not pre-empt a diagnosis but patiently 'teases out' Kit's knowledge and uses the client's health problem as a teaching situation. Kit as a learner in the situation appreciated her efforts and through the questioning and probing activity, is able to problem solve.

The patient teaching of the staff nurse will prepare Kit for her staff nurse role as a practitioner who is able to make clinical judgements that include acting upon intuition, analysis and evaluation of substantiated evidence to come to a reasoned diagnosis. The expert role of the clinical 'coach' is the means by which Kit has learnt how to go about solving clinical problems in the future.

Problem facing became part of the expected day to day practice for the students. They related many incidents when they were called upon to act with initiative and quick action. Caring for a patient following specialised surgery can be anxiety provoking, particularly when technology has been used to maintain a patent airway for a client. It is usual following extubation of an airway, that the client's respiratory system will respond and take up normal respiration. If it does not immediately respond to sustain life, an emergency situation is presented. Kerry who is working in the Intensive Care Unit illustrated how a nurse must always be alert and ready to step in to the breach if things do not go according to plan.

> I ended up being in charge of a patient [who was] extubated following jaw surgery and he stopped breathing in front of my eyes. It was well controlled -

> Staff Nurse, Doctor right there within seconds. I wasn't aware of their procedures so I assisted as I could but the Staff Nurse said later, I managed well which helped me a lot.
>
> Kerry: Diary, Day 8

Kerry demonstrated what can happen when a client, who has had vital functions assisted by way of an endo-tracheal tube and mechanical ventilation, has life-support apparatus removed. The body although expected to respond immediately by way of its own cardio-pulmonary function does not always respond as it should. Fortunately, Kerry was in an Intensive Care unit so resuscitation teams and equipment is ready-to hand. It was a frightening situation for Kerry but backed up by skilled staff, he was able to function within the situation in a way that was acceptable to the staff at the time. This he stated 'helped him a lot'. This small phrase in Kerry's diary revealed the vulnerability experienced by the student and the comportment of the staff toward Kerry. The stance was one of caring and encouragement. It is within a community that demonstrates caring not only to clients but toward inexperienced staff, that Kerry will gain confidence in the self.

Caring ethical practice was demonstrated when the students presenced themselves with clients in poignant interactions that did not involve any physical skills but required highly sensitive communication skills and an ability to relate to a person in human to human contact. The students had learnt that it is important to display a caring and empathic attitude toward their clients and a genuineness that evoked a sharing of sensitive feelings. Alexandra who is working in a specialised day stay clinic shared one such moment:

> I had been helping her and I was just standing by the machine and she just said "I think I'm going to die in the next few days", and I went Oh no, Oh no, and

> anyway there wasn't any escape. I had to sit down and acknowledge her seriously and I did. I think I just asked her "Why do you say that..//and she said something like it's not doing her any good anymore..//. then one of her family came in and it was stopped there..//I went away thinking "What should I have said in response or shouldn't I have said anything?" Actually there was a bit of a silence..//What she was saying was true. I couldn't say everything would be all right or it may not be - I wouldn't say it anyway.
>
> Alexandra: 1,12-13.

Caring in nursing involves an ethical stance that is personally very challenging. Alexandra stayed with her client and maintained an ethical comportment although uneasily. Ethical comportment has been referred to by Benner (1991, p. 2) as "the embodied, skilled know-how of relating to others in ways that are respectful and support their concerns." Alexandra began to reflect on the situation by raising the question "What should I have said ?" and demonstrated an openness to learning new ways of coping with similar ethical situations. She was certain of one thing however, she would have remained honest in the situation.

The unity of science and art in nursing is illustrated by D.J. as she created an environment where her client was able to express deep emotional concerns. Through the therapeutic use of herself in the situation and a caring approach, D.J. was able to intervene in a way that was effective in assisting her client. D.J. related:

> One client in particular was just sitting there quietly waiting for an ambulance to take her father back to hospital and it was going to be late and I sat down and told her and we just started talking..//..She was having severe problems coping with her father's terminal illness. She was a single parent, she was the oldest in her family and recently had the loss of her mother and

> had all sorts of problems and through just talking to her we were able to sort of make advances towards helping her, not only in the Oncology area but with outside help, from people appropriate..//..It just happened naturally. She was waiting, she needed somebody to talk to.
>
> D.J., 2,3.

D.J. created the possibility for a special moment in her life as a nurse. By being open to her client's distress, listening and responding in an empathic, genuine and caring manner within the situation, she was able to support her client in a way that opened possibilities to intervene in a meaningful way.

Making clinical judgements became a part of everyday practice as the study participants fitted more into the clinical setting and as their experience expanded and confidence in themselves grew. When confronted with problem situations, the students remained actively working with a problem rather than calling a staff nurse immediately to help solve the problem. The problems they encountered were varied but some required a high degree of involvement and courage.

Carrie who is working in a post natal ward illustrated how she used her clinical judgement:

> I had to pick a lady up from theatre who'd had a manual removal of her placenta and some vaginal tears sutured and she came back to the post natal ward and she had two IV lines running, one with Syntocin and one with just saline. She was still pretty drowsy and sleepy and I was just doing her post-natal checks quite regularly and looking after her baby and after about 3 hours I kind of thought, well the last bag had run through and it was time you really got up and used the toilet because I was thinking of all this fluid that had gone through and with the uterus and so forth. As I

> turned her to help her to get out of bed she said, "Oh! I think this ice pack's melting, I can feel a lot of water down there" and I pulled back the covers and lo and behold she was gushing blood. I'd never seen it like that before and so I just thought - oh well, this is it! So I rubbed her fundus, like exactly what we were meant to do, and because I did that it actually made it worse at first, it just even spurted out more and I thought - Oh, my goodness and I rung 3 bells and then I still wasn't really sure if this was a proper haemorrhaging, I'm pretty sure it was, but whether it was a 3 bells case or not, and anyway, I was glad I did because the mid-wife came and she took over rubbing her fundus and I went and got the Doctor, lucky, he was on the ward and things moved from there. She actually ended up having to have some units of blood and she had to be taken back to theatre because they had actually missed one of her vaginal tears as well. With that same incident, when the house surgeon came along she gave her some iron, syntocin and was wondering whether to call the Registrar and I kind of suggested well do you think we should catheterise her because I was still worried about all this bleeding and I actually did the catheterisation with the doctor and drained 1200 mls off in about 15 or 20 minutes and things started to settle down a little bit after that.
>
> Carrie: 2,1.

Carrie demonstrated how she used her theoretical knowledge in the situation to 'rub her fundus' as she had been taught to bring about the contraction of the uterus to stop the haemorrhage. What she could not know in advance without experience is that the worsened rush of blood that occurred as a result of her action was initiated through the contraction of the uterus with a resultant expulsion of blood that had accumulated in the muscular bag. Carrie although unsure if it was an emergency, decided to act as if it was and realised later it was the best thing that she could have done. An important point that is shown in dialogue concerning this incident was that Carrie did not let go of the problem. From her theoretical knowledge she was convinced

that she should empty the bladder because a full bladder would prevent the uterus from remaining contracted and therefore there was potential for further haemorrhage. With the eventual catheterisation of her client, and the resultant emptied bladder, a resolution of the problem was possible.

The learning of theoretical principles related to caring for post natal clients guided Carrie to act appropriately in the situation. As well, the experience informed her theory to contribute to a personal way of knowing that is a valuable source of knowledge in professional practice. It will be a combination of theoretical knowledge and her experience that will constitute a reservoir of personal knowledge that will inform her clinical judgement for future similar situations. She could now see how the elements that are theoretically espoused in a textbook combine in a real life scenario. When asked what she had learnt from the situation Carrie replied:

> Don't try and manage those sort of things on your own. I mean I wouldn't hesitate to ring 3 bells in something like that again even if I thought to myself well maybe this isn't right, maybe this isn't as bad as this...The vital signs are really important and also she had not put her baby to the breast or done anything since Theatre - obviously her uterus was not contracting, her bladder was filling, nothing was kind of going right there - so maybe just watch for that sort of thing.
>
> Carrie: 2,4.

Benner (1984a, p. 36) states that experience is the turning around of pre-conceived notions to reappraise a situation and the changing of perception as a result, thus contributing to knowledge. Carrie demonstrated how her knowledge was given a new dimension by her experience that would not have been gained without it.

Recognising the moral demands in nursing practice

Regardless of a person's background, a nurse must be able to provide non-judgemental humanitarian care. When students are introduced to the concept "non-judgemental" in a theoretical context, it has a literal interpretation that denotes witholding judgement over an event or person. However, nursing theoretical concepts that had been learnt took on new meanings when the students were faced with applied nursing science in practice.

Jane illustrated this point when she was confronted with a situation in the Emergency Department that disclosed how the term "non-judgemental" took on full meaning in nursing practice and how unrealistic such a demand is. For Jane to be 'non-judgemental was to deny her own humanity. For the first time for Jane, the meaning of the word "non judgemental" became a lived reality. Jane stated:

> This evening in the Emergency Department, I cared for a man who was responsible for the death of an innocent woman. He had been driving a stolen car, was drunk, and crashed into this woman's car. She died. He had only minor injuries.
>
> It was important for me to love this man, non-judgementally and give him the care that all people are entitled to. I found it no problem to do this. I administered a tetanus-toxoid injection for him. I was responsible for taking his initial recordings TPR,B/P, [temperature, pulse and respiration, blood pressure] neurological checks using the Glascow Coma Scale, documenting information, measuring pupil size, increased and decreased reactivity to light.
>
> He had not been concussed but was confused because of his high alcohol blood levels. His left eye opened spontaneously. His right eye was bruised and shut, but I opened it to test for pupil reaction to light. Observations were performed and recorded half hourly. He was eventually taken away by the police once the

> doctor had discharged him. I gave him a head injuries sheet. He was too drunk to take in the information at the time. I explained to him what happened. However, I didn't mention that he was responsible for manslaughter. When the effects of the alcohol have worn off the police will deal with him...//... None the less, it was an eye opener to deal with a man guilty of manslaughter and theft. I felt shocked, sad and angry.
>
> Jane: Diary, Day 4.

Jane illustrated how difficult it is to remain "non-judgemental" in practice. For Jane to detach her emotional response from her actions is to distance herself from the person. Under these circumstances she cannot treat him with warmth. The difficulty for her as a Christian nurse is portrayed in her statement that she "must love this man" but morally, she realistically responds in her statement that she was "sad, shocked and angry".

Jane was able to manage herself in the situation as a nurse to provide the care that her client needed in a manner that dealt with the needs of the present but in doing so, she also wrestled with the self. She had learnt the professional value of "non-judgemental practice" but had not bargained with the internalised spiritual and moral self. She was now in a specific situation where the personal self is in conflict with the professional self.

She correctly separated out the criminal aspects of the situation and recognised as a professional person, she was accountable for her nursing care and performed the necessary skills as a nurse to maintain her client's safety in the situation. Jane learnt that she was able to meet professional expectations in the situation. She also learnt that it is impossible to remain un-involved in the situation and her spiritual being will respond as a moral citizen regardless of her professional status. Jane has learnt that she can be a nurse and maintain

professional standards and she can also be true to herself and her own sense of values.

Being accountable was an important part of being competent and formed part of a personal philosophy of nursing that the study participants believed constituted professional practice. When a personal philosophy was compromised frustration was experienced as Patricia portrays:

> I'm finding in a lot of cases, staff blase about times, medications, etc. which if I did would compromise my philosophy of patient care. In one instance, my patient needed Augmentin 1.2 mg 6qh (four times per day at six hourly intervals). The nurse put it on the medication chart as 1-7-1-7 IV [intravenously]. I pointed out that she'd been put on it that day. The first time I went to give it, I asked an R.N. to come and check it out. She said fine and we did it together, but then she couldn't give it as she wasn't certified yet, so spent 15 minutes getting someone else available to give it. R.N. said that the normal time was 6.10.2 - that I should check it with Dr. who of course wasn't there, more time wasted till she could be found.
>
> Patricia: Diary, Day 2.

Patricia showed how important it was for her to practice accountably and to give medications on time. Her efforts were constrained by staff who were not yet able to give medication intravenously and a controversy in the prescription of the medication. The expert nurse in the situation with local knowledge of common medications and normal prescription values was able to guide Patricia to question the Doctor and ensure that a correct prescription is written. Patricia felt a frustration in the situation in so far as her personal quest to appear competent and accountable to her client had been compromised through no fault of her own. Part of becoming a team member in a community of practitioners is recognising that things do not always go

according to plan and it is important to stay alert to the possibility that others can make mistakes. Part of professional practice is to check prescriptions in a resource book until one becomes familiar with routine medications. Over time, and as she builds a repertoire of situation-specific knowledge, she too will question prescriptions that fall outside normal practice.

As the students experienced day to day practice, they became aware of role models that they desired to emulate. Although, they had formed their own personal style of practice at a much earlier point in their course to which they remained true, in their efforts to become competent practitioners they constantly sought to refine their skills. Karen illustrated this idea in her exemplar referring to a situation in the Emergency Department where she had been asked to connect a giving set in to an intravenous cannula for a client in readiness for intravenous fluid therapy.

> Over the three years you sort of see what different nurses do and you pick up the good points of what they are doing and you take them on board so I put a piece of tissue paper behind the luer and raised his arm and rested it on a pillow and felt for the end of the catheter inside and sort of cut that off, put pressure on with my finger and got the other end of the IV and it was sort of a bit fiddly at first holding both the IV line and the luer under, but once I got it in I was really pleased that no blood had come out because its actually quite embarrassing seeing a trained nurse put in one of these things which is really very basic and blood oozing out everywhere. To me it is not very professional,..//..I was really pleased and I feel so much more confident now that I can go and do it without making any sort of hiccups.
>
> Karen: 1,4.

Karen has formulated an idea of what for her constituted professional practice. She stated that she had observed many professional nurses as they

had changed or introduced an intravenous giving set and had witnessed practice that was to her less than professional. She had formulated a step by step approach to introducing an intravenous giving set into an intravenous cannula in order to commence intravenous fluids. Everything went well and she was pleased with herself and felt more confident with this procedure.

However, to her frustration, Karen found that the intravenous fluid unit did not function. She then recognised there were other facets to performance that she had not taken into account. Karen continued:

> Once I connected it and screwed it in and made sure, I taped it up, the nurse said we need 125 drops a minute. So we started to open the line up and nothing happened, it was completely blocked and I thought- "great"!

Karen was practising in the Emergency Department where her actions were in full view of the public. She was aware that she was under public scrutiny and she experienced a mismatch with her ideal of nursing practice and the real situation. She used a problem-solving approach to overcome the difficulty and expressed her feelings concerning the episode. The meaning for Karen was that she was self conscious as she practiced for the first time, a skill that she had observed many times before and knew how it should be done. She was embarrassed to find herself open to the scrutiny of the patient and his wife and the need to problem solve and call upon the Staff nurse to unblock the cannula with a saline flush. The drip then went well. Karen recognised that although she had performed the technical skill correctly and had no blood ooze, it was most probably due to the blocked cannula rather than her carefully executed performance. Nevertheless the practice gained by the experience will be useful for her in the future. She was able to call on her

registered nurse counterpart who acted as her coach (Benner, 1984a) to turn the situation into a problem solving exercise. Karen continued:

> We worked through right from the bag right down to the client to see what was wrong. So the nurse gave it a saline flush and it was fine after that but it's a bit embarrassing actually trying to fiddle around with this drip to try and get it going and the wife was sitting there looking and sort of thinking "what are you doing?" It was just that the line was a bit clogged so once that was started it was fine. I explained to the wife and to the husband that sometimes if the luer has been in for a while the blood can clog the cannula and it has to be flushed through."
>
> Karen: 1,4.

Karen did not forget her clients in the situation. Her words of explanation were important to them to understand the actions of the nurses. In a climate where quality health care includes free exchange of information between nurse and client, an information sharing situation is appropriate as well as being the right of the client.

As the study participants worked in a wide variety of settings, there were situations where they had to use their own initiative for they had not been prepared for what they encountered. The students had been taught during their educational preparation to undertake a thorough assessment of their client's health status as part of the nursing process prior to delivering nursing care. Some study participants found that in some agencies they were deprived of information about their clients. All information concerning clients prior to elective surgery was retained by the Doctor who had admitted the client for surgery. The nurse in such a situation is working with clients as if they are a part of an assembly line for surgery. Katherine demonstrated how she

practiced in one agency:

> They (the patients) all went down to theatre pretty much one after the other and then came back one after the other so I was really rushed between 6.30 and 10.30, getting them ready for theatre. They all tended to come back quickly and I had a D & C [Dilation and Currette) as well. Her blood pressure dropped down quite a bit and she started bleeding a bit so I had to keep a closer eye on her, gave her a wash, changed linen and all that sort of thing. It dropped to 90 over 60 and had been 130 over 90. It had been sort of quite low in theatre, about 110 over 80, they check up on, so I just sort of kept a closer eye on her and sort of made sure I was counting how many pads she used but after that sort of initial sort of bleeder, nothing else happened. She was talking and responsible, she was drinking, she ate lunch and she stabilised after that. You never know what is happening with them because they never have notes. All the notes are in the doctors, to find out you have to actually ask...//..This morning I just didn't even have time to ask what was going on.
>
> Katherine: 3,3.

Katherine is working with little information on her client's health status prior to surgery. In a situation where she is not so busy, she has time to find out important information in face to face conversation but the assessment process depends upon the client who may or may not be in a fit condition to share this with her. In situations where she is rushed, she has not time to assess her client, but also, she has no written documentation as background to guide her. She showed how staying within the situation, she monitored her patient with careful clinical observations to make her own clinical judgement. Katherine related that she is not always placed in this position for if she had admitted

her client prior to surgery, she makes it her practice to undertake her own assessment:

> Most of the people I look after post op. I admitted and if I didn't I always go in and look at the list. I know if they are allergic to anything, what they are on, what they think they are going to have done and what they had done and just go by that. I always try and do my admissions and talk. So many times you can miss out things and also if they are on any medications. I always ask now, have you got it on you, can I have a look at it.
>
> Katherine: 3,11

Katherine showed how she not only is guided by her theoretical knowledge concerning surgical procedures, but also how she has learnt the importance of doing her own assessment for her clients in collaboration with them in order to practice safely. Accountability in professional practice in the first instance is to the client and Katherine demonstrated this awareness through her nursing actions. It was situations such as Katherine encountered and the way the study participants managed the self within it, that contributed to a growing self reliance and self confidence in their professional practice.

Being a competent practitioner

As the study participants practiced daily and worked as members of the nursing team with their own clients, the essence of their experience was to be a competent practitioner and be accountable for their practice. All experiences were directed toward this end. They sought and gained experience and began to embody being a nurse with greater certainty as they felt and acted as staff

nurses. This was the expectation they had of themselves and others had of them. The dual proving purpose is portrayed by Kit:

> I really want to prove myself and prove that I am capable...
>
> Kit: 2,13.

> I wanted to function effectively as a member of the health team, and I wanted to carry a realistic patient load and give them quality care, basically I wanted to act as I would if I was a Staff Nurse.
>
> Kit: 1,1.

SUMMARY

In this chapter the essential nature of the practice of the pre-registration student has been uncovered. Although dwelling in the proving ground is fraught with uncertainty as the students try themselves out in the role of the staff nurse, they focus upon gaining the competence that they expect to have on registration and accepted that others will have similar expectations of them upon graduation.

The desire to practice competently required to be supported by the registered nurses in the context if the students were to have access to their own clients and provide total nursing care for them. The registered nurses in the context 'wait in the wings' as it were but are ready to support and facilitate the students efforts to become independent practitioners.

The registered nurses coached the students in a host of different ways from assisting them to gain technical competence, to offering opportunities for experience and assisting them to integrate theory and practice. In this way, the study participants were building configurations of practice situations in their minds as whole experiences rather than a series of fragmented parts.

The desire to prove themselves capable of managing a realistic workload of a staff nurse and to provide quality nursing care for their clients meant that the study participants were ready to align themselves to the shared world of nursing practice, stand side by side with their registered nursing colleagues, and were ready to work as a registered nurse. They were also ready to sever themselves from the educational institute that had prepared them for this moment and were keen to 'fly solo'.

ONGOING SUMMARY

Chapter Five addressed students' feelings as they worked to become 'insiders' to the work group as they sought to enter the proving ground. Chapter Six addressed the importance of the relational world to the student as they sought to become part of the professional community and claim their right to access the proving ground. Chapter Seven showed what it meant for students to embody being a nurse as they dwelt in the proving ground and Chapter Eight addresses the feelings that the students experienced as they realised their 'readiness' to practice as a professional nurse having dwelt and proved themselves in the proving ground. In addition, Chapter Eight, as the final data chapter, shows the temporal nature of the pre-registration experience and what it means for the student to live forward, yet seek to make meaning of the past and dwell in the immediacy of the present.

CHAPTER EIGHT

MAKING SENSE OF THE PAST - ANTICIPATING THE FUTURE

As the study participants were faced with daily work in the clinical setting a great deal of thinking through of each day's activities had to be accomplished. In the final data chapter, the focus is on the manner in which the study participants thought through the total experience to make sense of it while thinking about their future as nurses. This is captured in the phenomenological concept of **TEMPORALITY** which shows how the students perceived their Comprehensive Nursing course and the experiences they had to date to include their pre-registration experience in relation to the present and to the future. Themes that make up the chapter include ***involvement***, ***foreground thinking*** and ***background thinking***, and ***being aware of the self***. A fourth theme in this section addresses ***future practice***.

The study participants demonstrated complex patterns of thought that involved dealing with the immediacy of situations, problem solving, remembering, reflective and reflexive thought, critical thought, and conceptualization as they worked at their nursing practice. Thinking through their day required both ***background and foreground thinking*** as they dealt with immediate work demands, adapted their knowledge and skills to the demands of the situation, reflected upon their practice becoming reflexive in so far as they would try to improve upon a situation or to learn from it. The progressive thinking patterns illustrated the constant 'work' of the student which contributed to the exhaustion of which the students spoke.

The phenomenological term for time is ***temporality***. ***Temporality*** includes the notion that while one is focused in the present, thoughts and actions are anchored in the past because one is always working from what is known to

the unknown. In this way also, one is always working toward the future. Although the study participants were well aware that work must get done on time and that the ward work or area work was managed by a linear time frame which is ahistoric, they were also working on an expectation for their future practice as a graduate nurse. The students were operating within a temporal perspective and perceived the pre-registration experience as only a part of a greater whole. Anne illustrates this point.

> The course prepared us more to be a R.N. (registered nurse) than pre Reg. (Pre registration experience). Pre-reg. is not the highlight - it was good. You are doing the course to be a R.N. legal things, ethical things, knowledge, caring, communication - all the types of things we get tested on.
>
> There is so much - you can't really list them all. The course gives you the knowledge - it's up to you how to relate to staff and to the other things that make for working in the ward group. Things like the personality-things that make the ward great to work in. Staff relationships are very important it makes it either pleasurable or miserable to work in - the things we don't learn at Tech. they are the things that make the nurse.
>
> Anne: 3,31.

Thinking work was constantly organising the total experience and Anne is saying that there is a lot more to nursing than what can be taught. What was seen overtly was a student nurse who seemed to be managing well to the staff around about, therefore foreground thinking accomplished organisational work goals, personal time management and carrying out their nursing practice for their clients. It also showed the staff that the study participants were capable of meeting the demands of day to day tasks within a bureaucratic organisational structure. In this way, they could show that they were proving themselves in the eyes of others. What was seen overtly did not convey the

energy required by the study participants' involvement in the process. They worked also to prove to themselves that they would be able to manage being a nurse rather than being a student. Being a nurse was much more than getting work done in the time allotted -it meant that the study participants were not only organising their work, but also keeping a sharp thinking edge to the mind that involved the whole self in the situation.

INVOLVEMENT

The lived experience is an embodied experience of total ***involvement***. Not only were the students fully aware of what was occurring in the present, they were socially and politically aware of the society within which they lived and worked. Within the holistic practice framework in which the students had been taught, they reflected upon the socio-political milieu that often precipitated a client's admission into hospital as well as being aware of the conditions in society to which they would return. ***Foreground thinking and background thinking*** focused upon the self as a nurse and was client-centred as well as being totally ***involving***. The study participants' thoughts did not only stay with what they were doing. Thinking therefore is multidimensional and is extremely energetic. Sally expresses this idea:

> I think you are thinking all the time while you are doing things. There is not time to sit and think about the flowers or whatever, there isn't that sort of time for thinking.
>
> (Are you thinking about the routine ?)
>
> Yes, and the surgery and the patient themselves. The one I was looking after today who slashed his wrists very severely two days ago so it is really I think as much a part of the treatment to observe him, his attitudes and communicate with him as much as I can do.
>
> Sally: 1,11.

Sally reveals what it means to be a nurse. A nurse is thinking all the time about the many things that one has to be responsible for as well as the client and their concerns within their lifespace. A nurse is touched by the humanity of the person he or she is caring for and the factors that contribute to what it is for them to be within the clinical situation. Some situations are tragic. Sally reveals the depth of her understanding for her patient and her commitment to him even though she is engaged with other things, she keeps her mind attuned to the situation. She recognises that her patient's actions were those of a person driven to desperate means. She is not ashamed to identify with his humanity and in so doing, recognises her own. Sally continues:

> Yesterday he didn't communicate at all but today he did and I can understand his desperation, why he did what he did, he acknowledges now that he was silly, he wishes he hadn't done it but we have all been there, done that about something or other in our lives, even if we haven't taken such measures.
>
> Sally: 1,10.

Sally maintains a reflective stance but remains engaged in the situation, she continues:

> The Crisis Team came to see him. He said it helped but whether he will actually carry on with it once he is discharged I'm not sure and he's probably being discharged fairly soon.
>
> Sally: 1,10

Sally addresses a fundamental truth. In the final analysis, health is the responsibility of each person. A nurse can only do so much - the rest is over to the person.

Reviewing the past to make sense of the present was an integral part of the proving process. The study participants reflected upon their knowledge and skill and their education as to the fit of it to the everyday world of nursing practice. The students reflected on the beginning of their course and they could see that what they had learnt could now fit into their daily practice not as theory but as part of a lived practice. D.J. expressed her feelings concerning this:

> Over the last two clinicals - ..//..I found a lot of what I learnt in year one, in the theory where they were just drumming you with the stuff - is actually now starting to really work and I can utilise it..//.. Couple of little famous words "I hear where you're coming from" - yes it can actually trigger people. When I first heard it I thought 'what a load of rubbish, nobody speaks like that'. But I have now used it myself heaps of times. When a client is sitting there and they are trying to say something, and you can see that they are really upset, you can just sort of put your hand on them and say "Look, I can really see you are upset by this" and it just makes that little link, and it is silly things like that, that make a difference.
>
> D.J., 1,24.

D.J. can now appreciate the relevance of identifying with the patient's need and the value of having an empathic approach which can alleviate tension in a relationship to create possibilities within it.

Successful practice using the skills that they have learnt assisted them to continually gain confidence in themselves and to begin to appreciate a congruence between the things that they had learnt and the real situation.

Cultural beliefs concerning death and the sacredness of the body differ from culture to culture but all cultures have respect for the dead person. Nurses are

entrusted to care for a client in both life and death but each nurse must come to terms with death as a part of his or her nursing practice. Mere explains how her belief in the spiritual dimension of the person impacts upon her practice following the death of an elderly gentleman in a surgical ward:

> I felt quite reverent really for him, respect../ I thought if he was alive and I was caring for him I would probably do the same cares if I was assigned to him..//.. I do believe personally that we live spiritually beyond this life. I've had that sort of respect and so I sort of felt like that he was looking over his body and for those who were caring [for it] - its like a shell and this is how I would want it to be for me, the same care for myself.
>
> (so your own personal beliefs made the difference to the way you responded to him ?)
>
> Yes and my actions.
>
> Mere: 3,2.

Nursing draws out the best in the person and a belief system that is part of the nurse as a person impacts on the way she or he interacts in the situation.

Value conflicts arose for them when they had direct conflict with what they had been taught on Primary Health Care and reality as it appeared through the doors of the agency that they were working in. Health care as a universal right as opposed to one's ability to pay was something that the students came up against particularly in the private sector where a number of them were situated.

> In the A&E [Accident & Emergency], you don't know who is coming in. The one thing with it being private that I have noticed is like the monetary side of things - everybody pays and they pay there and then or they could be refused treatment. It's really hard for me to

> hand them a piece of paper and tell them to take it to the counter and then people say how much,and I don't know...//..I couldn't refuse anybody because I believe everybody is entitled to health care and if they are injured or ill they need medical advice - that's what I'm there for, that's what I'm training for and I'm not there to say well I'm sorry I'm not treating you because you haven't paid for your last one.
>
> D.J., 2,6.

Preparing for the State Examination was done by some, consistently, but most of them were too busy with the demands of the day to day world of practice to study. They would come home exhausted and did not feel that they could get out the books. As Kerry states:

> ..Doing the shift work has been hard. Its been a 5 day week plus your working week and I haven't had much time off - it's been hard - keeping your interest up, showing an interest, learning all the time and with State coming up as well. I don't reckon I've done much study.
>
> Kerry: 3,1.

For some, they felt that they 'knew a lot' and their practice had confirmed this. Some stated that the difficulty would be writing down their practice. Examination questions did not typify their reality and calling forth their knowledge in written form would prove difficult for them. Some felt that their practice would facilitate the writing down of answers on the examination papers.

The experience of being a student included feeling the exhaustion of the accumulative effect of working as a team member and as a soon-to-be-staff nurse as well as preparing for an examination that was critical for their future. The examination was seen as a leviathon looming over them as D.J. states:

> I love nursing, I love what I do ..//that's what makes this exam so terrifying because the thought of failing it is just so horrifying..//..I would like to pass the first time. I can only hope that what I do write down is safe for if I write down what is safe I will pass.
>
> D.J., 3,13.

D.J. understands that the criteria to become registered as a Comprehensive Nurse is to be able to demonstrate 'safety' in the written State Examination. But the staffing levels in clinical practice areas within the Health Care System were dangerously low. The students worked hard and expressed feelings of being exploited. While appreciating that they were gaining valuable clinical experience they were also aware that they were helpful to a short-staffed and strained health care system. Kerry illustrates this point:

> Working 8 hours and getting a workload and just working like a staff nurse when it's for no money and when at the moment they use us more than they should. As far as I'm concerned and from what everyone else [fellow students] have been saying, we've been life-savers for those staff nurses. Being around and taking on people with IV's - we've been working hard.
>
> Kerry: 3,2.

The situation as personally meaningful meant that the students dwelt in the proving ground intentionally. On a personal level, the temporal nature of the experience for the students showed that they had quite different intentions for their outcomes. Some of these concerns had grown out of past personally satisfying clinical experiences in their course, some of them were future oriented career aspirations, and some were related to gaining experiences that they felt would be of personal value for their developing professional competence.

To perform competently was primarily on their minds as they recognised that they must be able to demonstrate what they could do if they were to gain employment post graduation. This employment was not likely in New Zealand and the students knew that they would have to compete with other graduates from other parts of the world on a capability basis. Traditional technical skills related to hospital styled nursing, were the skills that they perceived they would need to demonstrate competence if they were to gain employment overseas.

Being aware of the self

Specialist teams provide a professional service to clients within a people-oriented system but the specialised nature of their work and the knowledge and experience required to function effectively within it cannot be the practice of a novice practitioner. It takes time to learn the 'know how' and to experience the interplay between theory and experience before a practitioner can work effectively. Because the encounters of the team experts are one-off encounters with clients, it would not be safe or ethical for a beginning practitioner to be responsible for such a critical interaction.

Rachael who is working with a specialist team has been in an observer role for most of the time in her clinical setting. To an objective observer, it would have appeared that Rachael was sitting passively on the side-line. In dialogue with Rachael during the research process the way she comported herself in the situation was very different. Rachael demonstrated her involvement:

> I think up until the end of last week I was still observing a lot and because I was doing that it was quite difficult to actually gauge how much I was learning but on Friday I took my first interview. I was really nervous about that but it went really well..//..I'm not really one that is very good at asking open ended questions and I tend to lead the person and give them

> the answers that I'm looking for and it's really important that you don't do that so yeah, I didn't but I wasn't really aware that I did that which was really good. A couple of times I had to kick myself but just sort of knowing the right questions to ask was really good. Went over it beforehand but still it's a new person and you don't know whether you are actually going to get them out in time.
>
> Rachael: 3,1.

Rachael shows how she has learned by observing the experts in the field, how to ask the right questions in an interview situation but she also shows a way of ***being aware of herself*** in the situation. Rachael continues:

> I thought it was going to be difficult but it wasn't actually, he made it really easy for me. Initially he was quiet and he wasn't giving away too much and after a few minutes he was really responsive and we got some really interesting stuff.
>
> (Tell me a little bit about how you went about the process, sort of like what sort of questions you asked and how he responded ?)

Rachael demonstrated her use of a theoretical check list of questions that gave her an initial grasp on the situation. She also showed how she used this knowledge to work with the client.

> There were four major things that we had to assess. .//.. It was really easy to ask all those sorts of questions but the difficult thing and I think really inexperience comes in is that I didn't know how far to push it, how far to push him in different areas and at one point he began to cry and I didn't know whether to keep asking questions .../..I was just in the process of trying to decide what to do and the other nurse she said to me just give a tissue or something and it meant that he was

> able to be sort of more honest and it helped us to develop a really good rapport I think..//..
>
> Rachael: 3,2.

Rachael showed how her thinking has been shaped by her observations involved with experts in their field. She showed also that regardless of knowing what to do, being in the situation challenged her beyond that for which she had rehearsed. Her subjective experience demonstrated her vicarious learning which illustrated the 'how' of her involvement - listening, watching, and thinking. When the time came to demonstrate her learning it had been comprehensive but in addition, there were the human factors present in the situation which enabled her to gain an appreciation of what it is to work therapeutically with a client with a mental health problem. She was taken up with the honesty and genuineness of her client and, with the help of her registered nurse colleague, was able to develop a therapeutic relationship. From this vantage point, possibilities were opened up.

Preparation for the future included embodied knowledge that comes from internalising a host of feelings and emotions that are embodied in expert technical skills. Gaining technical skills is a complex learned ability that involves the whole person. All that is observable to an onlooker is the technical skill without recognition of the complexity of the psychomotor and affective components that are integrated creatively by the 'doer' which involves the whole person. On the basis of what could be observed, that is the 'doing'role the nurse traditionally has been judged a success or failure. Benner (1984a) calls this the 'know how' of nursing practice. The theoretical component constituting the knowledge base for professional practice is taken as a given if the nurse is a registered nurse. Benner (ibid) has called this 'knowing that'.

Most of the time, technical skills are performed without too much thought because the skilled practitioner has embodied the knowledge used in skilled activity. When things go wrong, this knowledge is then brought to consciousness as Kiri states:

> I gave an intramuscular injection and before we gave it the RN said to me was I quite happy about giving it and I said yes I was and she asked me to go over what I was going to do.. she said to me "the worse thing that's going to happen is you'll hit the bone and I said "what does that feel like?" She said "You'll know if it happens". I said "Do I just draw back and I mean pull the needle back a little bit and draw back again?" She said "Yes". Anyway we went off to see this man and he was just a skinny little fellow and I finally got everything sorted out and I put the needle in and I hit the bone and I thought "Oh my goodness, this is what it feels like!" It just felt like you're knocking, .. it felt like I could hear it and I could feel it and he was just sitting there like nothing was a problem..I just pulled the needle back a bit, drew back and then gave it and finished off..it was so uncanny.
>
> Kiri: 2,12.

Kiri re-evaluates a technical skill in the light of experience. She was afraid of hurting her client at the outset but she now has learned that she can perform a skill and it can go wrong without devastating consequences. She was amazed on two accounts - the first that she actually hurt someone without ill-effects and secondly, at the resilience of her client. She stated that this left her with an 'uncanny' feeling. Kiri's feeling could be alternatively described as remarkable or amazing (Pan Dictionary of Synonyms and Antonyms, (1991)). From this episode Kiri developed embodied knowledge that would be indelible among her repertoire of practical skills. By having had the injection go wrong, in the future she will know what it feels like to 'hit the bone' and will try to minimise this happening again. Her learning in the situation has

increased her self knowledge and her confidence in herself as a practitioner of nursing.

Technical equipment that was new to them or unfamiliar by way of lack of experience with it, was part of the challenges that the study participants faced daily, particularly in 'Hi-tech' areas such as the Emergency Department and Intensive Care Units. The students perceived technical equipment as part of modern health care and were not particularly phased by it. Kit exemplifies this stance:

> We had to set up an IVAC pump so she (the staff nurse) went through it with me while we were setting it up. It has a little bit in the middle that if you don't set it up the right way you are in big trouble. I never really knew about that before. You just connect it like a normal metriset to the bag and you run it through and you invert the cassette, so that all the air gets pushed out down through the tube, and then just push the casette into the machine and put a sensor on the part where it drips, and then you just dial up the rate you want and push start, really quite easy...The first time I had it explained to me quite thoroughly so it wasn't really a bother to me the second time. She just talked me through it and that was fine.
>
> Kit: 3,5.

The students had their focus upon their future for they could see advantages in being familiar with technical equipment and skills for future employment possibilities. A technically expert nurse as well as a caring compassionate approach to client care will make the expert nurse of the future. Part of that future is administering medication via the intravenous route, a technical skill denied them as a student nurse. Kiri states:

> The first two nights I was mixing them for the RN and on the third and fourth night, I was giving them under

> supervision and I thought "I know that you're not meant to give them and I know the risk that they're taking." I discussed that with the RN and the RNs both said they were prepared to take responsibility for it and I wanted to give them. I was nervous but the RN was there. I had a picture in my mind of what to do I felt comfortable about the patient and the patient felt OK. It was a really nice relaxed atmosphere, I felt alright about it. Having done it now, the big curiousity about doing it is gone and I feel that there is no mystery about it.
>
> Kiri: 2,4.

Both Kit and Kiri demonstrate the expert coaching (Benner, 1984a) function of the registered nurse. Both registered nurses set up the environment for ideal clinical teaching. The ability to coach through patiently 'talking through' a technical procedure enabled Kit to 'be fine' the next time she was required to set up an IVAC pump. For Kiri, the registered nurse stood by and created the ideal environment for Kiri to try a new skill feeling supported and confident within the procedure.

Preparing for Colleague Relationships

The study participants appraised their relationships with Doctors. In readiness for their post graduate experience, they began to communicate with doctors concerning their clients'health care. They sought to work collaboratively with the doctor recognising that each made a contribution to the health outcomes of clients. Theresa illustrated this stance:

> We are taught that we should converse with the doctors and decide on our client's care but it's not done, not that I've seen, the places I've worked in it's just not done except in theatre. ..//..I like to deal with the Dr's about the client's progress myself. A couple of times I saw the doctor walk in and breeze out and I thought, well, that was quick. But then when I caught him the next time, I went into the room where my clients were and I said these are my clients, do you mind if I stay

> and I talked to him and he asked me questions and he said, "what have they done?" and I told him and so we did that together and I wrote it in the notes 'Doctor has been in and said this' and that has been decided in new treatment or whatever. So we collaborated that way because I was interested to see what he said and what he thought their progress was. I don't know how the other staff nurses go - whether they are just stuck in the pattern and they are so mundane they are used to it but I would never be like that.
>
> Therese: 3,15.

Therese's way of being in the world is as a professional within collaborative practice. Therese expects to communicate with the Doctor and together they monitor the clients' progress. She states that nurses on the whole, are apathetic to take up the collaborative role but believes that it is important to develop a colleagial approach to client care. Therese's thinking is that of a contemporary view in nursing that the nurse's practice can only be shaped by nurses themselves. Education alone is not enough to create new practice structures. Nurses themselves must make the change.

Clinical judgement that leads to advocacy for a client takes a commitment and a willingness to act out of concern for their welfare. Being an advocate involves one to be sure of one's ground and have the courage to speak up. This can be all the more difficult when one is a student and when there are controversial aspects to the situation. D.J. discusses such a situation:

> It was a severe laceration under the heel of the foot. The dressing was soaked through, it hadn't been sutured and it should have been, it was huge. It had a giant haematoma under it, which had come up during the night. The child had not been told to keep his foot up, had not been told to stay home from school. I cleaned it up, cleaned off the yucky bits and then called one of the Doctors to come and assess it because I felt that the haematoma needed to be released and the wound needed

> suturing and when the child left it was relieved and sutured and well dressed and the child was not going to school that day or the next, he was going home...
>
> D.J., 2,9.

Being a student and being a shift worker

One of the differences for the study participants was that for the first time, a good number of them were to work in the clinical setting to cover twenty-four hours of the day. This was a new experience for them and it meant that they were placed on full rostered shifts. Not all, but most of the study participants, worked for some of their time on night duty.

Night duty had some special features which most of the study participants found facilitated the process of being able to prove themselves in the situation. One of its redeeming features was that there were less staff which gave them a greater opportunity to gain valued clinical experience. It gave them opportunity to do things that they hadn't done before and it usually meant a heavier workload which was a good test of one's ability to manage both time and the work to be done. It also meant that they had greater responsibility and had to think through their work as they went about it. The negative aspects of it was that it was very tiring. Jenny shows what it meant for her to be on night duty:

> It means that often your workload's heavier, it means that you've got to take on more responsibility because you haven't got that extra staff covering you and it means that you sort of have to be aware of what you are doing and think about what you are doing and organise yourself even better than you do during the day. I was lucky we had a really really busy week of night shift and it just covered everything. Like one night I think I had seven or eight clients and five of them had I.V.'s and one of them was having blood and one was on a PC Pump and I had to catheterise, this is all in one night,

> I had to catheterise one lady and it was really good because I got the opportunity to do things that I haven't had the opportunity to do in the rest of my training.
>
> Jenny: 2,1.

Students spoke of ***losing a sense of the habitual body*** which is the body up until this point that had been relatively predictable for them. Usual processes like digesting food are things of which we are unaware. Working shift work and particularly night duty was not only an external experience like coming on shift at 11.00 p.m. but it also was an internal experience where bodily processes were brought into consciousness due to the body having to readjust its bio-rhythms. It also meant the external world, the world outside of work became something that appeared apart and far off. What was normal and natural became something that was foreign with a sense of a loss of the habitual body that normally is taken for granted. Colleen showed this process:

> I started off on mornings and I started on time because getting up wasn't too bad, by the fifth morning I was quite tired but I knew I had the weekend and I had a fairly normal life, like I would go to the gym and I would do this and that and in the evenings I could actually study as well which was really good. But then I had to do afternoons and things started catching up on me and I'd stay in bed till later and later. I didn't feel like I had a normal life, like you just feel like you are going to work, sleeping, going to work, sleeping, eating and it's terrible. Then I went onto nights and was just totally blown away, I hated it, it's terrible and I'm really glad it's over. I've only done four nights but you know, once I got to work and by about the third night I was beginning to adjust to it but the first and second night I just cried half way through the night, ..//..just really upset and depressed about everything...//..I was really surprised, I am so tired and I've had theoretically enough sleep ..//.. just shaken upside down really.
>
> [It's a big change for you ?]

> Yeah, like I had to go for walks outside today and I went down to the shops because you feel not part of society basically, you feel like you're not part of the rest of the world, you just lose touch with what everyone else is doing normally, its terrible.
>
> Colleen: 2,15.

They often reflected upon being a student and were both excited and fearful of the future as they anticipated how it might be. They recognised that their student days were nearly over but they were not yet the 'nurse'. They were dependent upon others for both backup and opportunity. All of the study participants nevertheless talked about being a student and what it meant for them to be a student in the Pre-Registration experience.

Being a learner was one of the most significant statements used by every participant. The students dwelt in the world of nursing practice as a 'learner'. They knew that their education set them up to practice as a nurse but the true learning was discriminating how they would use their knowledge in the situation. The complexity of nursing practice can never be revealed in a text book nor can it be captured in scenarios of practice. It is only by being engaged in the situation that the nuances of nursing practice will show up the knowledge that is meaningful to them. It is this knowledge that is called forth in the every-day practical situations that every nurse encounters and which is so difficult to capture on a page. For the study participants, experience has become the teacher.

The study participants as they cared for people were situated in a practice world where physical problems were dwarfed by social or psychological ones. This would confirm that an educational preparation that views the person holistically is an important conceptual base for practice as a nurse. It enables the nurse to understand and provide appropriate care for their client because

each person dwells in a self interpreted world made meaningful by their life space. Jenny illustrates a capacity to listen, empathise and act out of concern which creates for her an opportunity to help her client:

> It was my last shift that I did and I had one lady she was having surgery, she came in one day and was having surgery the next day and she was really, really anxious, I don't think I've ever seen someone as anxious as her. But I mean she had an accumulation of things, her husband died 5 years ago, virtually the day she had surgery, her son was driving her car and he'd wrecked the car and she's a courier and that's her livelihood you know and she had to take time off work, she can't afford to take time off work. One of the other girls spoke to her about that and suggested that she go and see social welfare and get a sickness benefit. But she was really really stressed out, and I sat and talked with her for quite a while and she sort of came out, she would say things like well, it wouldn't really worry me even if I died under the anaesthetic tomorrow you know and I think deep down she probably felt that because she really still misses her husband and she hasn't come to terms with losing her husband yet. He died of cancer and she nursed him at home for 18 months..//..So I advised her, well I didn't advise her, I said to her look, you seem like you've got a few problems, would you like me to contact someone. I said we have a very good psych. team here and she said- Oh yeah, I'm as nutty as a fruit cake and I said no you're not as nutty as a fruit cake. I said everyone has problems and sometimes it helps to speak to someone who can help you with those problems and she agreed to it, she was quite happy about seeing someone. A lot of them take the attitude - oh you think I'm nuts, but when you explain to them that's not what it is about they are usually quite happy. In fact, they are relieved, they feel better about it, they feel something is going to be done about it.
>
> Jenny: 1,4.

Jenny illustrates in her exemplar that a societal stigma associated with mental illness is carried over in day to day myths embedded in how people are in

their worlds. In this exemplar, a woman has shared personal information that has a bearing on how she will proceed into her surgery. Prior to Jenny listening and caring about, as well as for her, she was not in an optimal state of mind conducive to healing and health. Jenny's intervention through caring and concern has made a difference.

Building confidence

The study participants found that conditions which built confidence were 'having a lot to do' by accepting responsibility and coping with it. When they felt they were coping with the demands of the situation, giving quality care to their clients to the best of their ability, being presented with opportunities and challenges which they relished they then felt that they were proving themselves. Jenny continues:

> Basically just it was a learning experience for me because I learnt that I could do it. I could cope, I really did have the confidence, that I did have enough knowledge to get me through..//.
>
> Jenny: 2,2.

Jenny reveals that she has proved to herself that she could do it. She could nurse safely and under pressure because that will be the situation in which she will be nursing in the future. She also reveals a fundamental truth to herself, one that the majority of the study participants each came to recognise. That not only were they learning clinical practice through doing it but also, they learnt about themselves and reflected upon their own growth over the two and one half years.

As Colleen states:

> When I think about myself then and now, it's a real challenge. I've refined a lot of parts to myself that were

> good and why I wanted to do this as a career..//.no matter if I do it for 5 years or 10 years whatever, 2 years, I know it's helped so much in personal growth and my own life, how you function. It is what I want to do but even from the point of view I mean that there is so many options of what to do within that but as I said, no matter even if I change, I know that it's been a really valuable experience, like for me personally.
>
> Colleen: 3,17.

Growth occurred for the study participants on personal and professional levels. They became aware that they were able to meet the expectations that they had for themselves and those that they perceived the registered nurses whom they worked with held for them. They felt that they could nurse clients safely and well upholding their educational preparation and all of this, within the reality of the daily demands within the work situation. This was the assurance that they sought at the outset and it was fulfilled through being placed in a multiplicity of situations where their knowledge and skills were called forth in a meaningful way. A number of the study participants stated that 'things' had 'clicked' for them. Kiri states:

> Getting this continuous practical and listening to other nurses talking about things, things start 'clicking', things start coming together more so. I suppose it's a combination of the two. You get the sort of basic skills and the confidence and then you get to this point and suddenly it takes another step and starts meaning a bit more and you can start interpreting things.
>
> Kiri: 2,12.

Ready to take the plunge

Putting it altogether was what had mattered to them and the study participants had done this. They had often heard this statement and were waiting for the mystery to be revealed. They had explored the 'know how' and could see how

it related to 'knowing that'. Experience had joined with theory to be the learning of most value. They now were ready. Ready 'to take the plunge'. Patricia reflects on her pre-registration experience:

> For me it was worth while, in that I got more practice putting skills into effect - seeing the nursing process really working for the patient - and just a general feeling of competence, being able to work safely with the patients and all the people - staff as well as patients. ..//..Just that feeling of confidence and that I am equal with them out there I mean you always hold them up in awe the other RN's and the Drs. but really they are not. You don't have the skills and the knowledge that they have, but you can communicate with them on an equal footing.
>
> [How do you feel about your knowledge and skills - at what level do you feel that they are ?]
>
> READY TO TAKE THE PLUNGE - ready to do that and that was something I didn't feel before the pre-registration started.
>
> Patricia: 3,21.

The culmination was the acknowledgement by the study participants that they were ready. They also knew that the State Examination had to be passed before they could practice and then, they may not get to practice because of job opportunities. This was a dampening factor and gave them an impression that the future was void. Kerry illustrates how many of the students felt:

> - we all got letters today from the health board saying there would be no interviews for students because there are no jobs. Why do we bother !
>
> Kerry: Diary, Day 9.

Kit discloses how much her pre-registration experience has meant to her and her feelings of loss with which she is leaving the ward:

> I have been really happy with the experience up to now and I'll be very sad to leave. I would like to get a job as a staff nurse on that ward, but it is not possible so it will be the end of an era I suppose. It's been such an enjoyable learning experience.
>
> Kit: 3,1.

Kiri continues the same theme concerning feelings of loss and a sense of meaningless:

> I left full time employment to start training. This is what I want to do, if I don't follow it through then the whole three years has been an absolute waste of time - and it's what I want to do. So I'd be basically letting myself down if I didn't follow it through.
>
> Kiri: 3,5.

The frustration that they felt with the no job situation meant that some were already turning their attention to creating opportunity for themselves to open their own doors. Innovative thinking had already begun and possibilities were beginning to show up. Rather than be thwarted by a government policy that deprived them of practising nursing in the future, they were exploring for themselves, opportunities outside the conventional hospital corridors.

The study participants had proved to themselves what was of most concern and confirmed their ability to practice. Caring for and about people and caring for them in a professional manner. They were able to combine their knowledge and skills in a uniquely personal way to practice as a professional nurse.

As Jenny states:

> With the clinical experience I feel I've been really lucky working in the ward, I have been working in because I've been able to get in and do what I want. Not so much what I want but get in and just do it and work as an individual and I've found that it's been a real confidence builder as well as an ego booster. I just feel, the staff don't always come back and say a lot to you but your patients do and you know that they are looking forward to having you come to work.
>
> Jenny: 3,3.

SUMMARY

The lived experience of the student can only be appreciated by seeing the whole. The study participants worked not only at their day to day practice but also to create meaning for themselves of the total pre-registration experience, and their three year nursing education programme. The students enjoyed their clinical practice but were aware in their thoughts of parts of their education that appeared to have nowhere to be expressed. They were totally immersed in the happenings of their own world and the world around them and sought to accomplish their nursing education goals at the same time. They were working hard daily as a staff nurse and the total experience left them with feelings of exhaustion and an inadequate feeling of preparation for their crucial State Examination.

Positive feelings of personal growth and fulfilment of educational goals were expressed by the students as well as negative feelings of propping up a strained Health Care System under the guise of clinical learning.

The students made sense of their nursing education and were able to place their theoretical learning into context and find the fit. They dwelt in the world

of clinical practice as learners and appreciated the meaningful learning that made their career choice and their clinical experience a personal feeling of fulfilment.

CHAPTER NINE

DISCUSSION AND CONCLUSIONS

This chapter begins with an overview of the entire study and then draws out significant findings from each data chapter. Discussion of the findings follow, which are compared with related relevant literature from research that has been accomplished since the data collection for this study. The chapter concludes with statements on the limitations of this study and implications for future research.

OVERVIEW AND SUMMARY

The central thesis drawn from this research is that the study participants (students of nursing) used the last period of pre-registration clinical experience, to which they were assigned prior to sitting their state registering examinations, as a ***proving ground***. During this time they tried to make meaning of their nursing education as they related it to a context similar to the ones on which much of their future professional lives will be lived out. The title of the thesis ***'the proving ground'*** came from the many explicit and implied references that the students made to this concept.

Phenomenology as a research method gives expression to the experience in its entirety. Students live their pre-registration experience in terms of what it means to them in the light of their past, present and future aspirations. In phenomenological terms, these are the intentional, relational, spatial and temporal dimensions of their lived reality.

It is claimed that students of nursing enter their pre-registration experience purposefully and use this time carefully. First they set out to prove to themselves that they are capable of nursing clients safely and competently and secondly, to prove to registered nurses in the context where they are working,

that they are worthy to join the cadre of registered nurses who make up the body of the nursing profession - in this way they expect to become insiders, party to the shared knowledge and practices that make up the discipline of nursing.

The bi-dimensional nature of the proving process, to the self and to others, is not experienced separately but is expressed as a unity which the study participants could only come to know through the embodiment of what it means to be a nurse. This they do by actively taking up the challenge of working as a soon-to-be staff nurse in the context of clinical practice. The ultimate concern in the pre-registration experience is to nurse competently in order to provide a safe nursing service to clients and find employment to practice as a professional nurse.

The study participants experience is an embodied one, that is, the students' live the experience through their body and perceive the world with their body (Merleau-Ponty, 1962, p. 206). Heidegger (1962/1927) calls this a state of "being-in-the-world". The total experience takes into account the students' in their wholeness, what it was for them to be in the clinical setting where they were found, and the many relationships that existed within the context that connected them to other nurses and allied health professionals in a world of shared practices and common meanings. It was in their endeavour to become part of this world that this study gains significance.

The study participants were involved in a six to eight week experience at the conclusion of a three year course of which they had completed two and half years at the time of the study. They were expected to perform as a registered nurse, and often carry the work load of a registered nurse, in their effort to 'prove' that they were able to perform as a registered nurse as soon as they passed their State Examination.

Students of nursing, when engaged in their clinical experience, span two institutions and two subcultures, the educational parental institute and that which is part of the health care system. What is not evident to either institutions, is the socio-political and cultural nature of this span. The students are constantly negotiating multiple sets of expectations, as well as continually negotiating the different sub-cultures. In the first instance, there are the expectations of the self to be competent for the provision of high quality nursing care to clients. In the second instance, there are the expectations of the clinical agency staff to be reliable, responsible and accountable for the nursing care provided. In the third instance, there are the expectations of the educational institute which seeks assurance that the student is able to meet personally defined objectives for the pre-registration experiential learning component of their course as an endorsement of the nursing education provided. Finally, the 'big one' as D.J. (3,5) stated, is the expectation of the Nursing Council for a standard of knowledge tested through the State Examination that ensures their 'fitness' to be registered as nurses in New Zealand. In addition the students are learning the norms and practices that will allow them to move from the world of being a student to the world of work as a nurse.

There are few other professions that demand so much of their neophytes and further, that they function at a level of competence that mirrors, from day one, those of the professionals whom they are joining (Reinkemeyer cited in Salmon, 1971; Perry, 1985a; Clare, 1991a; Horsburgh, 1990/91). The study participants are fully aware of the expectations that registered nurses have of them, hence their pursuit in the proving process. What is shown in this study is the willingness and enthusiasm of the students as they learn in their clinical practice thus confirming the assertion made at the outset, that the students enjoy their clinical experience and learn much from it. But, what is it that

they learn ? Why do they enjoy their clinical practice so much ? The findings of this study provides some answers to these questions.

LIMITATIONS OF THE STUDY

One limitation of this study is that the researcher was in full time work while analysis, interpretation and writing of the report was undertaken. This reduces the continuity of the writing and impairs the vision of the whole consistently. Interpreting the data alone is also a disadvantage although my Supervisor viewed the transcripts and guided me throughout on this process.

The conception, data collection, interpretation and the writing of this research report from an educator's point of view creates a bias that is acknowledged. The findings cannot be generalised as the data can only relate to the students who took part in this study. Given a similar group of senior students of Comprehensive nursing with the same gender, age and experiences, it is likely that similar findings could follow.

In as much as that the participants were volunteers who came forward from a much larger pool of potential participants, the 21 students who took part in the study could, by virtue of their motivation, be considered a special group. There is no way of assessing the effect, if any, of this difference. Their willingness to participate was a bonus for the researcher and no doubt had some influence on the data collection process. Certainly, their high level of motivation created an environment that was rich in interaction and dialogue.

The students did not prepare their interview ahead of time but responded at the time of interview to the opening statement "Tell me about your week ?" In phenomenology, minimum structure or questioning is desirable in order for stories of clinical practice to emerge. The study participants' diaries which they kept for ten days while in their pre-registration experience complemented

the data gathering process. Of significance, is the frequency with which the narratives in interview co-incided with entries from the students' diaries. On many occasions the narratives were so long and so rich that I, as the researcher, wished I could have used every word in the research report.

This study focuses upon the nurse's thinking and the narrating of their experience in the context of nursing practice. It does not take into account nursing clients or nursing staff in the context.

Essential components of evaluating a study include looking at those aspects which may limit the confidence that can be placed in the findings, and/or their generality; and assessing how fruitful the study has been in promoting further research. As discussed above, this project has clearly opened the way for other studies focussed on the teaching and learning of clinical nursing skills, particularly those approached from a phenomenological stance. Although some methodological and procedural limitations have been acknowledged here, none of these are serious enough to undermine the worth of the study.

FINDINGS

In Chapter Five, it was shown how students bring to speech the orientation phase of their lived experience in relation to the proving ground. In phenomenology, orientation refers to an appreciation of 'space'. The term 'space' is not interpreted in its traditional meaning as a logical and real dimension but as a 'clearing' ground where things can be positioned to enhance possibilities (Merleau Ponty, 1962, p. 242). Of significance in this chapter is the learning that is required by the students in order to function within a clinical setting. Kit referred to this as 'finding my way'(Kit 1,19). A constitutive component of the pre-registration experience is learning the setting, the people and the protocols within it. It is only when the student

feels that they have learnt the spatial dimension of the setting, that they can feel secure and are then free to become an independent learner within it.

Time allotted to this phase varied from two days to two weeks which has implications for Schools of Nursing who send students to placements for two weeks clinical experience. The student would not have begun to learn the clinical work that they are sent to learn as the orientation period and the socio-politico-cultural nature of it, can take the whole time.

In chapter Six, the study showed that relationships between staff and between staff and students are an essential link in the learning process. Hence a second constitutive component of the pre-registration experience is a relational component. In fact, if the relationship between the student and the registered nurses in the context is not optimal, the student is less likely to be given enriched opportunity to gain the valued clinical experience they seek. Commonly, the relational aspects of students' nursing education as they interchange between educational and clinical settings frequently throughout their Diploma of Comprehensive Nursing programme, has not been given high priority in students' learning experiences. Yet, these are a critical part of their learning. The registered nurses make covert subjective judgements on the competence of the student and if they 'measure up', then the way is opened more readily for the student to be given the responsibility of client care in a manner which is challenging. By being challenged, they learn the fit of their educational preparation to the demands of the clinical context.

In support of these findings, Peters (1989) in popular literature concerning excellence in industry, suggests that collaborative practices promote the success of organisations. Similarly, Dixon & Paterson (1986), Paterson (1989) emphasised the vital role of nurses working together for the benefit of improved client care and for the growth of their own professional practice.

What is needed is a renewed vigour in nursing education to enhance the development of collegial and collaborative professional relationships with specific learning experiences focused to this end. Achieving the goals of interchange between settings and increased colleagialship will require commitment, time, energy and resources but the results could be "astounding for nursing, health care, and the people we serve" (Hegyvary, 1991b, p. 148).

In Chapter Seven, the essential nature of the pre-registration students' practice was uncovered as they dwelt in the world of nursing practice thus giving expression to the 'intentional' dimension of the pre-registration phenomenon. In the clinical setting, the students as they worked with their clients, reflected their theoretical teaching. It gave the student a "handle" on the situation from which they could re-appraise their theoretical knowledge. If the fit was snug, then the theory came to life, became useful and gave a utility to the students' knowledge which facilitated meaningful learning. The experience thus gave meaning to their theory and raised questions within the thinking processes of the student. Thus theory and experience configure in a personal way of knowing that essentially becomes, over time, the substance of professional knowledge. Ultimately, it is personal knowledge built up from a host of different practice experiences that are significant to the nurse which become paradigm cases to empower the nurse in expert practice, (Benner, 1984a).

A significant finding of this study was the involvement of the study participants with their clients in their practice world. The willingness and enthusiasm of the students as they worked with their clients reflected their enjoyment of their clinical practice and demonstrated their commitment to professional practice and to the profession of nursing. The concept of 'involvement' (Benner, 1991) would seem to be an essential component in ethical service-oriented quality nursing care and is what makes for satisfying

The sustaining energy for the study participants is the enjoyment and personal satisfaction that they get from their clinical practice. This enjoyment and satisfaction is inextricably bound in the ethics of a caring profession and the caring practices entwined in the 'notion of good' (Benner, 1984a). As the study participants assisted clients meet the challenges of illness, trauma or tragedy or to cope with the demands that come from living a life suddenly disrupted, they themselves were challenged. Being able to meet the challenges of clinical practice and give expression to their nursing education enabled them to prove to themselves that they were ready 'to take the plunge' (Patricia, 3,21).

DISCUSSION

In the process of separating nursing education from service settings, something has been lost. One identifiable loss has been the opportunity offered by proximity for close collaboration between nursing education and practice which is required if the two are to be seen as a unity. In 1990 the American Association of Colleges of Nursing (AACN) voted unanimously to set goals for all member schools of nursing to develop collaborative relationships with practice settings to advance the goals of nursing practice, education and research (Hegyvary, 1991a). This goal could well be set for New Zealand Nursing. This study demonstrates how learning in the clinical context becomes meaningful learning (Polanyi, 1958), and is of value because it shows how the students think in their practice. The findings demonstrate clearly that theoretical formulations give the student confidence in the initial encounter but quickly the student's practice becomes personalised and individually focused to meet the demands of clients in the nursing context. The beginning point therefore for nursing education is practice which should then become the focus for theoretical teaching.

There needs to be a transformation in nursing education that begins from the stories of practice. Diekelmann (1992) states when focussing upon returning Registered Nurses for continuing education, that innovation for nursing education can be found in the familiar. Nurses have always had a strong oral tradition and stories of practice are usually well told at tea breaks or when there are get-to-gethers. What is needed is a greater valuing of these stories as part of everyday practice, nursing education, and a continuing focus for research. By refocusing nursing education on practice stories as a beginning point for theoretical formulation, the substance of nursing knowledge takes on a reality and a distinctiveness that makes learning experiences meaningful for would-be nurses as well as those already practising as registered nurses. In addition there is a call for ongoing research to uncover knowledge embedded in nursing practice (Benner, 1984a) which is to be found empirically in the clinical field and in the work of nurse teachers (Diekelmann, 1992).

Benner & Wrubel (1989) point out that nurses have become knowledge workers because of the complexity of nursing practice. This trend will continue as society extends into the information age and the demands for cost effective health care escalate driven by complex socio-economic, political and philosophical forces (Sanford, 1990). Expert clinicians of the future will use knowledge that is shaped by clinical experiences that the nurse encounters, developing over time an increasing perceptual sophistication in interpreting what is significant within the perceptual field. It is this clinical practice environment that the study participants are poised to enter.

This study shows how the pre-registration student of nursing is guided carefully and skilfully by expert nurse clinicians in the clinical context. What is also needed is an environment where this learning in nursing education is enhanced through greater collaboration and information sharing between nurse educators and clinicians.

There has been a failure, by many employers, to acknowledge the breadth of nursing education which in New Zealand, since 1973, has included a considerable body of social science as applied in nursing as well as a body of scientific nursing knowledge. As stated earlier in this report, bureaucratic goals have overridden professional goals (Horsburgh, 1989) and have inhibited the expression of a certain amount of this broader knowledge gained as part of comprehensive nursing education courses (Perry, 1985a; Clare, 1991a). Yet nursing services in a changing societal environment are required to be versatile, integrative and collaborative with nurses being able to think creatively to solve practice problems with fewer resources.

In New Zealand, restructuring of the health system provides an opportunity for leadership by nurses to develop alternative structures for their practice and at the same time, contribute to an environment where professional nursing could flourish.

The Concept of 'Involvement'

As stated, a significant finding of this study was the 'involvement' of the study participants in their nursing practice. To focus a little more on this concept, it could be said that 'involvement' is different to commitment as it involves a greater emotional contribution by the nurse. To extend this concept further, Benner (1991) believes that 'skilled involvement' is the hallmark of the expert nurse. Hagerty and Early (1992), have proposed a model for professional practice that has been constructed from nurses' descriptions of their use of applied liberal educational competence in their practice to include the concept of 'involvement'. The model has two emphases, the first is "involvement" and the second "conditions of practice", (ibid:34).

'Involvement' is contingent upon the connectedness that the nurse has with the practice situation, is individually chosen, and is characterised by either a reactive or a proactive stance. In a reactive stance, the nurse responds to external demands present in a situation using the nursing process, nursing systems and professional expectations to guide her actions. In a proactive stance, the nurse is motivated by internal influences with the belief that future events can be shaped or controlled by his or her actions. In the latter situation, applied liberal education competence gave meaning to the acts of nursing.

The proactive mode for nursing practice was characterised by two levels of involvement. The first was experimental, and the second, internal integration. The experimental mode showed a willingness to take risks and to venture into the unknown when compared with the internal integration mode. The experimental mode held a greater degree of discomfort for the nurses because of the unknown risks in a situation. The present study shows that the study participants were able to venture into the unknown and were willing to experiment with their nursing practice within limits in the interests of safe client care.

There were many situations evidenced in this study where the study participants demonstrated their involvement as a nurse in client care. These included critical conditions (Carrie: 2,1, 136), (Anne: 1,10) as well as deeply sensitive (Alexandra: 1,12-13), (D.J., 2,3) or controversial situations, (Jane: Diary, Day 4). Involvement was a key feature of the students' practice.

Hagerty and Early (1992) also examined System-related involvement which included the health care system's culture, norms and rewards. A system that encouraged flexibility and creativity to engage in professional practice was seen to enhance involvement. Job expectations also influenced involvement.

A key feature of the present study was that the students were involved in their practice in spite of dismal job expectations, demonstrating that the satisfaction that comes from their nursing practice over-rode a potential for despondency.

This study provides a further dimension to profession-related conditions for enhancing involvement as espoused by Hagerty and Early (Benner, 1991) by way of the colleagial relationships and support present in a clinical setting for students as they develop clinical expertise. Students of nursing should be treated as professionals-in-training which would then facilitate and enhance nursing education for professional practice.

Similarly, Benner (1984a) identified a nurse's involvement as a fundamental way of being in the nurse client relationship. She extends her discussion to skilled involvement (1991) as a critical way of being if the nurse is to provide therapeutic nursing intervention that is appropriate and relevant to enhance client recovery. Involvement therefore appears to be an important dimension in the delivery of quality professional nursing. The concept of 'involvement' has many dimensions that, as yet, have not been fully explored and so hold implications for further research.

Nursing Education - The Value of Clinical Practice

Nursing education curricula have been founded upon the Tylerian Behavioural model (Tyler, 1949; Diekelmann, 1988). In the behavioural tradition, the curriculum is teacher centred in so far as the teacher chooses 'what' the student should learn by way of setting learning objectives. Traditional evaluation tools based upon a behavioural approach to learning, sought a correspondence between objectives set and measurement of achievement by the learner. When correspondence occurred, it was assumed that learning had taken place. This form of curriculum fosters a dependent learner, one who

responds to external cues rather than a learner who seeks to question and enquire into issues that may arise from their practice world about them.

A behavioural curriculum fails to adequately address the multifaceted nature of nursing practice and, by the nature of the principles of measurement that it embraces, edits out aspects of nursing education that are paramount to becoming a professional nurse. In nursing clinical practice, this form of education is suitable for technical skills but, for example, relational aspects of nursing practice, shown by this study as being of critical importance, are difficult to measure in an objective manner.

Diekelmann (1988) has called for a curriculum revolution in order to reconceptualise nursing education. The curriculum as lived by the students in their day to day experience is the starting point for a model in nursing education, namely the Dialogical and Meaning model (ibid,p. 146). This model sustains two kinds of knowledge, one instrumental and theoretical and the other practical and reliant upon experience. Knowledge that is used by practitioners in clinical practice Diekelman (ibid) states is 'transactional' rather than applicational. Knowledge when illuminated through practical experience, becomes meaningful. In the classroom, students' of nursing can learn 'about' nursing practice but it is through clinical experience that they learn the 'know how' of being a nurse.

While, nurse educators are important in the classroom but equally, so are the clinicians in the field. What is needed is a marriage between the two. This study shows how clinicians facilitate students' learning in clinical practice and the importance of the right climate to foster the development of the students'

practice. Diekelmann's Dialogical and Meaning model of preparing students of nursing states that:

> ..The relationship between theory and practice or theoretical knowledge and practical knowledge, is **transactional** rather than applicational. The practice area is the place where students enter into dialogue with the theories they learn in the classroom. It is through practice that theories are refined, elaborated, and challenged. Practice is theory-generating, and in this sense, as Heidegger's notions (1962/1927) of practical knowledge preceding theoretical knowledge suggest, theoretical concerns are derivative (ibid, p. 147).

To reveal how the students use their theoretical knowledge in practice is to capture stories of care for clients. Thus stories of care, both in caring about and in caring for, form the substance of ontological knowledge in nursing education but should also be the substance of epistemological knowledge in curriculum content. It is the focus upon the caring component in nursing stories of practice that is meaningful, restorative and healing (Benner, 1991) for both client and clinician alike. These stories not only capture the science and art of nursing in context, but also provide the substance for meaningful dialogue among students, clinicians, educators and researchers with nursing practice as the focus. In this way, the professional discipline of nursing can be advanced, through a congruence between practice, research, theory and education.

Competence

Another important issue raised by this study is the emphasis by the students on 'competence'. The students sought to be competent in the situation both as adult learners and as safe clinical practitioners. For the adult learner, meaningful learning is seen only in relationship to competence (Knowles, 1984). Nursing students expect to be competent at the conclusion of their

nursing education in order to practice safely and in a manner acceptable to the professional community that they seek to join. Employers are demanding that all graduates from tertiary education settings, including nurses, be able to perform at a level of competence that is acceptable to the work place.

Competency based standards for vocational education and training have swept Australia and are developing rapidly in New Zealand (Gonczi, 1993). There has been an impact of this movement on professional education, and nursing is no exception. Although there are several perspectives on the nature of competence, the one that professions are readily identifying is the idea that competence includes an integration of knowledge skills and attitudes combined uniquely with professional judgement to meet demands within specific situations.

The Australian Nurses Association[3] has identified central competencies that an employing agency can expect a nursing graduate from any nursing programme to demonstrate on employment. This initiative has been developed in response to service agencies demanding relevant standards of practice to meet current practice demands. New Zealand Nursing programmes must be approved by the Nursing Council before they are offered through the Polytechnic as basic education for Nursing[4]. In addition, Accreditation and Approval processes by the New Zealand Qualifications Authority (1991), a government Agency set up to ensure national standards for all educational

3 Refers to ANRAC, national competencies for the registration and enrolment of nurses in Australia, 1990.

4 The Nursing Council of New Zealand is the statutory registration authority for nurses. Its statement of purpose is "to protect the people of New Zealand by setting and enforcing minimum standards of education and practice to ensure that those whose names are entered in its register meet these standards" (Nursing Council, 1972, Wellington, New Zealand).

programmes, approve current Bachelor Degree nursing programmes[5]. The most recent programmes have identified central capabilities that a graduate will demonstrate on the completion of the programme.

This study demonstrates the need for collaboration between Nursing education providers and service agencies as the field for clinical practice. The students developed confidence as they had successful experiences. Successful experiences rested upon a two-way process between the clinicians in the clinical setting providing opportunities for the students and the initiative of the student to maximise opportunities opened to them. Confidence came by way of 'know how' in context. Proving the self to the self and to others required an awareness in the study participants that the knowledge and skill developed was relevant and useful in the situation.

SUPPORT FROM SIMILAR RESEARCH

The study participants' experience is consistent with Patricia Benner's research into making explicit the knowledge embedded in nursing clinical practice. As stated in the literature review, Benner (1984a) identified five levels of competence of the developing nurse practitioner and suggested that a new graduate is at the level of an advanced beginner. While the students in this study displayed an ability to apply text book knowledge when first encountering a client, this knowledge was elaborated upon and extended to maintain relevance as contextually required.

They also displayed a wide variety of skills including an ability to enquire, to think critically, and to use intuitive judgement which would lead on to correct diagnostic and treatment in the interests of the patient's health. The

5 New Zealand Qualifications Authority (NZQA) - an independent statutory body established in 1991 under the Education Amendment Act 1990 to ensure quality education and training in New Zealand through a national qualifications framework.

dimensions of their thinking are captured in the language of their narratives which were unrehearsed as they were relayed to myself as the researcher. It is a combination of empirical, aesthetic, and ethical knowledge and the way in which it is called forth, that culminates in a personal way of knowing which becomes the basis for professional nursing practice. In New Zealand, a grounded theory study carried out by Christensen (1990) involved a research population of student nurses and registered nurses. The outcome of this research was a partnership model for nursing practice.

Part of this model focused upon the work of the nurse. The present study reiterates many of Christensen's findings, in particular, the work of the nurse in partnership with clients.

SIGNIFICANCE OF THE FINDINGS

The significance of this study is partially captured by the method. The strength of phenomenology lies in the method's ability to bring to speech that which has been hidden. This thesis is based upon the students' narrations of their practice, it is directly from the students' accounts that it has been formulated. Therefore it preserves the immediacy of the experience and captures an initial reflective mode of thinking and ways of being of the students in their practice world. This feature is of significance in itself as the literature search did not reveal any accounts of previous research in which student's of nursing have been asked about what they learn from their clinical practice. Most importantly, this study reaffirms the value of clinical practice as central to the development of nurse practitioners.

Polanyi (1958) views learning that is meaningful as bringing about a change in 'being'. The study participants experienced profound change from the time they began their pre-registration experience as students external to the clinical practice setting, to a point of 'readiness' - a transforming, almost to a point

of impatience to be a nurse. The learning thus experienced was independent of chronological time - it came about rather as the result of a congruence between what was aspired to and that which was achieved. Thus the study participants experienced a new way of being as an outcome of their learning - a fulfilment that ripened through meaningful learning experiences.

Equally noteworthy for students, is the important role of developing trusting relationships with registered nurses in clinical settings. As stated earlier in this study, staff relationships have not been given high priority in nursing education programmes yet this study shows that they are of critical importance. It is through the relationships between the registered nurses in the setting and the students, that possibilities for learning experiences are opened up and essential support is gained. The students value their registered nurse colleagues and value their support as they learn.

Of significance is essential knowledge that students require to function adequately within a setting. This includes local knowledge of the setting, the people in it, the common language terms of the group and a feeling of being accepted. All of this is needed before the student can begin to learn what they have come to the practice setting to learn, namely to apply their clinical knowledge within the client nurse relationship.

The important role that the registered nurses play in clinical teaching requires formal acknowledgement in job descriptions. This study shows that there are some registered nurses more suitable for this role than others but their support and assistance to the students is an essential component of the developing nurse practitioner's experience. It has been envisaged for a number of years that a clinical teaching role would be part of the Clinical Nurse Specialist's job description but this specialist position has been slow to develop within New Zealand (Jollands,1974; Laws, 1990), and indeed world wide (Nuccio,

S. A., Costa-Lieberthal, K. M., Gunta, K. E., Mackus, M. L., Riesch, S. K., Schmanski, K. M., & Westen, B. A., (1993)). This study demonstrates that there are registered nurses who are very suited to such a role and that their contribution to the education of future nurses would be extremely valuable.

Heidegger (1971) states that thinking is questioning and putting ourselves into question. Learning to think in a particular way as a nurse meant that the students needed to incorporate into their daily experience organisational knowledge, relationship knowledge, theoretical and practical knowledge. The demands of the total lived experience in their life-space was exhausting for them.

The students focused intently on the self because they had concern about their competence in the situation. Heidegger (1962/1927) explains concern in three ways: the first is 'concern' as involved or interested, the second is 'concern' as solicitude meaning that the student was keenly anxious or willing to learn and to perform competently, and the third is as 'caring'. All three were demonstrated in the way the study participants practiced.

'Caring' as Heidegger relates it to 'concern' means that the students' of nursing were concerned for their clients and were caring toward them in practice. Human care towards others demands a high sense of spirit of self. (Watson, 1985). But 'caring' is a quality that needs also to be experienced by those who are expected to demonstrate it. That the study participants could maintain a 'caring' comportment in the light of their personal circumstances is salutory. For a number of the participants, they were working in the weekends to financially maintain their student status during the week. As they worked in clinical practice, they were expected to function as a staff nurse and take on as full a work-load as was possible in the circumstance. This has

been built from an ideology that clinical practice is the most important constituent of nursing education and theoretical knowledge is of lesser importance. This study shows that both are of equal importance. The secret is the relevance of the latter.

Pressure from socio-political and cultural forces are changing the world of nursing practice. In the past a professional elitism has held sway within health care services related to the esoteric nature of professional knowledge held by a select few. The contemporary public demand a highly educated sophisticated professional person, who is able to practice in a comprehensive environment and who can deal with people knowledgeably, ethically and sensitively. According to Hegyvary, (1991a) the new environment in health care has at its centre the consumer of health care services and the nurse as 'enabler' rather than 'decision maker.' An environment that the student of comprehensive nursing has been led to believe will be the practice environment of their future and one for which they have been educationally prepared.

The question arises what of the current environment, will it be conducive to preparing graduates appropriate to this style of nursing practice ? The answer must lie in genuinely collaborative relationship between education and practice sectors in the interests of relevant, high quality nursing education and client care; something not always easy to achieve when economics are driving health care. In a system that is dominated by efficiency and profit margins, the person for whom the system exists is unlikely to be top priority in real terms. Watson (1985) states that nursing has a mandate to care which is the moral imperative of nursing practice both from an individual point of view and from the professional collective. The question arises as to how this imperative can be fulfilled in a competitive cost containing health care system which will demand increased input and throughput of patients with minimal time for

nurses to provide anything other than essential care ? It would appear that external forces for change through Health reforms, and forces for standards of ethical professional practice, which both the public and the profession seek, are potentially in conflict.

IMPLICATIONS

The major implication of this study is that there needs to be a renewed coalition between nursing education and nurse clinicians in clinical practice. The two are essential in the preparation of the nurse. Students of nursing are aware of the competence they require to practice effectively. They require a professional environment that will allow them to build confidence in themselves as they begin their graduate practice.

Competence includes skilled ethical comportment, (Benner, 1991), honed diagnostic reasoning and a knowledge base that is sharp, current and relevant to meet the health needs of a diverse population. Contemporary society is constituted by people who are educated through the media on health matters and who expect a professional to be knowledgeable, competent, caring and compassionate in their delivery of health care.

SUGGESTIONS FOR FUTURE RESEARCH

This study was undertaken principally from a nurse educator's point of view. It would have been enhanced if the narratives relayed by the study participants could have been given a perspective from a clinicians point of view, especially when the clinician was in close collaboration with the study participants.

A future study could focus upon both perspectives which is likely to be an exciting and informing undertaking.

It could also be useful to conduct a follow-up study, if the existing study participants were willing, to show how a practitioners' knowledge and skills develop over time. The development of clinical expertise has been the focus of research for Benner (1984a) and Benner and Tanner (1987) which has been undertaken in the U.S.A. The New Zealand context differs socially, politically and culturally, which creates the need for contextually relevant research.

This study focused upon acute care settings. Similar research could be undertaken in a community context, using the same methodology. Such a study would provide insights into the practice of nursing students within community settings - the context where the literature suggests much more nursing practice will be located in the future.

CONCLUDING STATEMENT

The strength of this research study is that not only does it affirm the appropriateness of an extended clinical placement as the culminating event in the three year education programme for comprehensive nursing, but also the findings offer new insights into how this time is experienced by the students. It is, in contrast to earlier placements, not just a time for learning, it is in their words a ***proving ground***. This means that effective transition from "being a student" to "being a nurse" depends on students having opportunities in their practice to test themselves out, and equally important, upon them receiving positive feedback as to their progress. Therein lies the clue to how both clinicians and tutors can work to further their common goal of ensuring that newly registered graduates are both caring and competent.

REFERENCES

Benner, P. (1984a). From novice to expert: Excellence and power in clinical nursing practice. Menlo Park: Addison-Wesley.

Benner, P. (1984b). Stress and satisfaction on the job: Work meanings and coping of midcareer men. New York: Praeger Scientific Press.

Benner, P. (1985). Quality of life: A phenomenological perspective on explanation, prediction, and understanding in nursing science. Advances in Nursing Science, 8(1), 1-14.

Benner, P. & Tanner, C. (1987). Clinical judgement: How expert nurses use intuition. American Journal of Nursing, 87(1), 23-31.

Benner, P. & Wrubel, J. (1989). The primacy of caring: Stress and coping in health and illness. Menlo Park: Addison-Wesley.

Benner, P. (1991). The role of experience, narrative, and community in skilled ethical comportment. Advances in Nursing Science, 14(2), 1-21.

Bergum, V. (1989). Being a phenomenological researcher. In J. Morse (Ed.), Qualitative nursing research: A contemporary dialogue (pp. 43-57). Rockville: Aspen.

Bevis, E. O. & Watson, J. (1989). Towards a caring curriculum: A new pedagogy for nursing. New York: National League for Nursing.

Brown, M. (1991). The Auckland School of Nursing 1883-1890: The rise and the fall. Unpublished M. A. thesis, University of Auckland.

Burnard, P. (1987). Towards an epistemological basis for experiential learning. Journal of Advanced Nursing, 12(2), 189-193.

Carper, B. A. (1978). Fundamental patterns of knowing in nursing. Advances in Nursing Science, 1(1), 13-23.

Carpenter, H. (1971). An improved system of nursing education for New Zealand. Wellington: Department of Health.

Chenitz, W. C. & Swanson, J. M. (1986). From practice to grounded theory: Qualitative research in nursing. Menlo Park: Addison-Wesley.

Chick, N. (1991). More on nursing degrees. New Zealand Nursing Journal, 84(2), 18.

Christensen, J.A. (1990). Nursing partnership: A model for nursing practice: Hauora takirua he tauira mo nga kaupapa. Wellington: Daphne Brassell Associates.

Clare, J. (1991a). Teaching and learning in nursing education: A critical approach. Unpublished doctoral thesis, Massey University, Palmerston North.

Clare, J. (1991b). Professional disunity: The effect on preparation for practice. Nursing Praxis in New Zealand, 6(3), 19-21.

Clifford, J. C. (1982). Professional nursing practice in a hospital setting. In L. Aiken, (Ed). Nursing in the 1980's: Crises, opportunities, challenges (pp 101-130). Philadelphia: Lippincott.

Corcoran, S. & Tanner, C. (1988). Implications of research on clinical judgement for teaching. In Curriculum revolution: Mandate for change (pp 150-176). New York: National League for Nursing.

Denzin, N. K. (1989). The research act (3rd ed.). New York: Prentice Hall.

Department of Health (1988). Nursing education in transition: The transfer of nursing education to the general system of education 1973-1988: The Department of Health's perspective. Govt. Print: Wellington.

Diekelmann, N. (1988). Curriculum Revolution: A theoretical and philosophical mandate for change. In Curriculum Revolution: mandate for change (pp. 137-157). New York: National League for Nursing.

Diekelmann, N. L. (1990). Nursing education: Caring, dialogue and practice. Journal of Nursing Education, 29(7), 300-306.

Dixon, A. & Paterson, B. (1986). Working together. A paper presented at the workshop Critical practice: Transition from student to graduate. Massey University, Palmerston North.

Donaldson, S. & Crowley, D. (1978). The discipline of nursing. Nursing Outlook, 26(2), 113-120.

Dreyfus, H. L. (1991). Being-in-the-world: A commentary on Heidegger's being and time: Division I. Massachusetts: The Mit Press.

Fry, S. T. (1988). The ethic of caring: Can it survive in nursing. Nursing Outlook, 36(1), 48.

Gonczi, A. (1993). An integrated competency approach to professional education and assessment: A consideration of arguments for and against. Paper delivered at a seminar on competency based education, Auckland College of Education.

Hagerty, B. M. K. & Early, S. L. (1992). The influence of liberal education on professional nursing practice: A proposed model. Advances in Nursing Science, 14(3), 29-38.

Hegyvary, S. T. (1991a). Collaborative relationships for education and practice. Journal of Professional Nursing, 7(3), 148.

Hegyvary, S. T. (1991b). The limits of curriculum. Journal of Professional Nursing, 7(4), 203.

Heidegger, M. (1962). Being and time. (John Macquarrie & Edward Robinson, trans.) John McIntyre and Ian T.Ramsay (Eds.). London: SCM Press. (translated from the German 7th ed. 1927).

Heidegger, M. (1971). Poetry, language, thought. (Albert Hofstadter trans.). New York: Harper & Row. (Original works published 1935/1936, 1947,1950).

Heron, J. (1981). Philosophical basis for a new paradigm. In P. Reason & J. Rowan (Eds.), Human inquiry: A sourcebook of new paradigm research (pp. 19-35). New York: Wiley.

Higgins, L. (1989). Students' perceptions of priorities in nurse education: Research findings and their curriculum implications. Higher Education Research and Development, 8(2), 117-127.

Horsburgh, M. (1987). Graduate nurses' adjustment to initial employment. Unpublished M. A. thesis, University of Auckland.

Horsburgh, M. (1989). Graduate nurses' adjustment to initial employment: natural field work. Journal of Advanced Nursing, 14(8), 610-617.

Horsburgh, M. (1990/91). Polytechnic by degrees. New Zealand Nursing Journal, 83(11), 27.

Hughes, B. (1983). 75 Years of Kai Tiaki. New Zealand Nursing Journal, 76(1), 4-9.

Jollands, E. (1974). The clinical specialist: Improving patient care. New Zealand Nursing Journal, 67(3), 11-14.

Kimchi, J., Polivka, B., & Sabol Stevenson, J. (1991). Triangulation: Operational definitions. Nursing Research, 40(6), 364-365.

King, I. M. (1971). Toward a theory for nursing. New York: Wiley.

Knowles, M. S. (1984). The adult learner: A neglected species (3rd ed). Houston, Tex: Gulf Publishing.

Kolb, D. A. (1984). Experiential learning: Experience as the source of learning and development. Englewood Cliffs, NJ: Prentice Hall.

Komorita, N., Doehring, K., Hirchert, P. (1991). Perceptions of caring by nurse educators. Journal of Nursing Education. 30(1), 23-29.

Laws, M. (1990). A clinical future. New Zealand Nursing Journal, 83(4), 25-26.

Leininger, M. M. (1978). Transcultural nursing: Concepts theories, and practices. New York: Wiley.

Leininger, M. M. (1985). Qualitative research methods in nursing. New York: Grune & Stratton.

Lincoln Y. S. & Guba, E. G. (1985). Naturalistic inquiry. California: Sage Publications.

McLeod, W. T. (Ed.) (1987). Collins dictionary and thesaurus in one volume. Glasgow: Collins.

Madjar, I. (1991). Pain as embodied experience: A phenomenological study of clinically inflicted pain in adult patients. Unpublished doctoral thesis, Massey University, Palmerston North.

Mahler, A. (1978). Declaration on Primary Health Care. In World Health Organisation Primary Health Care. Report of the International Conference on Primary Health Care, Alma Ata: September 6-23, Geneva.

Marram van Servellen, G. (1983). The ingredients of a successful primary nursing system. New Zealand Nursing Journal. 76(4), 9-11.

Meleis, A. I. (1985). Theoretical nursing: Development and progress. Philadephia: Lippincott.

Merleau Ponty, M. (1962). Phenomenology of Perception. New York: Humanities Press.

Merton, R. K. (1968). Social theory and social structure. New York: Free Press.

Miller, N. R. (1978). Problems experienced by comprehensive nurses. Unpublished M.A. thesis, University of Auckland.

Moccia, P. (Ed.). (1986). New approaches to theory development. New York: National League for Nursing.

Monahan, R. S. (1991). Potential outcomes of clinical experience. Journal of Nursing Education, 30(4), 176-181.

Morse, J. M. (Ed.). (1989). Qualitative nursing research: A contemporary dialogue. Rockville: Aspen.

Munhall, P.L. & Oiler, C.J. (1986). Nursing research: A qualitative perspective. Norwalk, CT: Appleton-Century-Crofts.

Nuccio, S.A., Costa-Lieberthal, K.M., Gunta, K.E., Mackus, M.L., Riesch, S.K., Schmanski, K.M. & Westen, B. A., (1993). A survey of 636 staff nurses: Perceptions and factors influencing the CNS role. Clinical Nurse Specialist, 7(3), 122-128.

Nurses Act, 1977.

Oiler, C. J. (1986). Phenomenology: The method. In P. L. Munhall and C. J. Oiler (Eds.), Nursing research: A qualitative perspective (pp. 69-84). Norwalk, CT: Appleton-Century-Crofts.

Orem, D. E. (1980). Nursing: Concepts of practice. (2nd ed.). New York: McGraw-Hill.

Orlando, I. J. (1961). The dynamic nurse-patient relationship. New York: Putnam.

Parse, R. R. (1987). Nursing science: Major paradigms, theories and critiques. New York: Saunders.

Paterson, B. (1989). Making a difference: The lived world of nursing practice in an acute care setting. Unpublished M.A. thesis, Massey University, Palmerston North.

Paterson, J. G. & Zderad, L.T. (1976). Humanistic nursing. New York: Wiley.

Peplau, H. E. (1952). Interpersonal relations in nursing: A conceptual frame of reference for psychodynamic nursing. New York: Putnam.

Perry, J. (1985a). Theory and practice in the induction of five graduate nurses: A reflexive critique. Unpublished M. A. thesis, Massey University, Palmerston North.

Perry, J. (1985b). Has the discipline of nursing developed to the stage where nurses do 'think nursing'? Journal of Advanced Nursing, 10(1), 31-37.

Perry, J. (1986). Transition from student to graduate: Phase one. Profile of third year comprehensive graduates nursing students. Wellington: Department of Health.

Perry, J. (1988). Transition from student to graduate: Phase two. Profile of (1986) comprehensive graduates first year post graduation. Wellington: Department of Health.

Peters, T. (1989). Thriving on chaos: Handbook for a management revolution. London: Pan Books. First published USA 1987.

Polanyi, M. (1958). Personal knowledge: Towards a post critical philosophy. London: Routledge & Kegan Paul.

Reinharz, S. (1983). Phenomenology as a dynamic process. Phenomenology + Pedagogy, 1(1), 77-79.

Reverby, S. (1987). A caring dilemma: Womanhood and nursing in historical perspective. Nursing Research, 36(1), 5-11.

Rodgers, J. A. (1985). Nursing education in New Zealand, 1883-1930: The persistance of the Nightingale ethos. Unpublished M.A. thesis, Massey University.

Rummel, L.G. (1992). To the world of practice I have come to the brink. Unpublished poem.

Salmon, E. B. (1968). Education for nursing: Address given at the Hospital Matron's Association Conference held in Wellington, April (1968). New Zealand Nursing Journal, 61(9), 5-8.

Salmon, E. B. (1971). Insulation bred those myths of nursing. New Zealand Nursing Journal, 64(4), 5-7.

Salmon, E. B. (1983). A view on training of nurses in hospitals: Paper prepared for State Services Commission Administration Course No. 76, 17-28 November, 1969. In P. Carroll, A. Fieldhouse & S. Shaw (Eds.), A profession in transition (pp. 39-43). Wellington: The C. L. Bailey Nursing Education Trust.

Sanford, N. D. (1990). Nursing opportunity in the world of 21st century technology. In E.C. Hein & M. Jean Nicholson, Contemporary leadership behaviour: Selected readings (3rd ed.). Glenview: Scott, Foresman.

Sandelowski, M. (1986). The problem of rigor in qualitative research. Advances in Nursing Science, 8(3), 27-37.

Reeder, F. (1988). Hermeneutics. In Sarter, B. (Ed.), Paths to knowledge: Innovative research methods for nursing (pp. 193-237). New York: National League of Nursing.

Schon, D. A. (1983). The reflective practitioner: How professionals think in action. New York: Basic Books.

Small, D. K., Taylor, A. J. & White, J. E., (1979). The evaluation of nursing courses in technical institutes: Interim Report. Wellington: Department of Education.

Small, D. (1977). The first graduates of technical institute nursing courses: A follow-up. New Zealand Nursing Journal, 70(11), 8-14.

Spiegelberg, H. (1976). The phenomenological movement. In P. L. Munhall & C. J. Oiler (1986). Nursing research: A qualitative perspective (pp. 75-79). Norwalk, CT: Appleton-Century-Crofts.

Street, M. (1982). An exploratory study of the competencies expected of the comprehensive nurse at the time of sitting the State Examination. Wellington: Nursing Council of New Zealand.

Stodart, K. (1992). How good is a polytech graduate? New Zealand Nursing Journal, 85(6), 23-24.

Swanson-Kauffman, K. & Schonwald, E. (1988). Phenomenology. In B. Sarter, (Ed.). Paths to knowledge: Innovative research methods for nursing (pp. 97-105). New York: National League for Nursing.

Tanner, C. A. (1987). Teaching clinical judgement. In J. J. Fitzpatrick & R. L. Taunton (Eds.). Annual review of nursing research, 5 (pp. 153-173). New York: Springer.

Tanner, C.A., Padrick, K.P., Westfall, U.E. & Putzier, D.J., (1987). Diagnostic reasoning: Strategies of nurses and nursing students. Nursing Research, 36(6), 358-363.

Taylor, A.J., Small, D.K., White, J.E., Hall, P.M., & Fenwick, P.R. (1981). An evaluation of nursing courses in technical institutes. Wellington: Department of Education.

Taylor, A. J. (1981). Nursing courses in technical institutes: A summary of the main findings of an evaluation. New Zealand Nursing Journal, 74(9), 3-6.

Tyler, R. W. (1949). Basic principles of curriculum and instruction. Chicago: University of Chicago Press.

Travelbee, J. (1971). (2nd ed.). Interpersonal aspects of nursing. Philadephia: Davis.

Upton, S. (1991). Your health & the public health: A statement of government health policy. Wellington: Govt. Print.

Urdang, L. (Ed.). (1991). The Pan dictionary of synonyms & antonyms. London: Pan Books.

Van Manen, M. (1990). Researching lived experience: Human science for an action sensitive pedagogy. London: The Althouse Press.

Walton, J. A. (1989). Nursing practice in New Zealand hospitals: Staff nurses and enrolled nurses: An investigation into the nature and organisation of nursing practice. Report of a study undertaken for the National Action Group, with assistance from the Health Workforce Development Fund. Wellington: Govt. Print.

Watson, J. (1985). Nursing: human science and human care. Norwalk, CT: Appleton-Century-Crofts.

Weidenbach, E. (1964). Clinical nursing: A helping art. New York: Springer Verlag.

Windsor, A. (1987). 'Nursing students' perceptions of clinical experience'. Journal of Nursing Education, 26(4), 150-154.

APPENDICES

APPENDIX A

RESEARCH PROPOSAL

CLINICAL PLACEMENT FOR 3RD YEAR COMPREHENSIVE NURSING STUDENTS: THEIR EXPERIENCE IN AN ACUTE CARE SETTING.

A phenomenological approach will be used to study the lived experience of senior student nurses assigned to acute care hospital settings. The principal method of data collection will be in depth interviewing. The purpose of the study is to gain insights into the meaning that this experience has for these students as developing practitioners. It is anticipated that the study will lead to a greater understanding of what it is that senior students' do in their practice and how they learn to use their knowledge and skills to make clinical judgements in delivering nursing care to clients.

AIMS OF THE STUDY:

1. To understand the meaning senior student nurses give to their experience within acute clinical placements.

3. To identify examples of clinical judgement as they are made by students in these contexts and to gain insight into the learning experience.

BACKGROUND TO THE STUDY:

Great care is given to nursing students' curricula in order to prepare them to practice effectively in the clinical situation. Classroom teaching often provides

simulated experiences that resemble the real situation in order to prepare students for the reality of clinical practice. It is expected that students will be able to translate theoretical knowledge into practice without too much difficulty. The ultimate goal is to provide relevant, holistic, individualised nursing care to clients in a variety of contexts.

The acquisition of experience-based skills is an essential precursor to developing clinical expertise. (Benner, 1984a). Classroom teaching relies heavily upon theoretical concepts. Theoretical concepts alone cannot adequately prepare student nurses to cope with the many situations they will face in the clinical setting as the contexts where nurses practice are complex, fraught with difficulty, requiring "situation-specific" decision making. Situations can arise where they must act immediately making clinical judgements particularly within an acute care context where nursing practice does not always proceed as expected. Little research has been carried out that examines how student nurses experience their clinical placements.

The insights gained from examining student nurses experiences in their clinical placements could lead to exciting new prospects for their educational preparation.

REVIEW OF THE LITERATURE:

Literature to date concerning student nurse's clinical experience has emphasised studies using the empirico-analytic paradigm in science. These studies do not acknowledge the influence of the context upon thought and action. Real life situations act to challenge theoretical formulations that guide decision making when confronted with situations that do not quite fit a preconceived notion of what one ought to do. (Benner, 1984a, Paterson, 1989).

Based on her own phenomenological research, as well as other studies, Benner (1984) asserts that perceptual awareness is an essential precursor to accurate clinical judgement. Perceptual awareness or a hunch that something is not "quite right" is not readily explained by analytical methods in science. According to Benner (1984a) perceptual awareness is gained over time by expert clinicians through exposure to many similar experiences that has taught them to trust intuitive feelings. These feelings will lead to further searching usually resulting in accurate problem identification. Clinical judgements are made on the basis of practical knowledge that comes from experience in a clinical field of practice.

Benner (1984a) also asserts that skill acquisition proceeds through a series of stages. She uses the Dreyfus model to describe five levels of clinical competence that accrue over time as clinicians refine their clinical expertise. These levels are not related to experience gained from a length of time in a clinical setting or from length of practice, but from the turning around of "preconceived notions and expectations (which) are challenged, refined, or disconfirmed by the actual situation." (Benner, 1984a, p3).

Often expert practitioners "know more than they can tell". (Schon, 1983). It is possible that student nurses could also "know more than they can tell" but are not aware that this is the case nor are their clinical teachers. By becoming aware of the knowledge that they have and use in making decisions about the nursing care for their clients and how they exercise this discretion, would be beneficial to their learning and their ongoing professional development within a practice discipline.

A second issue that understanding clinical experience from the student's point of view may illuminate is the central value of "caring" for the nursing profession. A number of nurse researchers, (Benner, 1984; Watson, 1985;

Fry, 1988; Diekelmann, 1988; Bevis & Watson, 1989; Benner & Wrubel, 1989; Komorita, Doehring & Hirchert, 1991) have asserted that "caring" is the "essence" of nursing and an expression of "caring" by the nurse in client care is essential for healing to take place. Although student nurses' learn that "to care" is an essential component in their educational preparation, it is a difficult concept to describe because of its qualitative nature.

If "caring" is a central concept within their educational programme, the question then arises as to how "caring" is demonstrated in clinical practice and more specifically, in the decision making process. It is hoped that expressions of caring that may be identified in the students' descriptions of their practice will throw further light on the characteristics of this quality and how it is used in their practice.

Lived experience is "situated" (Benner & Wrubel, 1989) in a context of past and current events and future aspirations, as well as the social and physical environments in which it takes place. The view of the students' lived experience adopted for this study is a broad one and includes students' concerns with patients and ward staff, the setting, their past learning and expectations of themselves as senior students, as well as the events encountered in the course of a particular day of clinical practice.

STUDY METHOD:

A phenomenological approach will be used to describe 3rd year Comprehensive student nurses experiences in acute care settings. Experience includes the "situation" that student nurses find themselves in. According to Benner & Wrubel (1989) the "situation" includes the "relevant concerns, issues, information, constraints and resources at a given span of time or place as experienced by particular persons." (Benner & Wrubel, 1989, p. 412). i.e.

nursing practice as it is experienced by the student nurse as it occurs in interaction with clients in the acute ward setting.

Data gathering will be carried out through at least three in depth interviews with each student participant, in a context that is mutually convenient. Interviews are expected to last no longer than 60 mins. and will be conducted at a time convenient for each student.

Interviews will be used to explore students experiences of clinical practice through a semi-structured, in depth style of interviewing, as well as to validate some of the preliminary analysis and interpretation.

Data gathering will be by an audio-tape which will be transcribed by a typist. From the typed transcript, the analysis and the interpretation of the text will be undertaken. The value of taping is that it allows auditability of the recorded data and validation of the interpretations made by the researcher. (Morse, 1989, p. 179). An additional method of data gathering will be by the use of diary records that each student will be asked to keep on their day to day practice.

ANALYSIS OF DATA:

Following the taped interviews with the students, the transcribed text will be the focus for analysis and interpretation. Analysis will require reading of whole interviews, comparisons between whole interviews, identification of themes arising from individual experiences, comparisons between themes, as well as detailed line-by-line analysis of the complete text. Exemplars will be identified that best capture and illustrate the themes arising from the data.

At the conclusion, the research report will provide a phenomenological description of the experience of being a senior student nurse in an acute care setting and the learning arising from the experience of clinical practice.

STUDY PARTICIPANTS:

Potential participants comprise a group of approximately 15 - 20 third year students in a Comprehensive Nursing Programme at an Auckland Polytechnic. Because these students are expected to be involved not only in clinical practice but also in on-going studies in preparation for their State Registration exams, some may not be able or willing to give additional time to participation in a research project. For this reason a group of students that will be assigned to the acute care setting, will be approached to volunteer and it is hoped that 15-20 students will do so, thus becoming study participants.

ACCESS TO THE FIELD:

A formal letter will be sent to the Dean of Nursing Studies at the Polytechnic concerned outlining the proposed study and requesting permission to ask students to volunteer to be participants in the study.

The letter will include a copy of the research proposal as information about the time and effort expected from each participant.

Following the letter, a meeting will be set up with both staff and students to explain in greater detail, the research, the methodology, its aims and purposes and what it would mean to be a participant in the study, as well as to answer any questions they may have. A full explanation of how the rights of participants will be protected within the study will be given. A written informed consent slip will be offered to all students and I will make contact with potential participants when these are identified from a returned slip at the base of the consent form.

RESEARCHER INVOLVEMENT:

In phenomenology, the researcher is personally involved in the world of the researched. I am aware that my experience as a teacher may influence my perceptions of student participants and their experiences, and of the need to "bracket" or set aside my assumptions and biases. In addition, I am aware of the need to maintain my position as the researcher in my dealings with the participants, rather than adopting roles of counsellor, teacher, or advocate.

ETHICAL CONSIDERATIONS:

The success of the study is dependent upon my establishing rapport and trust with the participants and my ability as the researcher to identify and pick up on cues that can lead to rich descriptions of the phenomenon under study. I am aware of the privileged position that I will have in sharing these moments with the student participants.

Four main ethical issues arise in relation to this study:

1. ***Informed Consent***: Informed consent will include informing volunteer participants of the purpose of the research and its potential to generate accurate descriptions of clinical experience as perceived by the senior student nurse.

   Participants will be told that the procedures for data collection are to be taped interviews and personally kept diaries. The work involved in keeping diaries, the time taken up for interviews, the presence of a tape recorder to keep track of conversation during interviews, and the authenticating of transcribed descriptions will all be shared at the outset.

Participants will also be informed of their right to withdraw from the study at any time and to share only information they feel able to share. A written informed consent will be obtained from all participants.

2. *Confidentiality of participants and information*:

Confidentiality will be assured by the erasing of tapes at the conclusion of the study as well as the giving back of the diaries to the participants. During the research process, tapes and diaries will be stored in my home with only myself, as the researcher, having access to these.

3. *Anonymity of participants*:

Pseudonyms will be used in any published reports and no identifying details will be included about the participants or institutions involved.

4. *Prevention of risk to the participants:*

I acknowledge that the gathering of data for my research study is an invasion of the students' privacy and there is a potential for reflections on experience to evoke both pleasant and unpleasant responses. Should the situation arise that a student recalls an emotionally distressing situation, I can listen and support at the time and refer on to professional agencies e.g. a counsellor if a need is established. There is however, known benefits from the sharing of experiences. Bergum, (1989) states that the process of sharing can make a difference in the life of the participant because it raises their own awareness of what they are going through. Morse (1989) states that the attention given to the participant as well as the validating of experience are seen to be beneficial rather than harmful.

APPENDIX B

[redacted]

AUCKLAND 10.

July 1991.

[redacted]

Dear student,

I am seeking voluntary participation in a research study as part of my MA Thesis through Massey University. The purpose of the research is to investigate what it is like to be a senior nursing student in an acute care setting. As a study participant, your involvement would be twofold. First, keeping a diary of your experience, and second, taking part in at least three approx. 60 minute taped interviews when you will be able to talk about your practice. To protect your anonymity, your name will not be used on any written documents, instead I will give you a pseudonym. (false name). Only you and I will know your true identity.

As the information you share with me is confidential, the only people who will have access to the data will be myself as the researcher, my Thesis Supervisor, and a typist. All taped interviews will be kept safely in my home during the study, and will be erased at the end.

I would like you to be aware that the information you share with me will be used for publication in the final research report, in any subsequent articles that may arise from the research, and in the presentation of the research report at research symposiums or nursing education workshops. Your identity will not be revealed in any of these contexts.

I appreciate the time you have given to read this letter. If you are interested, I would be grateful if you would indicate your willingness to participate by 'phoning me at [redacted](evenings). Any further information you may need can be clarified at this time.

Thank you in anticipation.

Yours sincerely,

Louise Rummel,
MA Thesis Student.

APPENDIX C

CONSENT FORM FOR RECORDING THE EXPERIENCES OF THE SENIOR NURSING STUDENT IN AN ACUTE CARE SETTING.

I volunteer to be a participant in the above study and to take part in at least three private interviews to provide information on what it is like to be a senior nursing student in an acute care setting. I have read the letter of information about the study provided with this consent form and agree to the following conditions :-

1. The interview(s) will be conducted in the setting of my choice and at my convenience.

2. My responses will be tape-recorded (audio only) and each interview will take approximately 60 minutes.

3. The tapes will be kept secure in the researcher's home until the study is completed, at which time they will be erased.

4. My name or other identifying details will not appear on the transcripts of the interviews or in the final report.

5. I agree to keep a diary of my day to day experiences for a period of 8-10 days recording my impressions and involvement as I practice as a senior student nurse in the acute care setting. I will also record specific instances that stand out in my mind that capture the essence of

what nursing is all about for me. I will not identify any clients by name so as to ensure their anonymity in the record keeping.

6. I give my permission for information that I provide in the interviews and in my diary record, to be used for publication in the research report, at research symposiums or nursing education workshops.

7. I am willing to be contacted by the researcher following an interview if clarification of information becomes necessary.

8. I understand that I am free to withdraw from this study at any time.

9. I can 'phone the researcher at [redacted] to follow up my interest in this study or to gain any further information I may desire.

Thank you -

APPENDIX D

AN EXAMPLE OF DATA GATHERED AND DATA ANALYSIS

Daily Diary: Carrie

Morning duty: Allocated eight women and eight babies. One new admission that I collected from theatre. She had manual removal of Placenta and for suturing of vaginal tears. She had IV NACL running 1000mls over 4 hours and IV NACL with syntocinin running as well over 2 hours (500 mls). On warding her observations were stable and ice packs were applied to her perineum.

Diary Relates to Interview 2. Clinical judgement linking theory to practice making connections between IV infusion urinary output and uterus contractility.

Keen to reduce swelling

She breast fed baby and then settled down for a rest. I leured her IV Syntocinin after a further hour and recheck her fundus and Lochia which was moderately heavy. After another hour I went to change her ice pack and to encourage her to get up and pass urine as she had had nearly 2000 mls of fluid since she in theatre. As she turned on to her back, I noticed a trickle and I

immediately felt for her fundus. She began to haemorrhage. I heard another RN outside the door. I called for her quickly and she immediately rang 3 bells. After a few minutes of rubbing up a contraction the loss steadied and another midwife had started in fusing 30 units of Syntocinon. The house surgeon was on the ward and was happy with the treatment given.

Haemorrhage

Called for help via 3 bells

Theme Clinical judgement

Engages in Nursing actions promoting uterus contraction

I was still concerned that she hadn't pu'd since delivery and that she had had a lot of fluid infused. I suggested catheterising, however the house surgeon thought we should let her try to pu on a bed pan first. After 15 mins. of trying I initiated the house surgeon into catheterising as the client had extensive swelling around the vulva. I did not feel confident in attempting the catheterisation. In approx. 20 mins. 1200 mls of urine had drained. I continued to check her fundus ½ hourly which stayed quite firm once her bladder had emptied. However, approximately 2 hours later on checking her fundus, she began

actions to maintain fundus level & uterus contractions

aware of own limitations

another moderate trickle. I immediately rang 3 bells. The midwife rechecked her fundus and agreed it was contracted. We began to wonder if it was in fact a laceration that was bleeding. I called the Registrar who came and checked the client and was quite happy with her. Due to the extensive swelling, her catheter was left insitu. I told her about how to feel for her fundus and made sure her bell was handy to call. I continued to do regular Post Natal checks and monitor her IV lines and catheter. I had no further problems with her on this shift.

Theme involvement

maintaining involvement

engages in client education

remaining stable

2.

This was a particularly heavy day as I had three babies under phototherapy and another lady who could not speak English who was having problems feeding and with other mothercraft skills. The babies under PTY had to be weighed and had to have ACT & R, SBR's had to be written up and charted and all the babies had to be comped.

Some weariness in this statement

heavy workload

Diary: 2nd day: Carrie

I started my morning as any other, checking Bilirubin had been written up for babies under lights. Checking feeding charts. Post Natal and baby checks. I had to prepare a urine Spec. off a baby for a CMV specifimen, had to be packed in ice and sent to Auckland lab. before 11 a.m. CMV urine is tested for Cytomegalorrus, a herpes virus which occurs in 2% Neonates which can cause mental retardation.

Understands rationale behind urine test

I had 3 demo. baths to do and I was still trying to educate my Indian mum and had arranged for an interpreter to come as the baby had to be put under Phototherapy, as she was still having problems feeding. Spent over and hour sitting with her feeding and bathing, and half an hour with the interpreter explaining everything from feeding to cabbage leaves, to purpose of lights etc.

spends time

My lady from yesterday who haemorrhaged, was looking much brighter and I removed her

Satisfaction with yesterday's practice.

Has maintained her involvement.

indwelling catheter and asked her to let me know when she P.U'd. She was managing her baby well and her perineum was less swollen.