A mixed method approach to investigating therapeutic commitment towards adults with learning disabilities: the perceptions of final year adult, mental health and learning disability student nurses

June Grace Isa Brown

Student ID: 1726075

Faculty of Health Studies and Sport

University of Stirling

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Declaration

I declare that the work in this thesis is my own, except where otherwise stated.

June Grace Isa Brown

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Abstract

All nurses should have the ability and disposition to engage in therapeutic relations with people who have learning disabilities. Therapeutic commitment is described as a therapeutic attitude that is influenced by nurses' perceptions of role competency and role support. It is essential to the provision of nursing care leading to improved patient outcomes.

The study aimed to explore final year adult (AD), mental health (MH) and learning disability (LD) student nurses' perceptions of therapeutic commitment towards people with learning disabilities and the factors they perceived influenced it. A mixed method, convergent approach for complementarity and expansion purposes was used. A survey collected quantitative and qualitative data from 398 final year student nurses across four Higher Education Institutes in Scotland.

Integrated findings suggested when caring for people with learning disabilities that student nurses are therapeutically committed, with LD student nurses' perceptions being greater than their counterparts. LD student nurses also perceived greater role competency and reported they could access experienced support more readily. Having education, a personal experience, the opportunity to provide care whilst on clinical placement and previous work experience with people with learning disabilities influenced the therapeutic commitment and role competency all students perceived. Other influencing factors included receiving thanks, being challenged by the task and the attitudes and qualities held by the nurse. Some AD and MH student nurses believed that people with learning disabilities characteristics negatively influenced their therapeutic commitment.

This study has implications for nursing practice and education as it builds on the theory of therapeutic commitment, providing new knowledge of the factors that influence it, either positively or negatively when caring for people with learning disabilities. This knowledge will support nurses to engage in positive therapeutic relationships with people with learning disabilities to enhance the delivery of nursing care.

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Chapter one: Introduction and overview of thesis

The aim of this study was to explore final year adult, mental health and learning disability student nurses' perceptions of therapeutic commitment to people with learning disabilities. There have been no previous published studies focusing on therapeutic commitment of any health professionals to people with learning disabilities. Therefore, in order to meet the aim of this mixed methods study, the following research questions were formulated:

Overall question -

What are the differences in therapeutic commitment to people with learning disabilities between learning disability, adult and mental health student nurses and what factors influence this?

Quantitative questions -

1. Do final year student nurses perceive they are therapeutically committed to people with a learning disability?
2. Is there a difference between specialist (learning disability student nurses) and non-specialist (adult and mental health student nurses) perceived levels of therapeutic commitment?

It is hypothesised that -

- Final year student nurses are therapeutically committed to people with learning disabilities.
- Learning disability student nurses will report higher levels of therapeutic commitment than their adult and mental health peers.

Qualitative question –

3. What factors do final year student nurses believe influence therapeutic commitment?

Mixed Methods question –

4. Does the qualitative data help explain the results from the initial quantitative phase of the study?

1.1 Introduction

The primary motivation for this thesis was fuelled by the researcher's interest in why nurses who are not from the field of learning disabilities feel and demonstrate that they are unable to provide quality care for people who have a learning disability. The researcher became interested in this problem whilst employed as a Consultant nurse working with acute hospital and primary care staff who had patients with learning disabilities in their care. Anecdotally, many highly skilled and experienced nurses who were seen as experts in their field expressed numerous reasons why they felt they were unable to be effective in their role. From the discussions, it was evident they felt out of their depth, lacked knowledge and skills and often unconsciously disengaged from their patient. This led to a desire to have a fuller understanding of the problem.

From the previously described discussions, it became more apparent why there is increasing evidence that people with learning disabilities often report poor health care experiences within primary and secondary healthcare services (Iacono et al. 2014). Having this knowledge, in conjunction with literature supporting that primary and secondary care adult and mental health nurses feel ill-equipped to provide effective care (Lewis et al. 2016; Melville et al. 2005; Adshead et al. 2015). Further understanding of the problem was sought.

As the NMC directive (NMC 2010) states caring for people with learning disabilities is every nurse's business, there was a desire to understand if nurses are competent to provide care to this patient group and what helps or deters them in doing so. Providing person centred care is paramount for any nurse in ensuring effective outcomes for their patient. In order to achieve this, first the nurse must engage in a therapeutic relationship with their patient (Foster and Hawkins 2005). Certain pre-requisites are required before a therapeutic commitment can be established; these include role competency and role support (Lauder et al. 2000). Although previous studies have investigated generalist healthcare practitioners' perceptions of certain patient groups (Bush and Williams 1988; Lauder et al. 2000; McLeod et al. 2002; Albery et al. 2003; Chorwwe-Sungani and Shangase. 2013), there are no published papers utilising this approach with any healthcare practitioners caring for people with learning disabilities other than from grey literature (Brown 2008).

The researcher previously explored the therapeutic commitment of adult nurses in a Scottish acute hospital in a Master's thesis. The results showed that nurses who were 0-2 years post qualification perceived significantly higher levels of therapeutic commitment than those who were 20+ years qualified (Brown 2008). Since then, Lewis

et al. (2016) advocate that to ensure the delivery of safe and effective care, student nurses require to be appropriately educated. Hence, the researcher chose to explore the therapeutic commitment of student nurses who were learning how to develop therapeutic relationships with their patients and this willingness and ability to engage with people who have a learning disability should grow as they become registrants.

1.2 People with learning disabilities

Learning disability is defined as an irreversible lifelong condition which is present prior to the age of eighteen and has a significant effect on a person's development. People with a learning disability have many abilities but will need more support than their peers to understand new and/or complex information, learn new skills and to lead independent lives (Scottish Government 2013). Within the medical model, learning disability can be clinically diagnosed by a clinical psychologist, using standardised intelligence tests (IQ), alongside social adaptation assessment (WHO ICD-10 2007). The IQ of an individual, together with a social adaptive skills rating indicates the classification of an individual's learning disability. Depending on the classification of the learning disability each individual will have varying problems with complex information; comprehension, communication, social skills, motivation, generalising, interaction skills and concentration. Generally, ability levels in all areas previously described reduce as IQ scores lower.

Historically, the term learning disability is synonymous with the following terms; learning difficulty, intellectual disability, mental retardation, development disability and historically mental handicap. These various terms are used worldwide depending on culture, social policy and theoretical perspective of policy makers (Brown 2007). However, within the United Kingdom the term learning difficulty has been advocated by those who experience the condition (Nunkossing 2011). Scior (2011) reports the public are confused by the different terminology used. Within health services, the term learning disability is frequently used by professionals and services. In recent times, the term intellectual disability has been the preferred terminology adopted internationally and by the academic world. The term learning disability is used within this thesis to provide consistency, as it was used at the beginning of the research journey and aligns with United Kingdom policy. No matter what the actual term is, it is important to recognise the negative effect that placing a label like 'learning disability' may have on an individual, however it can be argued that having a label may reduce stigma and increase compassion (Scior et al. 2013).

An accurate calculation of the number of people with learning disabilities in Scotland is unknown due to the varying ways rates are reported (Scottish Government 2013). Hughes-McCormack et al. (2017) report 0.5% of the adult population has learning disabilities. However, these are the individuals known to health and social services that support them; there may be others who receive no services (Scottish Consortium for Learning Disabilities 2017). The size of the learning disability population may seem insignificant in comparison to the rest of the general population; conversely as a group they experience poorer health and multiple morbidities (Emerson et al. 2011).

1.3 Health inequalities and health needs

Most people with learning disabilities now live in community settings receiving care and support from families and professional carers (Hannon and Clift 2011). To have health care needs met individuals access universal services. There is now substantial evidence supporting the view, people with learning disabilities experience health inequalities accessing these services (Emerson et al. 2011; Krahn and Fox 2014) and that by having a learning disability, an individual is more likely to have greater physical and mental health needs than the general population (NHS Scotland 2004; Jensen et al. 2004; Ouellette-Kuntz et al. 2005; Michael 2008; Cooper et al. 2015) which are often unrecognised and unmet (Cooper et al. 2004; Campbell 2007), this makes them high users of universal health services. They are more likely to require a hospital admission than the general population (Balogh et al. 2010; Glover and Evison 2013) and the stay will be longer and more frequent (Ailey et al. 2015). In particular, they use emergency departments more often than the general population where accessing alterative primary care services would have better met their needs (Glover and Evison 2013). People with learning disability are also more likely to experience a premature death, some of which is preventable (Heslop et al. 2013; Lauer & McCallion, 2015). Life expectancy for this group at birth is 19.7 years less than those without a learning disability (Glover et al. 2017).

1.4 Institutional discrimination

People with a learning disability have the right to live an ordinary life, be treated as individuals and experience equality and inclusion (Scottish Government 2013). Equality for people with disabilities does not mean treating them in the same way as everyone else. Current legislation within the United Kingdom, in the form of the

Equality Act, in particular the Public Sector Equality Duty (United Kingdom Parliament 2011) clearly articulates that it is illegal to discriminate against disabled people in the provision of healthcare services. In addition, healthcare services require making reasonable adjustments to ensure the promotion of equality. However, too often people with learning disabilities experience problems when accessing healthcare services (Ouelette-Kuntz et al. 2004; Straetmans et al. 2007; Michael 2008). The barriers can take various forms including diagnostic overshadowing, staff attitudes, staff being inexperienced and untrained, therefore unable to make reasonable adjustments to care delivery (Emerson et al. 2012), restriction on time and staff shortages (Brown and Kalaitzidis 2013) which in turn creates gaps in the overall care and treatment provided. Mencap (2007; 2012) have evidenced this, campaigned and challenged policy makers and health service providers to act to eradicate institutional discrimination. Michael (2008) conducted an independent inquiry following the publication of Mencap's Death by Indifference report (2007) highlighting the failings of the NHS that led to the deaths of six individuals and concurred with their findings, making recommendations to overcome institutional discrimination. Recommendations of the Michael's report initiated the Confidential Inquiry into the Deaths of People with Learning Disabilities (CIPOLD) (Heslop et al. 2013) which concluded healthcare staff did not take responsibility for care, make adjustments to their practice in order for people with learning disabilities to receive person centred care and did not engage with families and carers, leading to delays in diagnosis and treatment, amongst others.

1.5 Reasonable adjustments

Many reports have directed healthcare services to ensure they meet current equality legislation (Heslop et al. 2013; Mencap 2012; Parliamentary and Health Service Ombudsman 2009; Michael 2008; Mencap 2007; Disability Rights Commission 2006) due to evidence there are deficiencies in their systems. To ensure equity, individual healthcare professionals require an understanding of the legislative framework and how to apply it in their own practice. Reasonable adjustments should be made to ensure people with learning disabilities experience equality in the outcome of care and treatment. By treating everyone the same, people with learning disabilities may not receive equal care due to the difficulties they have accessing it. Marsden and Giles (2017) highlight there is a lack of guidance on how to make reasonable adjustment to care. Systematic changes in services with the introduction of care pathways, hospital passports, communication aids, hospital identification systems and frameworks for

practice are recommended and developed (Marsden and Giles 2017; Public Health England 2017; Public Health Wales 2014; Quality Improvement Scotland 2006).

1.6 Healthcare staff

In order to prevent institutional discrimination, healthcare staff require being competent to effectively deliver person centred care. Evidence indicates that healthcare staff who do not specialise in the care of people with learning disabilities lack understanding of the patient's quality of life (Heslop et al. 2013; Mencap 2007). Disabling attitudes are seen as an organisational barrier to healthcare in both primary and secondary care (Pelleboer-Gunnink et al. 2017; Emerson and Baines 2010). Both positive and negative attitudes towards people with learning disabilities have been expressed by health care professionals (Rose et al. 2012; Lewis and Strenfert-Kroese 2010; Melville et al 2005; Longo and Scior 2004; Gill et al. 2002). Non-specialist healthcare staff report having little experience or confidence caring for this patient group and find communication, gaining consent and information sharing challenging (Lewis et al. 2016; Adshead et al. 2015; Donner et al. 2010; Alborz et al. 2005). As a consequence of these challenges, some healthcare professionals are unable to make reasonable adjustment to care delivery, hence people with learning disabilities may not receive compassionate or person-centred care that may lead to neglect (Donner et al. 2010), compromising the patients physical safety (Tuffrey-Wijne et al. 2014) and preventable deaths (Heslop et al. 2013). Hemm et al. (2014) highlight the specific training needs of some healthcare professionals and their recommendations request educational strategies to increase skills, knowledge and confidence of non-specialist staff (Backer et al. 2009).

1.7 Guidelines and standards

A plethora of guidance and standards have been published to support and evaluate the provision of safe and effective care to this patient group. In Scotland, Quality Improvement Scotland (2004; 2009) published quality standards to be met by health services. Standards two and three are aimed at general healthcare settings and have been in place for some time, however have not been reviewed since 2009. Guidance for non-specialist health care staff is also available (NICE 2017; Public Health Wales 2014; GAIN 2010; Mencap 2008; Quality Improvement Scotland 2006), as well as guidance relating to patient safety (NSPA 2004). A workforce development framework

has been produced to ensure training needs are met (Skills for Health 2016). Additionally, a competency framework has been developed for non-specialist staff (White and Clark 2014). However, these do not guarantee the enhancement of non-specialist nursing knowledge or skills.

1.8 Support from specialist learning disability services

The National Patient Safety Agency (2004) recommended the development of learning disability liaison nurse services and was supported by research (Backer et al. 2009). Accessing support for specialist learning disability services is seen as a way for non-specialist healthcare professionals to receive advice, guidance and support to make reasonable adjustments to communication and care (Heslop et al. 2013). Various service models exist to achieve this; community learning disability teams support primary care or mental health and learning disability liaison services supporting acute hospitals (Quality Improvement Scotland 2009). MacArthur et al. (2015) and Castles et al. (2013) reported the effectiveness of the learning disability liaison nurses to facilitate and enable access by supporting non-specialist staff to make reasonable adjustments, whereas Hastings (2007) and Parkes et al. (2007) emphasises the benefits of support from the community learning disability nursing team to a mainstream mental health admission unit. The development of learning disability liaison models is recommended for all acute care hospitals (Heslop et al. 2013; Backer et al. 2009). No literature exists on similar purposely developed models in mental health hospital care.

1.9 Policy context

Learning disabilities care has changed substantially over the last 40 years seeing people move on from institutional care to live within communities through policy reform (Parliament of the United Kingdom 1990; Department of Health Social Security 1971). Learning disability care was no longer based on the medical model and social model of disability gained momentum with new rights-based policies driving the closure of long stay institutions and living in a community setting based on models of social care (Department of Health 2001; Welsh Assembly Government 2001; Department of Health and Social Security 2001; Scottish Executive 2000). The emphasis was no longer on trying to cure individuals but moved to one of rights-based focus with a goal of inclusion. However, these policies were viewed as not hard hitting enough to make an impact (Mansell 2008). There was also a risk of increasing the health inequalities

people with learning disabilities experienced if the social care model was fully implemented, as it lost focus on good health outcomes for individuals (Gilbert 2006). People with learning disabilities sought to access universal healthcare services and received care from non-specialist health care staff. In relation to mental health care and treatment, policy advocates for access to mainstream services, however care is generally accessed through tertiary learning disability services. Although this position is changing and people with learning disability will be seen in general mental health services more often.

With a growing literature, evidencing differing health needs, NHS Scotland (2004) produced the Health Needs Assessment highlighting the health inequalities people with learning disabilities were experiencing but was mainly directed at specialist learning disability healthcare professionals. For the first time in the public health arena, the Scottish Government (2008) recognised the learning disabled subpopulation and they were seen as a disadvantaged group who are at particular risk from poor health.

From then, health care and social policy has continued to strive to improve the quality of people with learning disabilities lives (Scottish Government 2013; Department of Health 2009) and within these renewed policies consideration was given to the health inequalities people with learning disabilities were experiencing. The health recommendations from these policies have now been strengthened following the reviews by Michael (2008) and Heslop et al. (2013).

To align with the changes in health and social care policy, the direction of nursing policy required to follow suit. In Scotland, the publication of 'Promoting Health, Supporting Inclusion' (Scottish Executive 2002) attempted to ensure that all fields of nursing understood the role and responsibility they had in providing nursing care, however again it was received by learning disability nurses but mainly disregarded by their nursing and midwifery peers. This message was briefly revisited in the United Kingdom wide review of learning disability nursing 'Strengthening the Commitment' (Scottish Government 2012) with recognition in the more recent evaluation report that further commitment to support and educate non-specialist health and social care staff is required (UK Strengthening the Commitment Steering Group 2015).

From a nurse education perspective, when 'Healthcare for All' reported that a lack of knowledge and experience of caring for people with learning disabilities led staff to experience ignorance and fear, resulting in poor care and preventable death (Michael 2008), recommendations stated that providers of undergraduate and postgraduate education programmes for healthcare professionals mandate the inclusion of

competency-based education on learning disabilities within curricula. The Nursing and Midwifery Council (NMC) as the professional regulator have the responsibility to ensure education standards are in place to provide public protection, thus ensuring people with learning disabilities receive care from competent registered nurses (NMC 2010). Pre-registration nursing education standards are in place for four fields of practice; adult, mental health, child health and learning disability. The standards currently in place state all nurses, across all fields should be able to recognise and respond to the needs of all people who come into their care which includes people with learning disabilities (NMC 2010). However, it is unclear how these standards pertaining to adult and mental health fields of practice are evaluated or monitored.

The Nursing and Midwifery Council have revised their standards for pre-registration education (NMC 2017a) stating that all nurses require to meet the physical and mental health needs of people with learning disabilities and opportunities to engage in experiential learning should be sought. No evidence exists to support the effectiveness of the inclusion of these standards on the competence and confidence of new registrants. The changes in the standards may pose a challenge to higher education institutes who do not deliver learning disability pre-registration programmes as they may not have lecturing staff with the necessary skills, knowledge and experience to incorporate learning disabilities care in to curricula (Glasper 2011).

Following the publication of CIPOLD (Heslop et al. 2013), the Council of Deans acknowledged the recommendation and responded by developing recommendations on how best to support universities develop competent registrants to meet the needs of people with learning disabilities (Beacock et al. 2015). Conversely, in the report's foreword time is taken to point out that their view is universities play a small part in the issue and education is not the solution. This view may be true to some degree; however it is important to realise if all parts of the 'jigsaw' hold this opinion, people with learning disabilities care will continue to be inadequate and unsafe and staff will continue to feel incompetent and vulnerable. Everyone must take responsibility and the review does so by providing leadership to universities with the recommendations made.

1.10 Organisation of the thesis

Chapter two presents an appraisal of the literature relating to the study topic which includes; person centred care, current perspectives on therapeutic relationships from people with learning disabilities and families and carers and from nurses, nurses attitudes to people with learning disabilities and therapeutic commitment theoretical

framework and in doing so highlights the lack of research on the therapeutic commitment of student nurses to people with learning disabilities. This is followed by Chapter three which describes and gives the rationale for the research methodology, provides the study aims and research questions, mixed method design and ethical considerations. In Chapter four, five and six quantitative, qualitative then the integrated findings are presented. Chapter seven discusses the research findings in relation to wider literature, the quality of the study is critiqued and recommendations for practice, education and future research are made. Finally, conclusions are drawn.

Chapter two: Literature review

2.1 Introduction

The previous chapter highlighted the health inequalities people with learning disabilities experience and how nurses can contribute to this when they have not engaged in a therapeutic relationship with their patient and person-centred care is not delivered. The aim of this literature review is to critically appraise current knowledge and evidence surrounding the therapeutic relationship between student nurses and people with learning disabilities. Within this chapter, initially the search strategy utilised is described. This is followed by an analysis, critique and synthesis of the literature found.

The literature review is presented in themes with the exploration of the literature relating to therapeutic relationships, firstly from the perspectives of people with learning disabilities and their families/carers then from nurses' perspectives. The next theme is related to nurses' attitudes to people with learning disabilities. A focus on therapeutic commitment is then undertaken. This literature review is concluded by the identification of gaps in the literature to support the requirement for further research within this area.

2.2 Search strategy and inclusion criteria

In order to understand the research problem, develop the research questions and the initial proposal, a review of the related and parallel literature was conducted. Databases were searched in 2010 then periodically until 2017 and were restricted to English language published between 1975 and 2017.

An electronic search for articles was performed in Ovid Medline, Cumulative Index to Nursing and Allied Health Literature (CINAHL), British Nursing Index and PsycINFO. The inclusion criteria for this review was peer-reviewed studies that considered the relationship between nurses and adults with learning disabilities in universal care settings; therefore, studies relating to children or based in learning disability care settings were excluded. An example of a search using CINAHL is presented in Appendix 1.

Many terms are used to represent the condition of learning disability; therefore, the following search terms were used; intellectual disability, developmental disability, mental retardation and mental handicap. To capture the breadth of the subject area other search terms were used individually in conjunction with learning disabilities. These terms included 'nurses', 'therapeutic relationship', 'engagement', 'caring relationship', 'care experience', 'nursing care', 'attitudes' and 'therapeutic commitment'. These were then entered using key words and title tabs. The search was limited to full text and English language then duplicates removed. An illustration of the search trail has been presented (Appendix 2) using PRISMA guidance (Moher et al. 2009).

Critical appraisal of all reviewed qualitative studies was undertaken using questions from the CASP Qualitative checklist (2018) and using Strobe statement questions (von Elm et al. 2007) for observational studies to determine rigour and quality.

2.3 Person centred care

Person centred care underpins international and national healthcare policy (McCormack et al. 2015). The aim in NHS Scotland is to deliver the highest quality of care; one quality ambition in place to achieve this is the provision person centred care, as one of the three strands of the Quality Strategy (Scottish Government 2010a) and is a key tenet in policy and legislation implementation (Scottish Government 2010b; 2011).

Person centred care has foundations in the work of Rogers (1961) and Kitwood (1997) and is defined as 'providing care that is responsive to individual personal preferences, needs and values, and assuring that the patient values guide all clinical decisions' (Scottish Government 2010a p22) at the same time the Institute for Medicine (2001) include in their definition that the patient has a right to education and support to make decisions and participate in their care. The key elements of person-centred care are; patients are seen as unique beings (Binnie and Titchen 1999), equal partners in care (Slater 2006), where dignity, respect and autonomy are vital (Leplege et al. 2007), patients and their families are active participants in their care and building a therapeutic relationship is paramount (McCance et al. 2008). However, there is a lack of consensus on what person-centred care actually means (Sidani and Fox 2014) and difficulties in its implementation to nursing practice (Nilsson et al. 2013).

Successful engagement in person centred care, results in improved patient outcomes and safety (Pirhonen et al. 2017; de Silva 2014; Charmel 2009; Stone 2008; Beadle-

Brown 2006). Enablers include leadership and education (Moore et al. 2017). Barriers are considered to be sceptical practitioners, tradition practices (Moore et al. 2017) and the presence of evidence-based practice where the professional believes they are the expert (Mazurenko et al. 2015). Also, tensions in the clinical environment between organisational priority and practitioners meeting individual needs can be a deterrent (Nilsson et al. 2013), as well as shortage of staff and time (Kelly 2007).

The NMC (2010) embed person centred care principles in nursing practice. The nursing profession has received political, public and media focus in recent times due to investigations into poor quality care (MacLean 2014; Francis 2013, 2010; Department of Health 2012b). In England, this led to nursing strategy being developed around the Compassion in Practice vision which focuses on the '6Cs': 'care, compassion, competence, communication, courage, and commitment' (Department of Health 2012a) which gained criticism for a lack of clarity on its vision which can be interpreted and implemented by staff (Dewar and Christley 2013). Recent review has focused on compassion related care as a model for care delivery and note the need for a greater understanding from patients and family's perspectives, as well as the factors within compassionate care that result in positive patient outcomes (Sinclair et al. 2016). Moreover, person centred care is seen to be wider than compassionate care (Brown et al. 2016).

2.4 Person centred care and people with learning disabilities

There is a plethora of studies that focus on the effectiveness of patient centred care for older people and people with dementia (Kirkley et al. 2011; Edvardsson et al. 2008; Nolan et al. 2004; Kitwood 1997), however very few in relation to the care of people with learning disabilities outside tertiary services (Brown et al. 2016). Furthermore, Cramm and Nieboer (2017) have validated a tool to measure the effectiveness of person-centred care in tertiary services. Person-centred planning underpins inclusion policy in the United Kingdom (Scottish Government 2013; Department of Health 2009). It has been used as a model for health and social care staff to support people with learning disabilities to plan care and shape their lives since the closure of long stay institutions commenced (Mansell and Beadle-Brown 2004). However, there is a lack of evidence to support the claims that person centred planning improves quality of life outcomes for individuals (Ratti et al. 2016). Robertson et al. (2007) report an individual is more likely not to have a person-centred plan if they have greater physical and mental health needs and/or autism.

The principles of person-centred care are similar to those of person centred planning where the person with a learning disability is at the centre, supported to have power to make decisions about their life and supported by family and carers. Paradoxically, Carl Rogers did not believe his person-centred theory would be suitable for people with learning disabilities (Becker and Pallin 2001). Nonetheless, person-centred care has featured in learning disability nursing for some time (Jukes 2006), although learning disability nursing has struggled with utilising the most effective model of nursing care, as the generic versions require adaption to fully incorporate the care needs of people with learning disabilities (Moulster et al. 2012). Hence, the creating further challenge for adult and mental health nurses in universal care settings. A newly developed model of person-centred care incorporates elements that need to be present to provide person-centred care for people with learning disabilities in general hospitals but requires further testing (Brown et al. 2016). These elements were identified from analysis of the input of learning disability liaison nurses to prevent care being compromised and they are congruent to the challenges expressed by nursing staff. However, to deliver person centred care, first the nurse needs to develop a therapeutic relationship with their patient.

2.5 Therapeutic relationships

The clinical problem previously described saw experienced adult and mental health nurses' express concerns at their ability to engage in a therapeutic relationship with people with learning disabilities. It is important to understand the perspectives of people with learning disabilities, their families and carers and nurses, as they engage in a therapeutic relationship with each other. Adults with learning disabilities receive care in a variety of settings; in primary care it could be from practice nurse, district nursing team, condition related specialist community nurse, community learning disability nurse, community mental health nurse, care home nurse, health visitor or midwife. In secondary care; from an acute hospital nurse or mental health nurse, emergency care nurse or condition specific specialist nurse to name but a few.

Therapeutic relationships are underpinned by the notion of partnership (Aldridge 2006). Person-centeredness is an approach to practice that requires the development and maintenance of therapeutic relationships between all healthcare professionals, family and carers (McCormack et al. 2010; Jukes and Aldridge 2006). Families and carers are often advocates, legally or informally. Therapeutic relationships are relational interactions between nurses and patients that are focused on improving and

supporting well-being (Lauder et al. 2002). They are initiated though interpersonal communication that allows the nurse to understand a patient's perspective and needs with the purpose of empowering the patient to improve (Forchuk and Reynolds 2001). If the nurse fails to show their commitment to understand the patient, this then can lead to them not being fully involved in their care (Lauder et al. 2002).

There is currently a dearth of research that has focused on adult and mental health nurses' ability and disposition to engage in therapeutic relations with patients who have learning disabilities and the little there is, is related to health professionals within tertiary learning disability services (Crotty and Doody 2015). Ryan et al. (2016) qualitatively explored the therapeutic relationship between nurses and people with learning disabilities receiving palliative care using focus groups. They found that the development of trust was important but required time. Although they were able to develop trust, nurses felt inadequate with people with learning disabilities. They noted the importance of continuity and fully understanding the person, however some palliative care nurses felt they were unable to fully engage in a therapeutic relationship; therefore, the quality of care was affected, and they were dissatisfied with the role they played. With an adequate sample size (n=91), the authors claim the study is valid and reliable due to the framework approach they used as it provides transparency, however this is difficult to concur with due to a lack of information presented on how the data was analysed and if there was corroboration by another researcher.

Gawande (2014) describes three different types of patient-professional relationship. Firstly, the paternalistic relationship which sits in the medical model of care with the healthcare professional as the decision maker, secondly, the informative relationship where the healthcare professional gives the patient information for them to make their own decisions. The previous two types of relationship do not fit with the ethos of patient centred care where as the third, interpretative relationship recognises the patient should have control, so time is taken to understand the patients' views and helps them make an informed choice. People with learning disabilities and their family and carers accounts of hospital experiences (Iacono et al. 2014) indicate they have experienced a paternal relationship with healthcare professional which is not conducive to the delivery of person-centred care (Gawande 2014).

Therapeutic relationships are underpinned by a number of abilities including self-knowledge, self-awareness, empathy and awareness of professional boundaries (Registered Nurses' Association of Ontario 2006). Therapeutic relationships are seen to be complex (Watt and Brittle 2008) and can be difficult to develop and maintain

(Chessum 2006). The nurse requires respecting their patients' beliefs and values (McCormack and McCance 2006), providing them with autonomy and control (Beadle-Brown 2006), allowing shared decision making (Press and Richards 2015) to develop a therapeutic relationship.

The level of ability the individual with learning disabilities has will affect their ability to partake in the therapeutic relationship (Jones and Donati 2009). Getting to know the person is paramount; care professionals who have acquired tacit knowledge about the person they are caring for are able to engage in a deeper understanding of their needs and strengthen their relationship (Crotty and Doody 2015; Reinders 2010). However, this may be a challenge for an adult or mental health nurse as different communication skills are necessary (Barber 2015) and having sufficient time to develop a therapeutic relationship within a busy acute care environment can be a challenge (Larsson et al. 2011).

Health professionals' inability to have person centred conversations with their patient is seen as a barrier to establishing a therapeutic relationship (Larsson et al. 2011), furthermore there is clear evidence showing that non-specialist healthcare staff report challenges communicating with people with learning disabilities (Hemm et al. 2015). This again may be due to degree of learning disability the person has (Lindsay and Hoghton 2016). Strategies to support getting to know the persons abilities, preferences, communication style include the development of easily accessed information held by the patient and can be shared at the point of admission or beforehand if its planned (Northway et al. 2017).

To support self-awareness and self-knowledge the nurse requires being reflective in order to understand their own attitudes, beliefs and values (Chessum 2006). Understanding their motivation to deliver care and being able to understand their experience, concerns and perspectives are values required by a nurse as they engage in a therapeutic relationship. However, having an overly empathetic approach can lead to sympathy being expressed which may affect the nurses' clinical decision making (Bulmer Smith et al. 2009) additionally, as the power relationship can often be unequal, the nurse requires to have the ability to manage the limits and boundaries of their professional role. The maintenance of professional boundaries prevents the nurse being over or under involved (Bowler and Nash 2014). Again, depending on the persons abilities will depend if the individual will be able to develop trust in the nurse. Some people with learning disabilities will immediately put trust in another, where as

some will not, and it will be difficult to achieve, others will not comprehend the concept of trust (Crotty and Doody 2015).

2.6 People with learning disabilities, families/carers engagement in a therapeutic relationship

The experiences of universal healthcare services from the perspectives of people with learning disabilities and their families/carers contribute to a growing body of evidence, some of which is based on general health care (Hart 1999; Iacano and Davis 2003; Gibbs et al. 2008; Dinsmore 2011; Howieson 2015) and mental health care (Longo and Scior 2004; Hastings 2007; Parkes et al. 2007; Donner et al. 2010; Szablowski 2017). Most studies are appropriately qualitative in nature as they are gaining an understanding of individual's experiences. They all report barriers and enablers to effective care provision. Previous literature reviews have been published encompassing this area; Backer et al. (2009) focus on access to secondary health care, Bradbury-Jones et al. (2013) consider the health, safety and welfare of people with learning disabilities in acute care and Iacono et al. (2014) on hospital experiences of people with learning disabilities. However, as this study is focusing on adult and mental health student nurses' willingness and ability to engage in a therapeutic relationship in order to deliver effective care, this will be the area of interest being reviewed.

Qualitative studies exploring people with learning disabilities and their families and carers' experiences in general health care are mainly homogeneous in their findings. In relation to accessing care for physical health treatment, Howieson (2015) reported that people with learning disabilities have a desire to engage in a therapeutic relationship with hospital staff resulting in them being valued and 'treated right' by staff. The participants reported staff attitudes and communication difficulties are deterrents to this. However, this study had a small sample (n=7) and lacks rigor due to a lack of a clear aim or study question to evaluate the findings against and no discussion on how rigor is assured. The same concerns are raised by Dinsmore (2011), in an interview-based study with people with learning disabilities and carers. Conversely, he also found when experiences were positive; staff attitudes were kind and empathic. A description of the biases from external sources is presented in this study but no reference is made to observer bias which is possible due to the researcher's occupation. Communication and staff attitudes are again presented as barriers to engagement in a care relationship with people with learning disabilities and

their carers (Gibbs et al. 2008), although the majority of participant comments appear to relate to medical staff. Her study describes hospital staff and does not distinguish between professions making it difficult to generalise findings to the nursing population.

On the other hand, some studies report general satisfaction with care in hospital (Iacano and Davis 2003; Fox and Wilson 1999). Iacano and Davis (2003) utilised a mixed methods approach, survey and interviews to explore individuals' hospital experiences, reporting in general, positive experiences and mixed attitudes. It is unclear how appropriate the survey would have been for people with learning disabilities to understand, as although it was designed using augmented and alternative communication, it was designed by a focus group of people with physical disabilities. The authors offer no further information, other than carers and families completed it on behalf of participants with learning disabilities. It could be questioned if people with learning disabilities views were therefore clearly captured. However, they noted similarly to other studies that nursing staff have a lack of time (Howieson 2015) and a lack of knowledge and skills which were perceived to contribute to poor communication and care delivery (Fox and Wilson 1999). This study had a low response rate, therefore lessens its generalisability and did not present the integration of the results of the two methods which would have strengthened its rigor. Hart (1998) highlights that people with learning disabilities did not perceive nurses to be caring towards them or attempt to engage in a therapeutic relationship to understand their needs which may have been due to a lack of communication skills, leaving individuals feeling ignored and vulnerable. This study again had a small sample (n=13) and lacked any discussion of how rigor is assured resulting in reduced trustworthiness.

In relation to studies where mental health nurses cared for people with learning disabilities in mainstream mental health settings, the findings were mainly heterogeneous. Hastings (2007) reports people with learning disabilities having positive views on care in an acute setting including positive staff attitudes and individuals feeling engaged and safe. This is seen to be due to the additional extensive support provided by learning disability nurses to their mental health peers. In contrast, in the Donner et al. (2010) study people with learning disabilities and carers reported feeling they were not equal partners in the care relationship and there were issues with joint working with specialist services. Similarly, Szablowski (2017) found families and carers had mixed views on their relationship with mental health nurses, some equal and empowering, others had difficulties with trust and being part of the care team with nurses presenting negative attitudes (Longo and Scior 2004). Parkes et al. (2007) commented that people with learning disabilities perceived they were not involved in

their care, although nurses had positive attitudes; they lacked skills in adapting care and were too busy to meet their needs. Due to lack of knowledge and skills to effectively engage, evidence of diagnostic overshadowing where nurses assume presenting problems are related to the individual's learning disability without recognising underlying physical or mental ill health is also reported in the studies (Longo and Scior 2004; Donner et al. 2010).

All the mental health studies were qualitative and varied in quality. Hastings (2007) as a service review lacked any methodological framework preventing transferability. Whereas Szablowski (2017) omitted to describe how they undertook the literature review. Parkes et al. (2007) failed to describe the qualitative method for analysis or how themes were established. The other studies highlight the use of member validation and clear description of theme development enhancing the quality of the studies (Longo and Scior 2004; Donner et al. 2010).

Overall, some studies involving people with learning disabilities were seeking for them to recall their experiences from the previous 2+ years (Hart 1998; Parkes et al. 2007; Donner et al. 2010; Dinsmore 2011). It could be argued this timeframe is too long for accuracy of memories to be recalled. Many argue that additional specialist training is required to improve attitudes (Iacano and Davis 2003; Longo and Scior 2004; Dinsmore 2011) and education on learning disabilities should be part of undergraduate programmes (Fox and Wilson 1999; Gibbs et al. 2008). Tuffrey-Wijne et al. (2016) found the nurses did not understand the role of carers in hospitals. This is important for the nurse as the therapeutic relationship could be enhanced with the patient if the family/carer can facilitate communication or help to get to know the person better (Chessum 2006). It is well documented that carers perceive that there is an overreliance on them to support communication and deliver care to people in hospitals (Iacano and Davis 2003); on the contrary other studies recommend that carers are seen as equal partners in care delivery and are listened to by nurses (Fox and Wilson 1999; Szablowski 2017).

From a general health context, only Hart (1998) and Howieson's (2015) studies touched on the exploration of the relationship between the patient with learning disability and an adult nurse. From a mental health nursing perspective, given that in mental health nursing the development of a therapeutic relationship is fundamental to the patients' treatment (Barker et al. 1999), all the studies but one discussed in some degree the importance of the patient/carer-nurse relationship. It is important to note the therapeutic relationship between individuals with learning disabilities and adult or

mental health nursing staff has not been fully explored from the patient or family/carer perspective. People with learning disabilities, their families/carers perceived adult and mental health nurses lacked competency, not possessing necessary additional skills and knowledge in communication, adaptions to care delivery or being equal partners in care. Negative attitudes were also seen as a barrier. There were no studies that focused on people with learning disabilities experiences of receiving care from adult or mental health student nurses; therefore, the researcher was unable to consider people with learning disabilities perspectives on receiving care from student nurses. Evidence of this nature could contribute to the understanding of therapeutic commitment of student nurses when caring for people with learning disabilities.

2.7 Nurses engagement in a therapeutic relationship

Nurses are the largest professional group within the NHS and the majority of their working life is subsumed with direct patient care. Given nurses are partners in a therapeutic relationship and usually initiate it in order to provide person centred care, there is a need to understand adult and mental health nurses' perspective on what supports or deters them from being effective partners and this will be the area of interest being reviewed.

A thematic and a narrative literature review were found that focused on the barriers preventing effective care delivery for people with learning disabilities (Brown and Kalaitzidis 2013) and the experiences of acute nurses when delivering care to people with learning disabilities (Lewis et al. 2016); neither discuss the quality of the research reviewed. Within the literature, the adult and mental health nurses' perceptions of caring for people with learning disabilities have been explored from; acute care (Lewis and Stenfert-Kroese 2010), accident and emergency (Sowney and Barr 2006), oncology (Flynn et al. 2015), palliative care (Cartlidge and Read 2010; Cooper et al. 2014), orthopaedic and trauma (Drozd and Clinch 2016), primary care (Melville et al. 2005) and mental health (Taua et al. 2017).

Experiencing stress and discomfort was evident in three studies. Many adult registered nurses are unprepared and uncomfortable delivering care to people with learning disabilities (Sowney and Barr 2006): in this study emergency care nurses expressed fear and vulnerability due to their perceived lack of knowledge and confidence to identify care needs and manage behaviours that challenged them. They also feared they were treating people differently, showing a lack of understanding of equality. This

in turn caused them to become passive and disengage from the patient. They were then reliant on carers to deliver care instead of them. This then consequently reduced the opportunities the nurse has to learn from the experience of caring for a patient with learning disabilities, creating a barrier that is difficult to break as the nurses had positive regard for the carers as they were proficient in providing care and communicating with the patient. Therefore, the insecurities they experienced were reinforced instead of been seen as a positive learning opportunity. This study was valuable given its robust qualitative design to demonstrate ways nurses perceived their contribution to care. Lewis and Stenfert-Kroese (2010) found comparable views of acute care nurses and health care assistants (*n*=42) including a small amount to student nurses (*n*=6, 6.1%), however there was no difference of views between registered or unregistered nurses and student nurses in perceiving fewer positive attitudes towards people with learning disabilities than physical disabilities. They reported feeling stressed when providing care which affected the quality of care they delivered. Nurses were seen not to attempt to engage in a therapeutic relationship by spending less time with them and relying on carers to provide their care. This study added to the literature as the consequence of the nurse's emotional reaction was seen to affect their behaviour and subsequently care delivery. The response rate of this study was low (20%) affecting generalisability.

Finally, Flynn et al. (2015) in a mixed method study focused on the perceptions of oncology nurses who similarly reported feeling less comfortable caring for people with learning disabilities than those without, due to a lack of knowledge, skills and experience, as a result reported experiencing more stress. They also described dependence on carers especially to aid communication rather than ask the person with a learning disability about the care they wished to receive. It could be suggested the nurses did not attempt to engage in a therapeutic relationship with the patient. This study reports a small sample size (*n*=83) which limits the generalisability of its findings. Also, the validity and reliability of the care perception tool could not be assessed.

Drozd and Clinch (2016) undertook a small quantitative study (n=13) to survey the experience of orthopaedic and trauma nurses but the findings have limited generalisability. Also, although it is claimed tests were independently performed to enhance rigor, the validity and reliability of the tool was not reported. The study was based on the 6Cs framework (Department of Health 2012a) where nurses perceived they provided poorer care, communication and had less competence to deliver care to people with learning disabilities than they have for non-learning-disabled patients. However, many were more committed to provide care, although the authors noted

social desirability may have influenced the results. Although nurses said they were committed, no evidence demonstrated nurses engaged in a therapeutic relationship with patients to support this. More positively, Cartlidge and Read (2010) studied palliative care nurses' views on end of life care for people with learning disabilities in one hospice in the United Kingdom. The qualitative study reported that nurses found it rewarding, recognising the need to get to know people well and build trust which supports a therapeutic relationship, although communication was challenging for them. It was reported when nurses were unsure and anxious this transferred to the patient, hence support was sought, and time was taken to overcome this. Interestingly, not all nurses had experience of providing care to this patient group, therefore they reported what they expected to experience rather than what they actually had experienced. Data were collated via a questionnaire and one large focus group (n=17) which was reported as difficult to manage. Content analysis was used to develop themes but no information was present on how any biases were managed.

Taua and Neville (2017) using semi-structured interviews explored best practice of mental health nurses (n=13) providing care for people with learning disabilities in mental health inpatient settings in New Zealand. Appreciative enquiry was used to collate the data with only a focus on the positive aspects of care, it could be argued that some aspects were not captured using this approach. Using thematic analysis it was reported that nurses recognised the need for additional communication skills to engage their patient and knowledge and understanding to be effective in improving their mental health, but the supporting qualitative data examples did not wholly reflect this occurred in practice. This methodology provided only one set of perspectives but there were probably many which were not explored, and as it was conducted in New Zealand these findings may not be generalizable.

In contrast, other studies have highlighted nurses perceiving high levels of self-efficacy (Melville et al. 2005; Cooper et al. 2014), however the first study noted positive attitudes, but nurses' lack of knowledge and the latter study expressed the belief that the nurses were over confident in their abilities. Melville et al. (2005) provide a robust quantitative study evidencing positive attitudes, although a high proportion of practice nurses had infrequently provided care and those who had experienced difficulties during appointments. In Cooper et al. (2014) study, the palliative care nurses were also highly confident in meeting people with learning disabilities needs, even though knowledge deficiencies were evident. This could be explained as nurses were highly skilled in their own area of practice, assuming their skills would easily transfer but due to the lack of contact with people with learning disabilities, they have not fully

understood any additional care needs (Cooper et al. 2014). Information on how the data in this audit were analysed is not provided and experienced a low response rate at 30%, therefore generalisability is challenged.

Communication is the central component of a therapeutic relationship. Communication takes time which is difficult in busy environments (Sowney and Barr 2006) and nurses communicate less with people with learning disabilities than others (Drozd and Clinch 2015). Challenging behaviour is seen as something to be managed and part of an individual's learning disability (Drozd and Clinch 2016; Taua and Neville 2017). Not as a way of communicating that an individual's health needs may be the reason for the change in behaviour, indicating a lack of knowledge.

Moreover, having previously worked with people with a learning disability was seen to reduce nurses' anxieties (Flynn et al. 2015) and increase confidence, skills and knowledge (Lewis and Stenfert-Kroese 2010). Effective partnerships with carers and learning disability nurses were seen as positive support. However, nurses are unclear of carers' roles and realistic expectations required being defined (Drozd and Clinch 2015). Learning disability nurses in roles like liaison nurse services and link nurses provided specialist support and enhanced nurses understanding to make reasonable adjustments (Cartlidge and Read 2010; Flynn et al. 2015; Drozd and Clinch 2016).

Various reasons are given for adult and mental health nurses being willing and able to engage with people with learning disabilities. Some studies gave a lack of knowledge, skills and experience as the rationale for perceiving inability to provide care (Sowney and Barr 2006; Cartlidge and Read 2010). Other views included stereotyping (Merrifield 2011) and being unsure if the person will comprehend and reciprocate (Lewis et al. 2016), therefore it is easier to employ avoidance techniques and disengage. The result of non-engagement with a patient affects their relationship and ultimately the care they receive.

From the critical appraisal of the studies presented, it could be argued the trustworthiness of the majority of the studies was questionable with a few exceptions. No studies explored adult or mental health student nurses' experiences when caring for people with learning disabilities; however others focused on their attitudes towards people with learning disabilities which will now be discussed.

2.8 Nurses attitudes towards people with learning disabilities

Beyond skills and competence, the attitudes a nurse holds will influence if they are committed to provide care to people with learning disabilities. Attitudes are important in caring to ensure the quality of person-centred care (Price 2015). The attitudes held by a nurse will affect their willingness to engage in a therapeutic relationship.

Various studies have explored the attitudes of healthcare staff in caring for people with learning disabilities including nurses (Slevin and Sines 1996; McConkey and Truesdale 2000; Rose et al. 2012), healthcare students including student nurses (Werner and Grayzman 2011; Kritsotakis et al. 2017), student and registered nurses (Slevin 1995) and others have focused on student nurse populations (Klooster et al. 2009; Temple and Mordoch 2012). Four international studies included student nurses, where no specialist learning disability fields of nursing exist (Klooster et al. 2009; Werner and Grayzman 2011; Temple and Mordoch 2012; Kritsotakis et al. 2017).

In studies pertaining to healthcare staff, some report positive attitudes from mental health care (Rose et al. 2012) whereas others from acute hospital care report negative attitudes (Slevin and Sines 1996). It was found that staff working in learning disability services had greater confidence and more positive attitudes than their non-specialist peers (McConkey and Truesdale 2000; Rose et al. 2012). Graduate nurses were seen to have more positive attitudes than non-graduate and negative attitudes were a result of a lack of knowledge and skills (Slevin and Sines 1996).

From healthcare student population studies, attitudes towards people with learning disabilities were negative on the whole and student nurses were found to have the poorest attitudes (Werner and Grayzman 2011; Kritsotakis et al. 2017). Werner and Grayzman (2011) believed students had a low level of intention to work with this patient group due to lack of skills and knowledge.

Echoing McConkey and Truesdale (2000) findings, Klooster et al. (2009) reported student nurses expressed fewer positive attitudes towards people with learning disabilities rather than physical disabilities. Having a family member with a learning disability did not affect attitudes held (Klooster et al. 2009). The non-nursing population for this study was recruited by student nurses who already participated. It is unclear if they were from another healthcare profession or not, their background and the process may have introduced social desirability bias between the two groups.

Several studies found having previous contact with a person with a learning disability improved the nurses' attitude (Slevin and Sines 1996; Rose et al. 2012; Kritsotakis et

al. 2017) and confidence (McConkey and Truesdale 2000). Within Slevin (1995) study, a comparison was made between student nurses who had a placement where they provided care to someone with a learning disability and the comparative group were registered nurses. It could be argued that other contributory factors may have impacted on the registered nurses' attitudes as they were in a different role with different responsibilities, not just educational preparation.

Sowney and Barr (2006) highlighted nurses who did not have an educational opportunity caring for people with learning disabilities during pre-registration education related to a reduced ability to meet patient needs when qualified. Others offer a convergent view advocating that education in pre-registration improves attitudes (Slevin and Sines 1996; Werner and Grayzman 2011).

Most of the previous studies discussed utilised the robust Attitude towards Disabled Person Scale (ATDP). Temple and Mordoch (2012) however measured attitudes with a tool designed from reviewed literature. It is unclear the rationale for the areas included. There was also no psychometric testing of the tool or description of the analysis affecting its reliability and validity. They found the majority of student nurses surveyed viewed care of people with a learning disability from a medical model standpoint where the role is to treat and cure, not understanding the social model of disability. They also perceived they were competent of provide care to people with learning disabilities as they had transferable skills to meet the physical needs of this patient group. However, they stated that nurses trained in learning disabilities should fulfil the role.

Although no studies were found that reported on student nurses' experiences caring for people with learning disabilities, some studies were found that discussed student nurse attitudes towards this patient group. Nevertheless, all but one was United Kingdom based. No studies have explored student nurses' attitudes from different fields of nursing.

2.9 Therapeutic commitment theoretical framework

People with learning disabilities should receive quality person centred nursing care. In order to deliver this, the nurse requires to engage in a therapeutic relationship with them. To achieve this, a number of conditions should be in place which includes possessing the appropriate interpersonal skills, knowledge and attitudes in particular, unconditional positive regard (Rogers 1957). As a way of understanding if a student

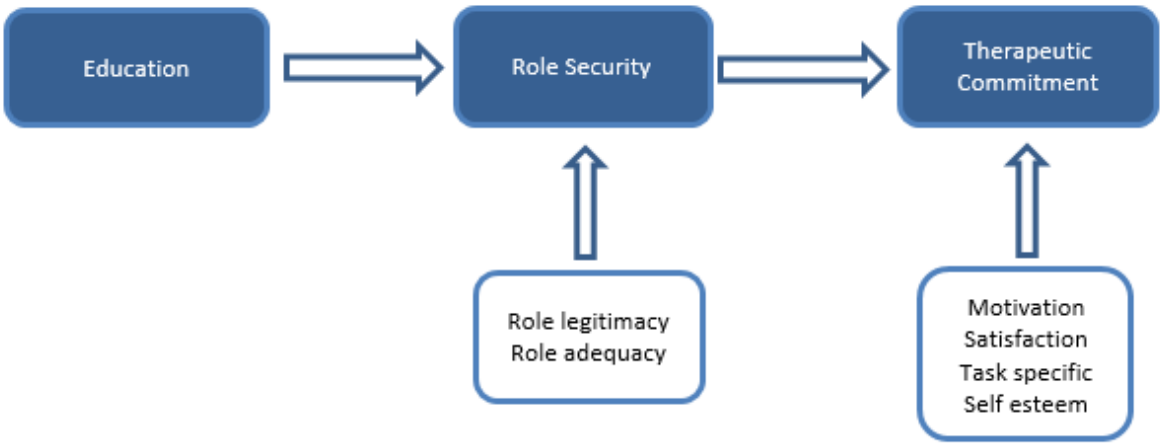
nurse is willing and has the ability to engage in such a relationship, the theory of therapeutic commitment is appraised.

2.9.1 Development of theory

The theoretical framework of therapeutic commitment has been developed through time. Shaw et al. (1978) developed the initial theory of therapeutic commitment to explain the factors that influence non-specialist healthcare practitioners to work with people who have alcohol problems, believing that non-specialists would be less reluctant to provide care to people with alcohol problems if they increased their therapeutic commitment. To measure the non-specialists' ability to enter into a therapeutic relationship with their patient, the original framework connected the following distinct but related attitudinal factors; motivation to work with a patient group, would contribute to work satisfaction and improve their self-esteem in this role which created the construct of therapeutic commitment (Cartwright 1980).

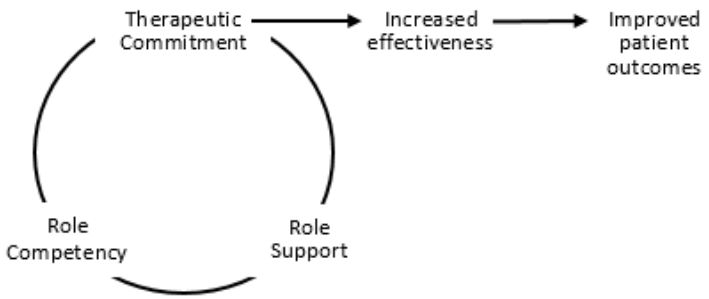
Cartwright (1980) established that support and experience had substantial influence on the non-specialists' therapeutic attitude which led to adding to the model, proposing that non-specialists experience a lack of confidence, if they perceived their skills and knowledge were inadequate to provide the care that was required by their patient and this was called role adequacy. Also, whether they had a legitimate role in the specialist field and this was called role legitimacy, both these factors created role security construct (Gorman and Cartwright 1991). The theory proposed that the level of therapeutic commitment a non-specialist holds depends on the level of role security they perceive. Role security is influenced by basic role requirements which are experience working with the specialist group, knowledge, perceived support and self-esteem (Shaw et al. 1978). The theory is predictive with therapeutic commitment being dependant on perceptions of role security which are influenced by the basic role requirements as illustrated in Figure 1.

Figure 1: Shaw et al. (1978) model of therapeutic commitment



The theory was later reconceptualised by Lauder et al. (2000) to apply to nursing and mental health. Whilst exploring a cohort of (non-specialist) district nurses' therapeutic commitment to people with mental health problems, the theory was adapted. The construct of therapeutic commitment was retained but changed and was seen as a 'general disposition' and a willingness to engage in a therapeutic relationship and is a pre-requisite for effective therapeutic care (Angus et al. 2001). From the process of factor analysis of the data, a new construct was identified. In Shaw's model, therapeutic commitment is influenced by the non-specialist's self-perception of their role security; however, Lauder et al. (2000) established that role adequacy and role legitimacy were one single construct which they named role competency. Role competency was defined as the perception a non-specialist has that they hold the necessary knowledge and skills to work with the learning disability group and perceive this is part of their role. Furthermore, the construct of role support was added to the model and is associated with the support the non-specialist perceives they can receive or access from more experienced or specialist staff to carry out their role. Lauder et al. (2002) theory proposed that mental health care will be improved by a greater willingness by non-specialists who provide care to engage therapeutically. The non-specialists' perception that working with this client group is integral to their role, as well as perceiving they have the appropriate skills and knowledge to carry out the role effectively as well as the support they can access will influence this and result in effective care as illustrated in Figure 2.

Figure 2: Lauder et al. (2000) model of therapeutic commitment



2.9.2 Therapeutic commitment

Lauder et al. (2000) states that therapeutic commitment is primarily a humanist view, similar to the work of Rogers (1957) where in this case the nurse's attitude, cognition and behaviour have an influence on the patient's growth. Rogers (1957) also discusses that when the nurse displays warmth, genuineness and empathy towards a patient, this in turn supports a trusting relationship between both of them, therefore creating a therapeutic relationship. This relationship requires trust allowing the patient to feel secure and participate with the nurse in the relationship. In turn, this creates the opportunity for empathy to be expressed by the nurse resulting in a more effective environment to work together to meet the patient's individual needs (Angus et al 2001; Lauder et al. 2000). The construct is supported by the nurses' motivation to care for the patient, expectation of work satisfaction and task specific self-esteem from the caring relationship. Commitment is seen as the conscious decision by the nurse to invest in a relationship with a patient with learning disabilities (Jukes and Aldridge 2006).

2.9.3 Role competency

Therapeutic commitment is dependent on role competency which is associated with the non-specialist's perception that working with this patient group is integral to their role, as well as perceiving they have the appropriate skills and knowledge to carry out the role effectively. Role competency may be influenced by previous experience with the patient group and additional education as well as support from another. Angus et al. (2001) link the perception of role competency with Bandura' (2001) concept of self-

efficacy where although a nurse may have the necessary skills and knowledge to effectively deliver care, however this is impeded by their self-belief that they do not have the ability to provide the care. This can deter nurses from fully engaging in the care they are to deliver (Stump et al. 2014); this may be due to the stress and anxiety experienced by the situation (Bandura and Locke 2003).

2.9.4 Role support

Role support is associated with the support the non-specialist perceives they can receive or access from more experienced or specialist staff to carry out their role. Bandura (1977) states by exposure and practice with experienced support, self-efficacy can be improved. Having this support will allow the nurse to develop stronger self-efficacy which will in turn positively influence their role competency.

2.10 Previous studies utilising therapeutic commitment theory

Shaw et al. (1978) produced the Alcohol Problems Perception Questionnaire (APPQ) to measure the levels of therapeutic commitment of non-specialist workers with people who had alcohol problems underpinned by their definition of therapeutic commitment. This questionnaire has been utilised in many studies (Bush and Williams 1988; Deehan et al. 1997; Anderson et al. 2003; 2004). The APPQ has been adapted for use where the researcher wishes to explore a non-specialist health professional's therapeutic commitment towards a specialist client/patient group in this case with drug dependency problems (Watson et al. 2006).

Lauder et al. (2000) and Angus et al. (2001) adapted and psychometrically tested the scale to produce a new instrument – Mental Health Problems Perception Questionnaire (MHPPQ) in line with the revised theory constructed. The study examined district nurses' level of therapeutic commitment to people who have mental health problems in rural areas. This work was then replicated in Australia by Clark et al. (2005) who studied adult nurses' perceptions of their effectiveness in working with people who experienced mental ill health in a rural setting. The results indicated low levels of therapeutic commitment, role competency and role support. The study saw the researchers adapt the survey tool and maintained its validity and reliability. Lauder et al. (2002) utilised the tool again to explore student nurses' therapeutic commitment to people with mental health problems. Students reported high levels of therapeutic

commitment. The study does not identify which field of nursing the students were from; therefore, it is difficult to establish if some may have more experience and knowledge due to their programme of study. Internal reliability testing proved the tool remained stable.

Chorwe-Sungani and Shangase (2013) used the MHPPQ to study nurses' therapeutic commitment to people living with HIV and experiencing mental ill health. The study reported that adult nurses varied in their therapeutic commitment to this patient group. It could be argued that two stigmatised areas were being focused on, mental health and HIV and with no control in place to establish if they were reluctant to work with people with HIV in general or those who were also were experiencing mental ill health. The validity and reliability of the study was not presented in the literature. The total number of participants was reported but not the response rate or total sample population. The researchers also personally collected the questionnaires from participants which could have introduced social desirability bias.

The theory of therapeutic commitment has been successfully used with other stigmatised patient groups to understand non-specialist health professionals' willingness and ability to engage in a therapeutic relationship with them and the tools developed are psychometrically robust. It therefore can be argued the survey instrument can be adapted to explore non-specialists in this case, student nurses' therapeutic commitment to people with learning disabilities.

Furthermore, a practice framework has been developed to operationalise patient-centred care in nursing (McCormack and McCance 2017) and tested for effectiveness (Slater et al. 2017). The Person Centred Practice Framework (PCPF) consists of four main components; whereby nurses require meeting certain attributes which are necessary to manage the care environment, in order to deliver effective care and achieve person centred outcomes (McCormack and McCance 2006). They found there are a number of pre-requisites to providing person centred care; professional competence and being committed to the job. These are congruent with the concepts within therapeutic commitment theory.

The three different constructs of therapeutic commitment will be compared with the PCPF and differences identified. Within PCPF, the authors believed the nurse requires being dedicated to the job and wants to provide the best for the patient. This is similar for therapeutic commitment, but it is particularly related to the willingness to work with a certain patient group they do not have experience caring for: in this study people with learning disabilities. Role competency as previously described has two

components; role adequacy where the nurse requires having the necessary skills and knowledge and role legitimacy where they need to believe that caring for the patient is their responsibility. In PCPF the requirement is to be professionally competent, this is defined as having the necessary knowledge and skills to make decisions, prioritise care and competence in the physical and technical aspects of care (McCormack and McCance 2006 p475). They are clear differences in the definitions between both models as therapeutic commitment encompasses the legitimacy of the role. The other difference is the in PCPF; beliefs and values are seen as part of the professional competency, whereas they are not in therapeutic commitment.

The ability to access support does not feature in the PCPF model, whereas in the therapeutic commitment model it is seen as a vital resource to support the nurse gain role competence and influence therapeutic commitment.

2.11 Conclusion and rationale

No studies were found that explored therapeutic commitment for people with learning disabilities by non-specialists. The literature review has demonstrated a dearth in current knowledge and understanding relating to student nurses' attitudes, perceived knowledge and skills to care for people with learning disabilities. Whilst elements of non-specialist nurses' ability to engage in a therapeutic relationship with people with learning disabilities is acknowledged in some existing literature, it has received little exploration and even less on student nurses' ability. Most of the research pertaining to nurses' experiences that were reviewed used a qualitative approach to provide initial exploration of the care episode between nurse and patient and mainly due to the small scale of the research, many were lacking in rigor. This gap now exists because past research has only in the main provided a partial view by qualitative approaches resulting in the need to provide a fuller understanding through comparing and synthesising both quantitative and qualitative data.

To understand and explore student nurse's willingness and ability to engage in a therapeutic relationship with people who have a learning disability, it is argued using the theory of therapeutic commitment will provide the appropriate framework to achieve this. Previous studies utilising this theory with a different patient group have offered data on the level of therapeutic commitment student nurses perceive but do not investigate what affects it. No previous research studies have explored any health

professionals' therapeutic commitment to people with learning disabilities. Also, it has strong similarities to the prerequisites required for person centred care with the PCPF which has been validated as an effective tool to develop practice. However, there are some differences between PCPF and therapeutic commitment, namely being committed to work specifically with a stigmatised patient group, believing this core to the nurses' role and having access to more experienced staff to support the nurse to provide care to people with learning disabilities. These could be important attributes to measure within student nurses as they are in the process of developing professional competence and may help understand what influences therapeutic commitment during the undergraduate programme for non-specialist nurses.

It is proposed this research will investigate final year student nurses' perceptions of therapeutic commitment to people with learning disabilities, and the factors that influence it. Furthermore, utilising a quantitative and qualitative approach to explore and examine perceptions both numerically and narratively and with integration, resulting in a broader understanding of the research problem described. Having considered the background literature and rationale to the study, the research methodology and design will be discussed in the following chapter.

Chapter 3: Research methods

3.1 Introduction

Understanding student nurses' perceptions of therapeutic commitment to people with learning disabilities has not been previously studied. This chapter presents the methods used in this study including the research purpose, research questions and rationale for adopting a convergent approach to understand this problem. The research design and analytic methods will be appraised, as well as, examination of the ethical considerations to ensure the aims of the study were met.

3.2 Purpose statement

The aim of this study was to understand final year student nurses' perceptions of therapeutic commitment towards people with learning disabilities, as well as any factors that may influence this. A convergent mixed methods design was used where quantitative and qualitative data were collected in parallel, analysed independently then merged together. In this study, a survey instrument was used to test the theory of therapeutic commitment. The theory posits that increased levels of role competency and role support will positively influence the overall therapeutic commitment of final year adult, mental health and learning disability student nurses. This was tested at four Scottish Universities. At the same time and with the same population, open-ended questions within the survey instrument were used to collate qualitative data that allowed exploration of therapeutic commitment and the factors that influence it. The reason for this approach was to discuss and compare the similarities and differences of the two forms of data, bringing greater insight into the understanding of the theory and its influencers than would be gained by either type of data separately.

3.3 Theoretical framework

Therapeutic commitment which posits outcomes for people with learning disabilities are improved if a practitioner has a greater commitment to engage with individuals therapeutically and was the chosen theoretical framework for this study. Therapeutic commitment is influenced by the practitioners' self-perceived competency, acceptance of the role and support they can access and receive. This framework was chosen

because it has been found to reliably measure non-specialists' levels of therapeutic commitment towards varying stigmatised patient groups including alcohol dependency, drug dependency, HIV and mental ill health (Chorwwe-Sungani and Shangase 2013; Clark et al. 2005; Albery et al. 2003; Angus et al. 2001; Lauder et al. 2000).

The theory was used in this convergent design to inform the structure of the data collection survey instrument (Learning Disability Perceptions Questionnaire), measuring perceived levels of therapeutic commitment revised from the Mental Health Problems Perceptions Questionnaire (Lauder et al. 2000) and to inform the structure of the open-ended questions to explore participants perceptions of the core concepts of therapeutic commitment, role competency and role support. The questionnaire is found in Appendix 9 and its development encompassing the therapeutic commitment model is discussed further in Section 3.10.1. The theory also informed the analysis of both data sets, as well as the integration of both sets of results as presented in Chapters 4, 5 and 6.

3.4 Mixed method research

Mixed methods research has been described as 'multiple ways of seeing and hearing' (Greene 2007, p20) by allowing the combination of both quantitative and qualitative methods to collect and analyse data to provide answers to research questions (Creswell and Plano Clark, 2007; Doyle 2015).

The main principle of a mixed methods approach is that a better understanding of a research problem can be sought using the combination of quantitative and qualitative methods, than any single method (Creswell 2007). Creswell and Plano (2017) go further by advocating that mixed methods goes beyond the method: it is a methodology that is surrounded by theory and philosophy. There has been a surge in the use of mixed method approaches in nursing research (Doyle 2015); however, the design is often poorly reported within publications (Tatano Beck and Harrison 2016).

Mixed methods research is seen as a new, third methodology (Tashakkori and Teddlie 2003; Johnson and Onwuegbuzie 2004) following the so-called paradigm wars between quantitative and qualitative followers claiming their method is superior (Reichardt and Rallis 1994). It was claimed that a mixed methods approach was not possible due to the different paradigms associated with quantitative and qualitative approaches (Guba and Lincoln, 1994). The philosophical debate continues (Tashakkori and Teddlie, 2003; Greene, 2008) as using both quantitative and

qualitative methods together is a challenge due to the different ways they interpret reality (Robson, 2009). Onwuegbuzie and Leech (2005) argue that quantitative and qualitative methods themselves have similarities as neither sits purely in their own methodology but use elements of each other. Mixed methods research has now moved on, Creswell and Plano (2017 p47) describe a five-stage journey from its concept to the current day where mixed methods researchers are not only 'reflecting and refining' the methodology but advancing it. Part of the refinement includes the school of mixed method researchers agreeing on a universal typology to classify the design of mixed methods studies (Nastasi et al. 2010; Creswell and Plano Clark 2017) as previously different scholars have developed their own leading to confusion on which to use (Onwuegbuzie and Combs 2010; Schoonenboom and Johnson 2017).

3.4.1 Philosophical Assumptions

All research has a philosophical foundation, however different epistemological and ontological assumptions support different paradigms or methods. Quantitative research is generally steeped in positivism/postpositivism, whereas qualitative research is seen to hold constructivism as its worldview (Bryman 2012). The remaining two worldviews of transformation and pragmatism are aligned to mixed methods research (Teddlie and Tashakkori 2009). Creswell and Plano Clarke (2017 p.39) see a paradigm as a worldview and advocate that mixed methods researchers either use one of the following positions; 'one best worldview, a dialectical perspective including multiple worldviews, the worldview best suited to the study context and design or the worldview shaped by the researcher's community'.

Pragmatism was seen as a supporting philosophical position of choice as a single paradigm, incorporating both qualitative and quantitative methods (Johnston and Onwuegbuzie 2004). However, Biesta (2010 p96) argues pragmatism is not a 'philosophical position' but a 'set of tools' to assist the research process. Pragmatism is viewed by the researcher as the gaining of knowledge from the active process of reflection and action (Biesta 2010). The research problem is seen by the researcher as a practical one (Greene and Hall 2010). She believes the research questions are of greater importance than the method itself (Biesta 2010), therefore this study did not begin from a philosophical position as it would not have been supportive to respond to the research problem being explored. From an ontological perspective, pragmatism also provides the researcher scope to see singular and multiple realities, from testing hypotheses as well as providing many perspectives from the qualitative data. From an epistemological perspective, the researcher has a practical relationship with what is

being researched and collects data by what works to address the research questions, therefore the most suitable methodology was employed.

3.5 Research questions

When conducting any type of research, the central purpose is to answer questions related to the phenomena being explored (Robson 2009). The purpose statement provided an overarching direction for this study; however more focused research questions are the conduit to finding answers to the research problem. Research questions are paramount in mixed methods research. They lead the process by setting boundaries for the study, explain its exact direction and direct the chosen research methods (Plano Clark & Badiee 2010; Teddlie & Tashakkori 2009). Different research approaches require different types of questions (Creswell and Plano Clark 2017). Quantitative research questions were required to understand the relationships between the variables; compare the two student nurse groups and relate the constructs of therapeutic commitment to independent variables. On the other hand, qualitative research questions assist the exploration of a phenomenon (Creswell 2009), in this study a qualitative question was used to explore the factors relating to therapeutic commitment from the student's individual perspective. The mixed methods question was posed to support the converging of the data, providing a more in-depth, richer understanding of student nurses perceptions of their therapeutic commitment to people with learning disabilities.

The mixed method design was valuable and important for comparing the findings from a qualitative and quantitative approach and to provide a detailed and realistic understanding of the student nurses' perceptions and experiences of therapeutic commitment when caring for people with learning disabilities, as well as the factors that influence therapeutic commitment. The overall question is as follows:

1. What are the differences in therapeutic commitment to people with learning disabilities between learning disability, adult and mental health student nurses and what factors influence this?

Specific approach related research questions were formulated as:

Quantitative Questions -

2. Do final year student nurses perceive they are therapeutically committed to people with a learning disability?

3. Is there a difference between learning disability student nurses and the other student nurse group (adult and mental health student nurses) perceived levels of therapeutic commitment?

Qualitative Question –

4. What factors do final year student nurses believe influence therapeutic commitment?

Mixed Methods Question –

5. Does the qualitative data help explain the results from the initial quantitative phase of the study?

3.6 Research design

The mixed method convergent design used here consists of one phase: quantitative and qualitative methods are done together (Creswell and Plano Clark 2017). In this design, quantitative and qualitative data are collected and analysed at the same time, then later the results are combined and compared as demonstrated in Figure 3.

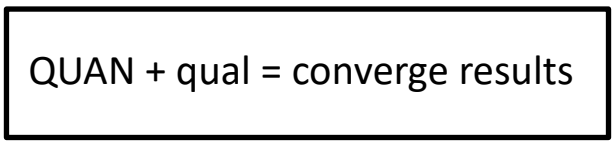
Figure 3: Convergent design

The quantitative approach was utilised to collect data and measure levels of therapeutic commitment perceived by non-learning disability group (NLDG) which comprises of adult and mental health student nurses and learning disability group (LDG) which comprises of learning disability student nurses allowing comparisons between NLDG and LDG to test the hypotheses. It also began to identify other factors that influenced the students' level of therapeutic commitment. In parallel, the

qualitative approach was employed to collect and understand what students perceived influenced their therapeutic commitment. The quantitative data resulting from the deductive theory being tested was seen as having greater priority because it measured the levels of therapeutic commitment using a validated tool with the aim to generalise the findings to other student nurse groups. The qualitative data was used to assist in explaining and interpreting the quantitative data. This approach is consistent with the research questions, so the qualitative data served a secondary purpose (Plano Clark and Ivankova 2016). The combination of these findings providing an opportunity to contrast and compare them, resulting in different perspectives and better understanding of students nurses therapeutic commitment to people with learning disabilities.

A self-administered questionnaire was used to collect all data. Creswell and Plano Clark (2017) describe this approach as the questionnaire variant; however, this approach reduces the quality of qualitative data that is produced. The design was also fixed as the method used was pre-set before the collection of any data was completed as planned (Creswell and Plano Clark, 2017). Within the design, although the methods occurred concurrently, the quantitative method had greater priority than the qualitative as it fully encompassed the theory used, then the results of both methods were brought together at the point of interpretation as illustrated in Figure 4.

Figure 4: Notation Diagram



The strengths of a convergent design are it is straight forward and efficient as data is collected at the one time and provides an opportunity for the researcher to ‘give a voice’ to the statistical data as contrasts can be made (Creswell and Plano Clark, 2017). On the other hand, a convergent design can be difficult to implement due to problems that can arise in relation to the sample size and the sample itself. As quantitative and qualitative methods need different sampling strategies to ensure adequate sample for analysis, decisions require to be made to ensure this is achieved which may mean the methodological rules for either research approach may be broken (Creswell and Plano Clark 2017). Also, at the interpretation stage of the integrated

data, difficulties can arise if the data sets have captured different perspectives (Cresswell 2009).

3.7 Ethical approval/considerations

Protecting participant's rights and ensuring their safety are the most important roles of a researcher, as any research could potentially be harmful (Long and Johnston 2007). It is essential that ethical approval is gained prior to its commencement (Ingham-Broomfield 2017). As the participants in this study were student nurses within four Higher Education Institutes in Scotland, ethical approval required to be sought from them individually. In addition, during the development of the research protocol advice was requested from Research and Development Department at NHS Grampian who confirmed there was no requirement for NHS approval. The University of Stirling agreed to undertake the role of sponsor for the study as outlined in the Research Governance Framework for Health and Community Care. Ethical approval was gained from all universities approached and an overview of the ethical approval process is provided in Appendix 3.

Confidentiality and anonymity were key considerations throughout the research process in line with Caldicott principles (1997). Questionnaires and consent forms were stored separately immediately after collection by the researcher and index numbers were used for anonymity; therefore, no person identifiable information was used after data collection. Both the questionnaires and consent forms were stored in separate locked filing cabinets that only the researcher could access.

The study was considered to be of low risk to participants; however, there was a chance that the participants, as student nurses, may have previously observed sub-optimal care practices. There was no safeguard to prevent this, however personal tutors were briefed prior to the commencement of data collection to ensure support would be available if required.

3.8 Sample strategy and sample size

A purposive sampling strategy was employed to recruit student nurses to the study. Although probability sampling is often associated with a predominant quantitative method as used within this study (Guest et al. 2006), a non-probability approach was chosen to provide the opportunity to include participants that would be able to offer the

essential data necessary to answer the research questions posed within this study (Bryman 2008). For example, participants required to be student nurses from the fields of adult, mental health or learning disability to compare them as directed by the research questions.

The total population for this study was all pre-registration student nurses undertaking undergraduate nurse education in Scottish Higher Education Institutes. Nevertheless, this population is too large for the purpose of this study, so a subset was developed (Parahoo 2014). The target population consisted of final year nursing students who were within one year of being eligible to enter the NMC register, if they successfully completed their programme. The student nurse required to be in year 3 of a diploma or degree programme or year 4 of an honours programme. Choosing final year students increased the probability of the student nurse having had an experience caring for a patient with a learning disability which was important but not essential to be involved in the study.

Pre-registration programmes in Scotland support the development of nurses from the four fields of the NMC register – adult, mental health child health and learning disability. Child health student nurses were excluded from the target population, as the survey is focusing on the therapeutic commitment shown to adults with learning disabilities. Students in the field of child health would have limited opportunity to experience this due to the nature of their educational programme. Although, the theory of therapeutic commitment focuses on non-specialist perceptions of a patient group, learning disability student nurses have been included in this study, as a comparison group for the non-specialists to answer the research questions posed.
At this time there were six Higher Education Institutes (HEI) in Scotland delivering large cohort (>200 per year) pre-registration nursing programmes. Again, recruiting from all six was too large a sample; therefore, four Scottish universities were selected. Two universities because they are the only ones that delivered the learning disability programme in Scotland as the study required having learning disability student participants for comparison purposes. The other two did not deliver the learning disability programme and were chosen as they are geographically more convenient for the researcher for data collection purposes.

Ensuring an adequate sample size that supports the quality standards of a mixed method study is crucial (Halcomb and Andrew 2007). As the study prioritised the quantitative data, the sample size required to be adequate for its analysis. A power

calculation directed the size of the sample required where the rule of thumb is, for each item within the questionnaire 5 responses are required (5:1); therefore, as the scale contains 29 items in Section B, 145 participants would be required for analysis. However, to perform factor analysis, there is no consensus on the appropriate size, except it should be large. Hair et al. (2010) recommend a sample of more than 100 is preferable, on the other hand Tabachnick and Fidell (2007 p. 613) consider it 'comfortable' if the sample size is higher than 300 cases, whereas Costello and Osborne (2005) recommend 10 responses per item. In this study, with a response of *n*=398, all of the recommendations made were met.

It was planned that the target population of adult, mental health and learning disability student nurses in the four universities was approximately 1500. With an anticipated 40% response rate, the total recruited would be 600. As the quantitative and qualitative data were collected at the same point in time via the one survey instrument, the same volume of qualitative responses was expected. This provided a large amount to qualitative data which was ample for thematic analysis (Braun and Clark 2013).

3.9 Process of recruitment

The recruitment process was directed by guidance given during the ethical approval process within each university and by their individual Heads of School. Within the four universities lecturers responsible for Years three and four of their programmes were identified to act as gatekeepers and support access to the students. They identified spaces in the students' timetables where the researcher could attend and distribute questionnaires. Dates were arranged to access the student groups through their class lecturer. Bryman (2012) highlights when there are layers of gatekeepers to negotiate, difficulties are common. At this stage as some lecturers varied in their willingness to support organising a slot following their class, therefore drop-in sessions were advertised instead.

One week before the arranged date, an electronic notice was sent to the students via the universities e-noticeboard inviting them to participate (Appendix 4) and provided a link to the participant information sheet. The use of advance warnings is believed to increase response rates as potential participants are informed and expecting to take part (Oppenheim 1992).

3.10 Data collection

Data collection took place in from August 2012 to November 2012 in one phase as per the convergent design method. A week after the e-notice had been posted, the researcher attended the university either at the end of a planned lecture or in a drop-in area to provide a verbal description of the study and offer the participant information sheet within the questionnaire booklet and consent form (Appendix 5). Students were given the opportunity to ask any questions regarding the study and if they wanted to participate they were asked to complete the consent form and the 'supervised self–completion questionnaire' (Bryman 2012). If they did not want to take part they were asked to return them uncompleted. All questionnaires were deposited into a box in the room to support anonymity. All students were thanked for their time and reminded they could withdraw at any time and this would not affect their future education or career journeys. The researcher's contact details were included on the participant information sheet to allow them to ask further questions. Additional questionnaire packs were left with lecturers to distribute to any students who were absent at that time and wished to participant. These were collated by the lecturer and returned to the researcher in person. There is recognition that an element of bias may have been introduced by the researcher being present and a lecturer gatekeeping which is discussed in Section 7.9. Some students (*n*=58) choose not to participate, the rationale for the relatively high non-response rate appeared mainly to be a time issue rather than relating to the characteristics of the individuals. The researcher on four occasions approached the students at the end of day when they had other commitments and were unable to stay and participate in the study.

3.10.1 Learning disability perception questionnaire

Using a questionnaire is seen as an economical way to collect volumes of information from a larger sample covering a wide geographical area (Bryman 2012). As this study required a large sample for statistical analysis and collected information from four different universities throughout Scotland; it could be argued this method was the most efficient. As this maybe a sensitive subject, using a questionnaire allows the respondent an opportunity to respond honestly without facing an interviewer (Braun and Clarke 2013). Sutton (2004) points out that the use of open-ended questions in the survey instrument provides standardisation, therefore simplifying the process for comparison with the quantitative data.

The Learning Disability Perception Questionnaire (LDPQ) used in this study is a self-administered questionnaire and is based on the Mental Health Problems Perception Questionnaire (MHPPQ) with permission from the author (Lauder et al. 2000). It was initially designed during the researcher's Master's degree for a quantitative study and with a different population. The initial development of the instrument and findings were also presented by the researcher at peer reviewed conferences (Brown, 2009; 2011).

3.10.2 Initial development of instrument

Streiner et al. (2015) discuss the benefits of using instruments designed and tested by others. The LDPQ, in principle, took the same format and design as the MHPPQ with some alterations. As the MHPPQ was already psychometrically tested by Lauder et al. (2000; 2001) and Angus et al. (2001), it was seen to be valid and reliable, therefore it was suitable to adapt for a different population who are also stigmatised (Disability Rights Commission, 2006). However, careful consideration required to be given to adapting the content of the questionnaire to ensure its validity and reliability (Boynton and Greenhalgh 2004). Synopses of the initial, main alterations to produce the LDPQ are discussed here.

The MHPPQ was constructed by three scales which measure the three core concepts that underpin the theoretical framework. In order to determine whether non-specialist nurses are therapeutically committed to work with people who have a learning disability, the underpinning theoretical framework was slightly altered to accommodate a different patient group leaving the three scales within the instrument measuring the following –

1. Scale one is therapeutic commitment, whereby it measures the nurses' perception of their willingness to engage therapeutically when caring for people who have a learning disability.
2. Scale two is role competency, whereby it is the nurses' perception that working with people who have a learning disability is part of their role and they have the skills and knowledge to fulfil that role.
3. Scale three is role support, whereby it is the nurses' perception that they can easily access support and advice when caring for someone with a learning disability.

The main adaptions were to the twenty-nine statements contained in Section B to measure the three constructs previously discussed. Polit and Yang (2016) stress the importance of maintaining the context of the statements whilst adapting them. This process was overseen by an expert panel that examined and compared the LDPQ to the MHPPQ to ascertain if the context of the statements had not been altered and continuing to measure the three constructs (Krabbe 2017). The panel consisted of three nurses with backgrounds from higher education, practice education and nurse management.

Primarily, the only alterations made were the words 'mental health problems' being exchanged to read 'learning disability'. However, this was not applicable within some statements as a learning disability is a condition not an illness or problem; therefore, some statements required to be reworded to accommodate this issue as per Appendix 6. Furthermore, two new statements (28 and 29) were created with the intention of adding to the role adequacy subscale and the role competency scale and pertinent to nursing practice of this patient population. Statement twenty-eight considered the nurses perceived ability to communicate effectively with a patient who has a learning disability. Healthcare practitioners (Lewis et al. 2016; Bradbury-Jones et al. 2012; Lewis and Stenfert-Krose 2010; Sowney and Barr 2007), people with learning disabilities (Howieson 2015; Iacono et al. 2014; Gibbs et al. 2008; Fox and Wilson 1999) and their families/carers (Hart 1998) often report the challenges they face communicating effectively with each other and is the central element in engaging in a therapeutic relationship. The expert panel felt it was important that it was included. As well as, statement twenty-nine was included as it was concerned with nurse's perceived knowledge about the varying health problems the learning disabled population can encounter which are often different than the general population (Cooper et al. 2004; 2007; Emerson and Baines 2010) and not known by general healthcare practitioners (Lewis et al. 2016).

3.10.3 Questionnaire – further development

To understand the theory of therapeutic commitment in more depth in this study, the LDPQ was again revised to meet the needs of the new population of final year student nurses and Section C added containing qualitative open-ended questions based on the theory. The revised LDPQ had three sections, the first Section A was used to collate demographic information and Section B was used to measure the level of therapeutic commitment and Section C had open-ended questions. An expert panel

evaluated and supported the changes to the questionnaire and the development of the additional qualitative questions.

Lessons were learned from the researchers Master's thesis and changes were made accordingly to produce the new version. Professional printing in a booklet format was used, so the participant could easily navigate their way through it (Dillman et al. 2009) and prevent missing out pages. Also, in Section A participants were asked about their experiences with people with learning disabilities, this was done using an open-ended question and it appeared that the wording of the question was not fully understood from the previous responses, hence within the new questionnaire participants were asked in separate questions about their work and personal experience.

The front page of the booklet displayed the sponsors logo, Oppenheim (1992) believes it may be perceived more official and influence participants to partake. It also contained a shaded box with text that explained the purpose of the questionnaire and to guide participants to the instructions (Oppenheim 1992). Additional changes included the participant information sheet being the first two pages of the questionnaire booklet. This allowed participants to take time to read it before they decided to commence the study. This approach could have made the survey appear too long and discouraged participation (Bryman 2012). Each section was designed as follows:

Section A – design and content

This section was used to collate demographic information about the participants. The only section poorly completed in this study was age and satisfaction with placement questions. The rationale for this is unknown however, it could be suggested that participants who did not fall into the average age range so omitted to share their age for fear of being identified. With regards to placement satisfaction, there may have been concerns regarding providing feedback on placements. As education on learning disabilities in fundamental to the pre-registration learning disability nursing curriculum, it could be argued that this question was not explicit enough for the NLDG to respond accurately to.

Section B – design and content

Section B contains twenty-nine items or statements. The expert panel reviewed this section and a consensus was offered that the statements all firmly related to the concepts they were trying to measure, and no further alterations were made from the first study. Overall, this section was well completed, however whilst administering the

questionnaire in one university, students asked for clarification on statement 20. The statement is concerned with the legitimacy of adult nurses' role when caring for people with learning disabilities when it should have been concerned with the role of all nurses and would require to be altered for future use.

Section C – design and content

Oppenheim (1992) believes open-ended questions allow participants the freedom to respond therefore providing further understand and knowledge. Eight open ended questions relating to the three constructs were initially developed by the researcher and shared with the expert panel to ensure there was no ambiguity or possible bias. Opinions varied, and they were discussed at length, with final agreement that there was some overlap and only six questions should be posed to reduce the length of time the participant would take to complete the survey. Appendix 7 describes the process used to develop the open-ended questions.

3.11 Pilot

Pilot work identifies indecipherable questions that result in unquantifiable responses (Oppenheim 1992) and tests if the tool functions as expected (Bryman 2012). The LDPQ was piloted with a group of six second year adult student nurses as they had similar characteristics to those in the planned sample (Nieswiadomy and Bailey 2017). They all agreed to complete the questionnaire and evaluation form (Appendix 8) to assess if the tool was practical and comment on its readability. The students reported that all the questions were understandable but felt that Section C would benefit from having a written instruction to guide the participant to answer all the questions posed. They noted additional space for the responses to the open questions was required.

LDG did not complete the LDPQ as expected, on reflection some questions may not have been relevant or made sense to them. For example, question seven in Section A which enquires it they have had university teaching on learning disabilities. The pilot only included student nurses from the non-learning disability group (NLDG) but should have included learning disability student nurses and been representative of the whole sample.

3.12 Data analysis

The aim of the analysis was to provide a detailed understanding of how a mixed method approach developed a wide and fuller understanding of student nurses' perceptions and experiences of therapeutic commitment when working with people who have learning disabilities. Both qualitative and quantitative datasets were analysed separately. Their findings were integrated at the interpretation stage in such a way that their findings were reciprocally enlightening. These findings are discussed in Chapter 6.

3.12.1 Quantitative data analysis

Quantitative research concerns itself with the systematic process of collecting numerical data and mathematically analysing it to explain observable phenomena (Bryman 2012). The quantitative data collected via the LDPQ were entered into the Statistical Package of Social Sciences (SPSS) version 23. A code book (Appendix 9) was developed to direct how the data was to be defined and supported the preparation of the data file. In Section A, all demographic data was entered as nominal scale, expect question 9 which along with all the responses to the statements in Section B were entered as ordinal scales. Once the data file was developed, all information for the three hundred and ninety-eight questionnaires was entered. Case summaries were used to clean the data, ensuring the entered information married that of the questionnaires. The handling of missing data is discussed in Section 4.3.

All 29 statements in Section B of the LDPQ were used to develop the subscales and scales as per LDPQ Researcher Guidance (Appendix 10). The guidance describes the statement numbers belonging to each subscale and scale leading to the development of new variables in the data set. The guidance also reports the possible score for each one using the following rules. The seven-point Likert scale was scored as follows – 1 point for strongly disagree, 2 for quite strongly disagree, 3 for disagree, 4 for neither agree nor disagree, 5 for agree, 6 for quite strongly agree and 7 for strongly agree. When computed the results translate to, the higher the score, the greater level of therapeutic commitment, role competency and role support the respondent perceived. The score for each subscale was calculated, and then the total scores for each scale. The data set represented the whole sample; however, the data was split into two to represent the NLDG and LDG as previously discussed to allow comparative analysis to take place.

Univariate statistical tests were performed in the form of frequencies to organise and structure the data then, followed by descriptive statistics which allowed the data to be described and summarised. Tests for normality and homogeneity were performed. From this the mode, mean and median were calculated, as well as the range of minimum and maximum scores and standard deviation for each variable thus allowing the parameters for use of the LDPQ to be established.

Parametric independent t-tests were used to test the difference in means between each group and all the scales and subscales as they were normally distributed. They were also used to examine the difference between gender and age, plus personal experience and the three scales. One-way ANOVA was used to compare mean scores of age and field of practice, as well as the three scales and work experience, education on learning disabilities and placement experience. Post-hoc Tukey HSD test was performed to establish if the differences were statistically significant. Cohen's d was calculated to test the effect size of all significant results. In order to describe the relationship between the different variables, correlation tests were performed. Pearson's product moment correlation coefficients were calculated to examine the relationship between the scales and personal experience, satisfaction with education and satisfaction with placement. The results to the quantitative data analysis are found in Chapter 4.

3.12.2 Qualitative data analysis

Qualitative approaches aim to understand a particular phenomenon from the participants' perspective (Creswell 2009). At the data analysis stage of this study, the researcher had to engage a different way of thinking than previously used. They had been detached from the quantitative analysis to ensure objectivity (Parahoo 2014). With a qualitative approach, the researcher becomes aware of the subjectivity they bring to the study; in this case it was mainly during data analysis and interpretation of the findings. Reflexivity is described as an individual activity where critical self-reflection is a conscious awareness of one's biases, theoretical predisposition and preferences during the entire research process (Schwandt 2001; Robson 2002; Parahoo 2006). Finlay and Gough (2008) believe reflexivity functions as an instrument to improve the quality of the research. Furthermore, Finlay (2002) suggests in order to increase the trustworthiness and integrity of a study, the researcher must be honest about the subjective areas that may have impacted on it.

To fit with the convergent mixed method approach being used within this study, a flexible qualitative approach was sought. Both content analysis and thematic analysis were considered as they both are qualitative descriptive approaches that would provide a lower level of interpretation, fitting with the level of data collated from a survey method (Marks and Yardley 2011). Thematic analysis was deemed to be the most appropriate approach, as content analysis is mainly used when little is known about the phenomenon (Vaismoradi et al. 2013) and quantifies, as well as qualifies data (Krippendorff 2013). Whereas King (2004) highlights thematic analysis is useful for working with a large dataset and allowed the exploration of a number of different participants' perspectives was more suited to this study. Additionally, Braun and Clarke (2013) suggest its simplistic approach is advantageous for new qualitative researchers.

Thematic analysis has existed in various formats for a number of years (Aronson 1994; Boyatzis 1998; Joffe and Yardley 2004, King 2004) with some variants being more steeped in theoretical positions (Guest et al. 2014) than others (Braun and Clarke 2006). Braun and Clarke (2006; 2013) describe thematic analysis as 'theoretically flexible' and apply only to data analysis. It does not hold a theoretical position, therefore fitting well into the pragmatic lens of this study. However, Holloway and Todres (2003) point out that flexibility can introduce incoherence and inconsistency affecting the quality of the research. Furthermore, to answer the qualitative research question posed, it was appropriate to use the deductive theoretical approach (Braun and Clark 2013), as the open-ended questions were linked to the core themes embodying the therapeutic commitment theoretical framework. They specifically explored the students' perceptions of factors that influence therapeutic commitment, role competency and role support. Further detail of the process by which qualitative analysis was undertaken is found in Section 5.2.

3.13 Data integration

In a mixed methods study, the mixing of quantitative and qualitative approaches can occur at various stages depending on the research design (Creswell and Plano Clark 2017). At the design stage the intent in this study was to have the first occurrence at the point of data collection, as all data was collected via one instrument (Morse and Niehaus 2009). The quantitative instrument and qualitative open-ended questions were intentionally based on the same theoretical framework to supporting the merging of the findings (Fetters et al. 2013).

The second occurrence was following the separate analysis of the quantitative and qualitative data. At this time, the convergent design merged the results together in order to identify if the qualitative findings confirmed and built on the quantitative ones. Additionally, the integration of quantitative and qualitative results produced new understandings that were greater than the individual approaches produced alone (Fetters et al. 2013). This in turn provided an answer to the mixed methods research question previously posed, providing a whole picture (Creswell and Plano Clark 2017). A joint display was used to provide a structure and a visual concurrent display of the findings of both approaches (Guetterman et al. 2015).

3.14 Quality in mixed methods research

There is continued debate in the literature regarding the assessment of the quality of mixed methods studies (Fabregues and Molina-Azorin 2017) and what counts as quality due to the different philosophical views held by individual researchers (Dellinger and Leech 2007). Frameworks have been developed to evaluate studies and are advocated by some (Tashakkori and Teddlie 2008; O'Cathian et al. 2008; O'Cathian 2010; Cresswell and Plano Clark 2011) whereas other authors do not discuss assessing quality (Hesse-Biber and Johnston 2015). The quality of both the quantitative and qualitative approaches has an impact on the quality of the overall mixed method study (Teddlie & Tashakkori 2009; Creswell & Plano Clark 2011). O'Cathian (2010) promotes that mixed methods studies must be assessed as a whole with clear criteria to assess the mixed methods process, however no fully agreed criteria exists (Creswell and Plano Clark 2017).

Chapter four: Presentation of results – Quantitative analysis

4.1 Introduction

This mixed method study utilises a convergent approach. A systematic method was adopted to conduct the analysis; first step was to analyse predominant quantitative data which measured the participant's perceptions of therapeutic commitment towards people with learning disabilities based on the therapeutic commitment theoretical framework. This was then followed by the analysis of the qualitative data by the thematic analysis method to provide different perspectives, in particular identify factors that influenced the student nurses' perceived therapeutic commitment towards people with learning disabilities.

The following chapter presents the findings from the data collated from the LDPQ which focused on measuring the levels of therapeutic commitment perceived by final year student nurses as a whole and in two groups, non-learning disability and learning disability. This chapter sets out to test whether the study findings support the hypotheses which proposed that final year student nurses within the learning disability group (LDG) would report higher levels of therapeutic commitment than the non-learning disability group (NLDG) through analyses of the quantitative data. Quantitative data was analysed using IBM SSPS Statistics version 23 programme.

The chapter begins by describing the characteristics of the sample, and then will explore and report data that describes the perceived levels of therapeutic commitment, role competency and role support reported by a sample of final year student nurses. Next, it will report the relationship between the demographic variables and each scale. Finally, the validity and reliability of the scale will be examined.

4.2 Sample characteristics

The target population of student nurses in the four universities across the three programmes was 1505 (Table 1). To gain access to students, each university was approached and lecturers responsible for leading pre-registration programmes were gatekeepers to gaining access to the students. Difficulties were experienced gaining access to all student populations in each university as discussed in Section 3.10. A total of 457 students were offered the opportunity to take part in the study. Some students (*n*=58) were not interested in taking part in the survey and returned the

questionnaire uncompleted. Responses varied by programme of nursing and by university and a total of 399 completed questionnaires returned, giving an overall response rate of 26.5% across all 3 programmes.

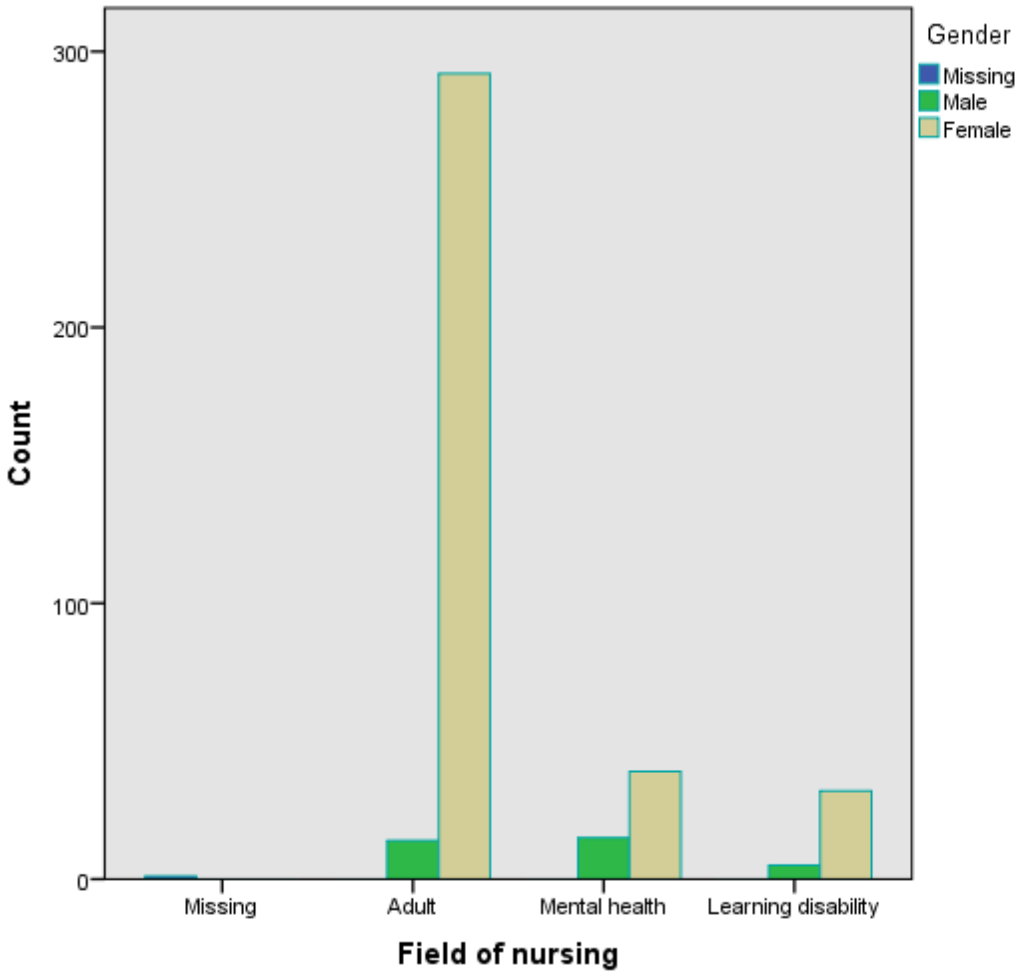
Table 1: Recruitment figures by field of nursing

Number of Student Nurses	Adult	Mental Health	Learning Disability	Missing Data	Total
Target population in 4 HEIs	1220	225	60	--	1505
Sample recruited	306	54	38	1	399
Percentage per field of nursing	25.1%	24.0%	63.3%	--	26.5%

When cleaning data it was evident that one case was an outlier. This was a participant from the field of learning disability nursing. Their responses to Section B in the questionnaire were all negative which was not in line with the rest of the learning disability nursing participant responses, also their responses in Section C were extremely positive where they had to articulate how they felt and did not relate to the Section B answers where they had to complete a Likert scale. It was decided to remove this participant from the study as it could be assumed they misunderstood how to complete Section B. This changed the sample to have 398 respondents.

Participants were recruited from the 3 fields of nursing practice; adult (*n*=306), mental health (*n*=54) and learning disability nursing (*n*=37) as set out by the Nursing Midwifery Council (NMC 2015) and one missing response (*n*=1). Female and male participants were studying in all three fields of nursing as presented in Figure 5. This gender split is not a sampling bias but representative of the nursing population in the United Kingdom (Meadus 2000).

Figure 5: Number of male and females by field of nursing in this study



This study aimed to understand student nurse's perception of therapeutic commitment to people with learning disabilities. Therapeutic commitment theory is intended to focus on 'generalists' or 'non-specialists' willingness and ability to engage in a therapeutic relationship (Lauder et al. 2000). In this study the 'non-specialists' are adult and mental health student nurses, whereas learning disability student nurses are the 'specialists', making a comparison of the two groups possible. Therefore, participants from the adult and mental health groups were joined to create the non–learning disability group or 'generalist' group (NLDG) (*n*=360), while the learning disability nursing participants became the 'specialist' group (LDG) (*n*=37). The mean age of the NLDG was 27.4 (*SD*=8.92) years and the LDG was 30.2 (*SD*=10.12). An independent *t*-test was conducted to compare the mean ages of the groups as the groups are unrelated. There was no significant difference between the groups (t(387) = -1.81, *p*=0.07).

4.3 Missing data

The questionnaires were returned largely complete, with very little missing data. Missing data analysis was performed, and the results indicated that no variables had 5% or more missing data. The data was tested using Little's MCAR test and was found not statistically significant, therefore missing data was considered as missing completely at random as there was no pattern to suggest a rationale for this. To maximise all the data available for each analysis, pair wise deletion was used to exclude the individual case only from the specific test using that data (Allison 2002). The main areas of missing demographic data were the age and satisfaction with placement variables, where 9 respondents for both areas did not complete the question; however, this did not affect the testing of the hypotheses.

4.4 Therapeutic commitment theoretical framework

As described in earlier chapters, this explicit theoretical framework was developed to underpin the core concepts of therapeutic commitment, role support and role competency (Lauder et al. 2000). Data were analysed using Kolmogorov-Smirnov test for normality that indicated the data sets were normally distributed. Parametric testing was then used for analysis. Homogeneity of variance is assumed by Levene's test for equality of variance as part of t-tests and ANOVAs and was not significant.

The theoretical framework consists of 3 scales and 5 subscales to align with the core concepts. Each subscale and subsequent scale are scored individually (Appendix 10), the higher the score, the more therapeutically committed the participant perceives themselves to be. The mean score for each group within each scale and subscale is reported here, between the groups the lowest mean score is shaded with blue and the highest is shaded with yellow.

4.5 Overall score

The overall score for this framework would range from 29-203. Scores reported for both groups are high, the NLDG with over two-thirds and the LDG over four fifths of the possible score indicating that both groups perceive high levels of therapeutic commitment towards people with learning disabilities.

Table 2 highlights that overall NLDG scored lower than the LDG. Calculation of an independent-samples *t*-test showed this difference was statistically significant, NLDG

(*M*=137.88, *SD*=18.86) and LDG (*M*=178.67, *SD*=10.56; *t*(380) = -12.76, *p*=0.001 one tailed). The effect size (using Cohen's *d*) would equal 2.67. This is very large (Sawilowsky 2009) and there is a consistent difference in the levels of therapeutic commitment, on average, between NLDG and LDG.

Table 2: Descriptive statistics for therapeutic commitment framework

Therapeutic Commitment Theoretical Framework	**Group**	***n***	**Range**	**Mean (*M*)**	**Standard Deviation (*SD*)**
	Whole population	382	44 -198	141.71	21.76
	NLDG	346	44 -187	137.88	18.86
	LDG	36	151-198	178.67	10.56
t-test	*t* = -12.76, df=380, *p*=0.001, one tailed. CI 95% = -47.07 -34.50, *d*=2.67				

4.6 Therapeutic commitment scale

The therapeutic commitment scale is the first of the three scales and comprises of three subscales: motivation, expectation of work satisfaction and task specific self-esteem. It aims to measure the willingness of participants to engage therapeutically with people who have learning disabilities. The possible score of this scale is 12-84 and this study showed a range of 17-84 (Table 3) with the LDG (*M*=77.38, *SD*=4.91) reporting higher levels of therapeutic commitment than the NLDG (*M*=61.47, *SD*=9.13). The effect size for this analysis (*d*=2.17) was found to exceed Cohen's (1988) convention for a large effect (*d*=0.80).

Table 3: Descriptive statistics for therapeutic commitment scale

TC Scale	**Group**	***n***	**Range**	**Mean (*M*)**	**Standard Deviation (*SD*)**
	Whole population	390	17-84	62.96	9.96
	NLDG	353	17-83	61.47	9.13
	LDG	37	62-84	77.38	4.91
t - test	*t* = -10.43, df=388, *p*=0.001, one tailed. CI 95%= -18.91 - -12.91, *d*=2.17				

4.6.1 Subscales of TC scale

The scores for each subscale are added together to calculate the therapeutic commitment scale. The descriptive statistics for the subscales are presented in Table 4. The LDG scored higher in the overall scale and all three subscales than the NLDG. These results show the LDG perceive they have a greater predisposition to working therapeutically with people who have a learning disability than the NLDG. Independent *t*–tests report all of these results to be statistically significantly. In all three scales Cohen's d effect size is large (*d*=2.31, 1.83, 1.53).

Table 4: Descriptive statistics for therapeutic commitment subscales

Subscale	Population	*n*	Range	Mean (*M*)	Standard Deviation (*SD*)
Motivation (Possible Score-: 4-28)	Whole	392	5-28	21.38	3.79
	NLDG	355	5-28	20.80	3.48
	LDG	37	21-28	26.95	1.43
	t - test	*t* = -10.62, df =390, *p*=0.001, one tailed. CI 95% = -7.28 - -5.01,*d*=2.31			
Expectation of work satisfaction (Possible score-: 5-35)	Whole	394	7-35	26.31	4.30
	NLDG	357	7-35	25.75	4.04
	LDG	37	25-35	31.81	2.37
	t - test	*t* =-8.95, df=392, *p*=0.001, one tailed. CI 95%= -7.39 - -4.73, *d*=1.83			
Task specific self-esteem (Possible score-: 3-21)	Whole	396	5-21	15.28	2.84
	NLDG	359	5-21	14.94	2.68
	LDG	37	14-21	18.62	2.10
	t - test	*t* = -8.11, df=394, *p*=0.001, one tailed. CI 95%= -4.58 - -2.79, *d*=1.53			

4.6.2 Responses to motivation subscale items

The motivation subscale aims to measure the level of motivation participants have to care for people with learning disabilities and comprises of statements 11, 13, 17 and the scores for 16 were reversed as this was a negative item. From the two groups responses to the statements within the motivation subscale (Appendix 11), 85.5% of respondents (*n*=339) indicated by agreeing at some level with statement 11 that they had an interest in the service provision for people with learning disabilities. In response to statement 13 asking students if they wanted to work with people who have learning

disabilities, 14.6% (*n*=58) disagreed with the statement, all responses were from the NLDG. Around one third of the students (*n*=132, 33.2%) indicated their indecision by neither agreeing nor disagreeing of which 131 were from the NLDG. The majority, from NLDG and all of the LDG (*n*=206, 51.9%) agreed that they would like to work with people with learning disabilities.

Also, the majority of students, from NLDG and LDG (*n*=356, 89.9%) disagreed at varying levels with statement 16 that said there was nothing that they can do to help patients with learning disabilities. Within the study 80.9% (*n*=319) of the students agreed with statement 17 that they felt they have something to offer patients with learning disabilities but 64 students (16.2%) from the NLDG neither agreed nor disagreed with this statement.

4.6.3 Responses to expectation of work satisfaction subscale items

Within Appendix 12, a summary of the responses to the statements contributing to the expectation of work satisfaction subscale are presented (*n*=396). This subscale comprises of statements 21, 22, 23, 24 and 25 and aims to measure the expected level of work satisfaction participants perceive when caring for patients with learning disabilities. The majority of students in both groups agreed that they get satisfaction from working with patients with learning disabilities (Statement 21) (*n*=354, 89.1%) and find it rewarding to work with them (Statement 22) (*n*=350, 88.1%). However, 44 students (11.2%) from the NLDG responded to Statement 23 that they often feel uncomfortable when working with this patient group and 56 (14.1%) were undecided on their views by neither agreeing nor disagreeing with the statement. Again, over a quarter of the NLDG (*n*=112, 28.3%) neither agreed nor disagreed with Statement 24 that they feel that they understand a person with learning disabilities and 51 (12.9%) students from that group disagreed with this statement. The majority of students in both groups responded to Statement 25 that they were satisfied with the way they work with this patient group, however 34 (8.7%) from the NLDG disagreed in some degree and 112 (28.3%) from that group answered they neither agreed nor disagreed.

4.6.4 Responses to task specific self-esteem subscale items

The descriptive statistics for the statements numbered 12, 18 and 19 contributing to the task specific self-esteem subscale are presented in Appendix 13. Whilst examining

the participants levels of self-esteem when working with people who have a learning disability, 89 (22.4%) NLDG students stated they were not able to work as effectively as they do with other patients in response to Statement 12, plus 61 (15.3%) were undecided if they agreed or disagreed with this statement. As a whole group, the majority of students (n=262, 66.1%) agreed to varying extents with Statement 18 that they feel they have much to be proud of when working with people with learning disabilities, however over one third were undecided if they agreed or disagreed from both groups (NLDG - *n*=115, 29.0%, LDG - *n*=3, 0.8%). When students were asked if they had a number of good qualities to work with people with a learning disability, the majority of students agreed (*n*=357, 89.1%) but 36 (9.1%) students from the NLDG neither agreed nor disagreed with Statement 19.

4.7 Role competency scale

The role competency scale aims to measure the participants' perceived ability to offer effective therapeutic interventions when providing care to people with learning disabilities and consists of the subscales of role adequacy and role legitimacy. The possible score for this scale is 12-84. The descriptive statistics for the role competency scale are presented in Table 5. An independent-samples *t*-test was conducted to compare perceived levels of role competency in NLDG and LDG. There was a significant difference in the scores of the NLDG (*M*=54.57, *SD*=8.69) and LDG (*M*=71.11, *SD*=4.78) conditions; *t*(-11.38)=388, *p*=0.001, *d*=2.36. These results suggest that the LDG perceive working with people who have learning disabilities is a legitimate part of their role and they have the skills and knowledge to fulfil it, greater than the NLDG.

Table 5: Descriptive statistics for role competency scale

RC Scale	**Groups**	***n***	**Range**	**Mean (*M*)**	**Standard Deviation (*SD*)**
(Possible score-: 12-84)	Whole population	390	18-82	56.15	9.69
	NLDG	353	18-78	54.57	8.69
	LDG	37	62-82	71.11	4.78
***t* - test**	*t* = -11.38, df=388, *p*=0.001, one tailed. CI 95% = -19.39 - -13.68, *d*=2.36				

4.7.1 Subscales of role competency scale

The role adequacy subscale was produced from seven statements (1, 2, 3, 14, 15, 28 & 29) and aims to measure the participant's perception that they have the skills and knowledge to care for people with learning disabilities. The role legitimacy subscale aims to measure if the participant perceives that caring for a person with a learning disability is a legitimate part of their role and consists of statements 4, 5, 6, 7 & 20. The LDG scored higher on both subscales. An independent *t*-test shows the difference between the groups is statistically significant with a large effect.

Table 6: Descriptive statistics for role competency subscales

Subscale	Population	*N*	Range	Mean (*M*)	Standard Deviation (*SD*)
Role adequacy (Possible Score–: 7-49)	Whole	392	13-48	30.68	6.93
	NLDG	355	13-48	29.55	6.24
	LDG	37	36-47	41.38	3.12
	t - test	*t* = -11.36, df=390, *p*=0.001, one tailed. CI 95% = -13.87 - -9.78, *d*=2.40			
Role legitimacy (Possible score–: 5-35)	Whole	394	5-35	25.51	3.89
	NLDG	357	5-35	25.07	3.73
	LDG	37	26-35	29.73	2.78
	t - test	*t* = -7.37, df=392, *p*=0.001, one tailed. CI 95% = -5.90 - -3.41, *d*=1.42			

4.7.2 Responses to role adequacy subscale items

Responses to the statements of the role adequacy subscale are presented in Appendix 14. When responding to Statement 1, 'I feel I know enough about the different causes of learning disabilities' nearly half of the NLDG (*n*=191, 48.2%) disagreed with it, 50 (12.6%) neither agreed nor disagreed and 119 (30.0%) agreed they had enough knowledge to carry out their role. Similarly, whilst responding to Statement 3, 'I feel that I can appropriately advise patients about health issues related to their learning disability', 208 from the NLDG (52.6%) disagreed to some extent with the statement and 81 (20.5%) agreed they were able to do this, the remaining 70 (17.7%) neither agreed nor disagreed with the statement.

In response to Statement 15, indicating whether the participants felt they could assess and identify the nursing needs of patients who have a learning disability, just under half of the NLDG (*n*=183, 46.3%) felt they did have the necessary skills, 96 (24.3%) specifying that they were undecided and remaining students (*n*=79, 20.0%) felt they did not have the nursing skills to care for people with a learning disability.

When questioned if they have sufficient knowledge about the different health problems people with learning disabilities can have in Statement 29, 156 (39.3%) NLDG responded negatively by disagreeing with the statement and around one third (*n*=129, 32.4%) felt they had the appropriate knowledge, leaving 75 (18.9%) undecided.

4.7.3 Responses to role legitimacy subscale items

The responses to the statements which support the role legitimacy subscale are reported in Appendix 15. Statement 20 said 'caring for people with a learning disability is an important part of an adult nurse's role', the majority of respondents (*n*=361, 91.2%) indicated this was their belief by agreeing to some extent with the statement, with 2.3% (*n*=9) from the NLDG expressing that they felt it was not part of the adult or mental health nurse role. The remaining 6.1% (*n*=24) neither agreed nor disagreed with the statement. When replying to Statement 4 asking whether they had a clear idea of their responsibilities when caring for a person with a learning disability, 235 (59.4%) students from the NLDG agreed they were clear about their responsibilities and 54 (13.6%) were either unclear or undecided.

The majority of participants when questioned by Statement 7, if they had a right to ask for further information about a patient's learning disability where appropriate indicated they did have that right (*n*=333, 84.7%), 17 (4.3%) nurses felt they did not have the right and 47 (11.8%) remained undecided if they agreed or disagreed with the statement.

In response to Statement 6, 60.4% (*n*=240) of participants felt that patients and/or carers believed the nurse had the right to ask for any information, 129 students (32.5%) were undecided in their response by neither agreeing nor disagreeing with this statement and 28 (7.0%) disagreed that patients and/or carers believed the nurse had the right to ask for information.

4.8 Role support scale

The role support scale aims to measure participants' perceived ease of access to specialist support and consists of five statements (8, 9, 10, 26 & 27). The possible score for this scale is 5-35. The descriptive statistics for the role support scale are presented in Table 7. An independent-samples t-test was conducted to compare perceived levels of role support in the NLDG and LDG. There was a significant difference in the scores of the NLDG (*M*=22.04, *SD*=5.10) and LDG (*M*=30.28, *SD*=3.06) conditions; *t* (-9.51)=392, *p*=0.001, *d*=1.96. These results suggest that the LDG perceived they have access to support where they can receive specialist advice more than the NLDG.

Table 7: Descriptive statistics for role support scale

RS Scale (Possible score – 5-35)	**Group**	***n***	**Range**	**Mean (*M*)**	**Standard Deviation (SD)**
	Whole	394	7-35	22.79	5.48
	NLDG	358	7-35	22.04	5.10
	LDG	36	24-35	30.28	3.06
***t* - test**	*t* = -9.51, df=392, *p*=0.001, one tailed. CI 95% = -9.94 - -6.53, *d*=1.96				

The responses to the five statements within the RS scale are presented in Appendix 16. Statement 26 asked if students felt they received adequate supervision from a more experienced person, 105 (26.4%) students from the NLDG disagreed with the statement, 158 (39.8%) agreed and 97 (24.4%) were neither agreeing nor disagreeing with the statement. Two hundred and fifty-four students (64.2%) indicated if they felt the need they could easily find someone who would be able to help them formulate the best approach to provide care for a person with a learning disability, 76 (19.2%) from the NLDG disagreed and 67 (16.6%) from NLDG responded that they neither agreed nor disagreed with Statement 10.

Furthermore, 22.0% of participants (*n*=87) all from NLDG felt they had no one they could ask if they had personal difficulties whist working with this patient group but 239 (60.4%), including everyone from LDG and majority from NLDG felt they did, leaving 70 (17.7%) undecided in their response to Statement 8.

4.9 Testing the relationship between the scales and variables

To examine the difference in categories of demographic variables and the means of the three scales – therapeutic commitment, role competency and role support, independent t-tests and one-way analysis of variance (ANOVA) were conducted. Each variable will be presented, described and explored individually. Data were tested for normality and heteroscedasticity indicating data was normally distributed and equal in variance.

4.10 Gender and age of participants

Of the 398 participants in this study a small number were male (*n*=34, 8.5%) and the majority were female (*n*=363, 91.2%), one (0.3%) did not respond. Using independent *t*-test, males reported (*M*=60.47, *SD*=10.01) statistically significant higher levels of role competency that females (*M*=55.73, *SD*=9.58; (*t*(388 =2.75, *p*=0.003, one-tailed, *d*=0.48).

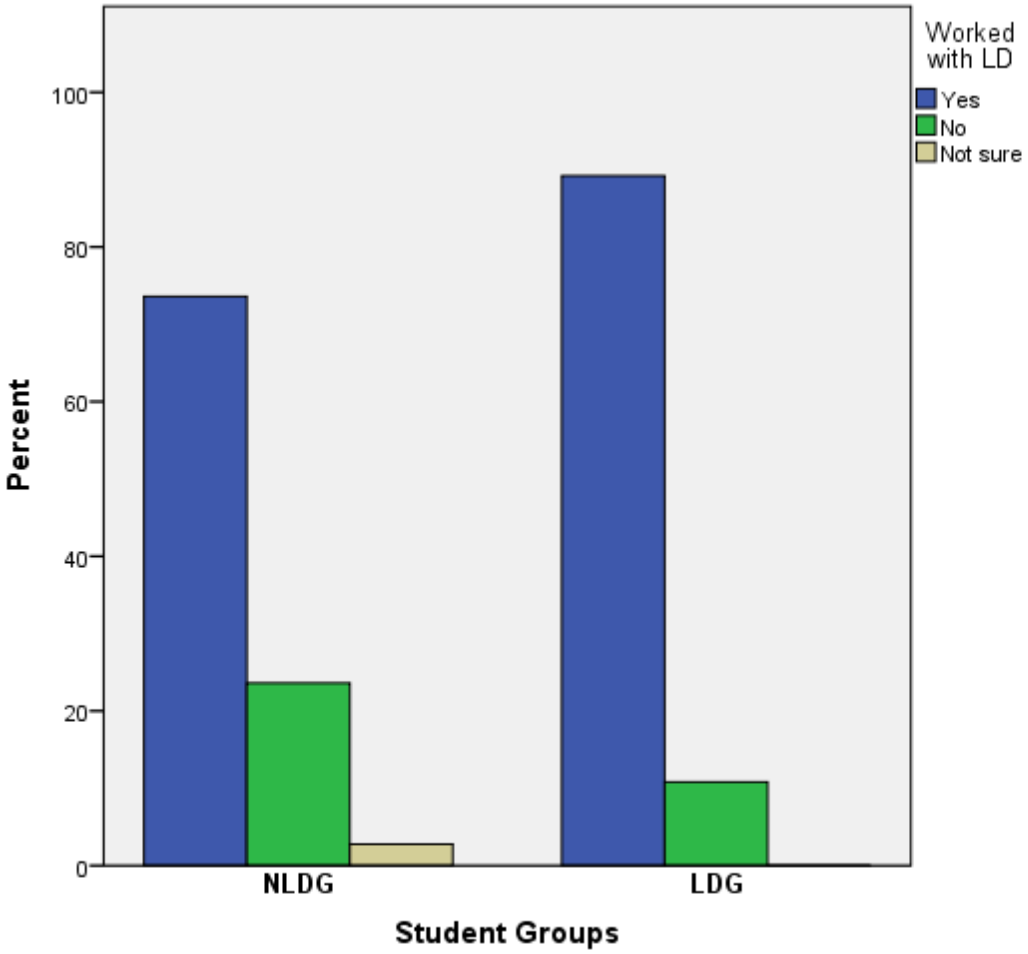
The mean age of the whole population is 27.6 years. The participants in the study ranged in age from 19 to 55 years with the largest group being 20 years old (*n*=77). Females (*M*=27.1, *SD*=8.73) were significantly younger than the males (*M*=33.1, *SD*=10.77), (*t* =3.67, df=387, *p*=0.001, one-tailed, *d*=0.6).

When considering the mean ages of participants in each field of practice groups, there are statistical differences as one-way ANOVA test reports (*F*=10.18, df = 2, *P*=0.001). The mean age of the adult nursing group is 26.5 years whereas the mean ages for the mental health and learning disability groups are 32.0 and 30.2 respectively.

4.11 Work experience

Participants were asked to indicate if they had currently or previously worked with someone who had a learning disability prior to the commencement of their education programme. The results are illustrated in Figure 6 below:

Figure 6: Percentage of students who worked with people with learning disabilities



It was interesting to note that nearly three quarters of the NLDG 73.6% (*n*=265) indicated they had previously or are currently working with people who have a learning disability. As expected, in the LDG 89.2% (*n*=33) had worked with people with a learning disability as prior to commencing a learning disability nursing education programme, it could be suggested that applicants will have had some life experience working with this group.

4.11.1 Comparison of Scales and Work Experience Variable

Table 8 presents the means, standard deviation, confidence intervals for each group within each scale. The ANOVA for each of the scales is also presented along with degrees of freedom (*df*) and *p* values.

Table 8: Relationship between scales and work experience

Current or previous work experience	Therapeutic Commitment			Role Competency			Role Support		
	Mean	*SD*	95% CI	Mean	*SD*	95% CI	Mean	*SD*	95% CI
No	58.86	8.32	57.09-60.63	52.08	8.11	50.35-53.81	21.94	4.47	20.99-22.89
Yes	64.47	10.04	63.31-65.62	57.60	9.72	56.49-58.72	23.18	5.70	22.53-23.84
Unsure	55.10	7.74	49.56-60.63	48.60	8.93	42.21-54.99	18.70	5.33	14.88-22.52
ANOVA	$F(2,387)=14.77$, $p=0.001$			$F(2,387)=15.01$, $p=0.001$			$F(2,391)=4.66$, $p=0.010$		

One way between groups analysis of variance was conducted to explore the impact of work experience on levels of therapeutic commitment, role competency and role support. Participants were divided into 3 groups; those with work experience, those with no work experience and those who were unsure. When considering the therapeutic commitment scale, there was a statistically significant difference at the $p < 0.05$ level for the three groups: $F(2,387)=14.77$, $p=0.001$. Post-hoc comparisons using Tukey HSD test indicated the mean score for the group with work experience ($M=64.47$, $SD=10.04$) was significantly different from the group who had no experience ($M=58.86$, $SD=8.32$) and the group who were unsure if they had any work experience ($M=55.1$, $SD=7.74$). Further, Cohen's effect size value ($d=0.6$) and ($d=1.0$) respectively suggested medium and large practical significances. The group who were unsure did not significantly differ from the group who had no experience.

For the role competency scale, the results on the one-way ANOVA indicate that mean scores differ if the student has had experience working with people with a learning disability ($F(2,387)=15.01$, $p=0.001$). Post hoc comparisons found that higher levels of role competency scores were associated with those who had work experience. Similar to the results for the therapeutic commitment scale, the group with work experience ($M=57.60$, $SD=9.72$) significantly differed from the group with no experience ($M=52.08$, $SD=8.11$). Cohen's effect size value ($d=0.61$) suggested a moderate practical significance. When compared to the group who were unsure ($M=48.60$, $SD=8.93$) the effect size suggests high practical significance ($d=0.96$). There was no significant difference in levels of role competency between the group who had no experience and the group who were unsure.

Exploring the role support scale, results of the one-way ANOVA and the work experience variable indicates that there was a statistically significant difference between the groups ($F(2,391)=4.66$, $p=0.010$). The only two groups that were significantly different were the group who had experience ($M=23.18$, $SD=5.70$) and the group who were unsure ($M=18.7$, $SD = 5.33$). The effect size indicates a moderate to large significance ($d=0.8$).

4.12 Personal experience

Participants were asked to indicate if they had a family member or a personal friend who has a learning disability of which 31.8% ($n=126$) answered they did have. Within the LDG - 18 (48.6%) students, and 108 (30.1%) within the NLDG, answered yes.
To address the question, is there an association between having a family member or a personal friend with a learning disability and higher levels of therapeutic commitment, role competency and role support the Pearson's product moment correlation test was applied. It is clear that having such personal relationships have a small impact on the levels perceived by the student on each of the three scales with statistically significant results as reported in Table 9.

Table 9: Pearson's correlation results between scales and personal experience

Pearson's product moment correlation test	Therapeutic Commitment Scale	Role Competency Scale	Role Support Scale
Personal experience	$r = -0.25$ ($p < 0.01$)	$r = -0.25$ ($p < 0.01$)	$r = -0.15$ ($p < 0.01$)

4.12.1 Comparison of scales and personal experience variable

As illustrated in Table 10, the data indicated that student nurses who reported to have a personal experience with people with learning disabilities had higher mean scores when measuring levels of therapeutic commitment, role competency and role support, than those who reported to have no personal experience. Independent t-tests showed that the difference between the conditions in all of the scales was significant in a small to moderate convention.

Table 10: Relationship between scales and personal experience

Personal Experience	Therapeutic Commitment			Role Competency			Role Support		
	Mean	*SD*	95% CI	Mean	*SD*	95% CI	Mean	*SD*	95% CI
No	61.31	9.24	3.27 - 7.43	54.55	9.29	3.09 – 7.14	22.22	5.16	0.64 - 2.97
Yes	66.66	10.58		59.66	9.71		24.03	6.00	
t-test	*t*(387)=5.06, *p*=0.001, one-tailed, *d*=0.54			*t*(387) =4.96, *p* = 0.001, one-tailed, *d*=0.54			*t*(391)=3.05, *p*=0.001, one-tailed, *d*=0.32		

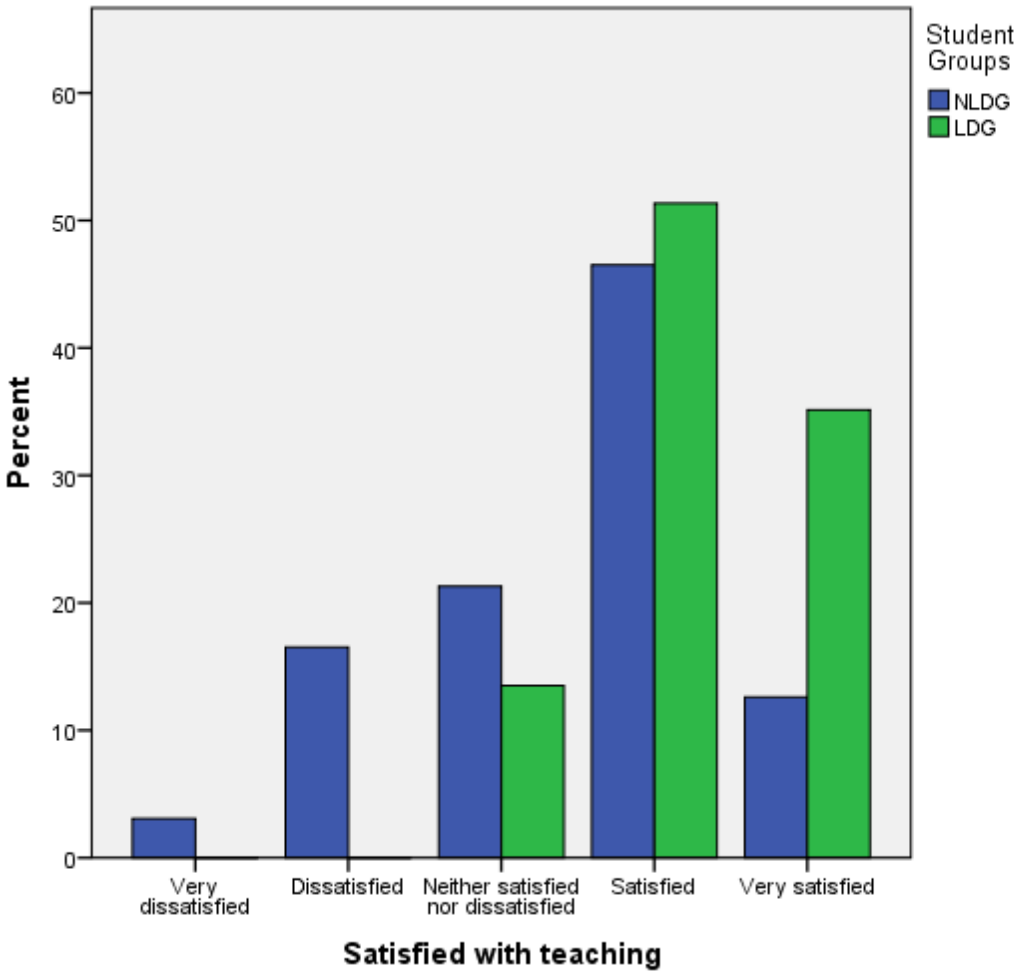
4.13 Pre-registration curriculum education on learning disabilities

When questioned if they had received any education on caring for people with learning disabilities in university 73.3% (*n*=291) said yes, 20.2% (*n*=80) said they had not received any education and 6.5% (*n*=26) responded saying they did not know. When focusing on the NLDG and LDG individually, it was interesting to note that in the LDG 9 (24.3%) students either responded no or do not know to this question. Within the NLDG 73.3% (*n*=264) said they had received education and 26.6% (*n*=96) stated they had not or did not know.

Participants were asked to comment on how satisfied they were with the education they had received in university. On the whole the majority of students (*n*=243, 61.7%) were either satisfied or very satisfied, 20.6% (*n*=81) were neither satisfied or dissatisfied and 17.8% (*n*=70) expressed some degree of dissatisfaction.

Figure 7 illustrates that the LDG were mainly satisfied with the education they had received, however within the NLDG 19.6% (*n*=70) expressed varying levels of dissatisfaction. The reason why students were satisfied or dissatisfied with the education they receive was not sought in the questionnaire.

Figure 7: Satisfaction with pre-registration education on learning disabilities



In order to explore the relationship between the three scales and the satisfaction students reported with the teaching on learning disabilities in university Spearman's rank order correlation test was utilised. The results are presented in Table 11. A moderate strength, positive correlation was evident between the two variables when investigating role competency and role support, however a weaker correlation was evident when exploring the relationship between therapeutic commitment and student's satisfaction with teaching.

Table 11: Spearman's correlation between satisfaction with education and scales

Spearman's rank order correlation test	Therapeutic Commitment Scale	Role Competency Scale	Role Support Scale
Satisfaction with education on learning disabilities	r_s = 0.20 (p = 0.001)	r_s = 0.37 (p = 0.001)	r_s = 0.40 (p = 0.001)

4.13.1 Comparison of scales and learning disability education variable

Within Table 12, the results indicate that the students who received education on learning disabilities within their pre-registration curriculum reported highest mean scores for all three scales. The group of students who were unsure if they had undertaken any education reported the lowest mean score. There was a trend towards education influencing levels of therapeutic commitment, role competency and role support but this did not reach statistical significance.

Table 12: Relationship between scales and education

Education on learning disabilities	Therapeutic Commitment			Role Competency			Role Support		
	Mean	*SD*	95% CI	Mean	*SD*	95% CI	Mean	*SD*	95% CI
No	61.45	12.10	57.08-60.63	54.95	11.72	52.32-57.57	22.20	6.66	20.72-23.68
Yes	63.65	9.43	62.55-64.74	56.73	9.14	55.66-57.79	23.08	5.16	22.48-23.68
Unsure	60.04	7.83	56.81-63.27	53.38	8.40	49.99-56.78	21.42	4.88	19.45-23.39
ANOVA	$F(2,387)=2.67$, $p=0.070$			$F(2,387)=2.18$, $p=0.115$			$F(2,391)=1.67$, $p=0.189$		

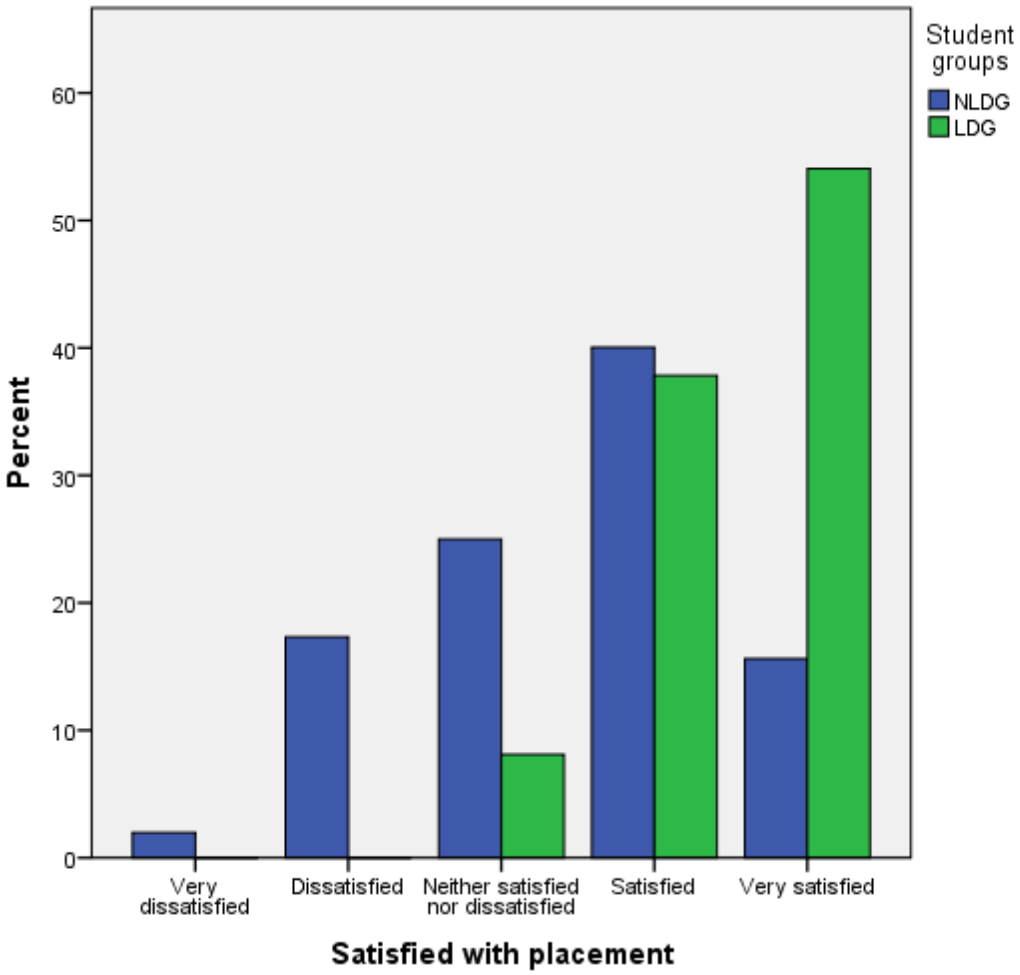
4.14 Experiences on clinical placement

Students were asked if they have had the opportunity to care for someone with a learning disability during a clinical placement as part of their pre-registration programme. The majority said they had (*n*=336, 84.6%), leaving 13.4% (*n*=53) answering no and 2.0% (*n*=8) not sure.

In response to being asked if they were satisfied with the learning opportunity they had in clinical placement to care for someone with a learning disability, over half of the respondents from both groups were in some degree satisfied (*n*=230, 59.1%), 91 (23.4%) were neither satisfied nor dissatisfied and 68 (17.5%) were in some degree dissatisfied.

Figure 8 has similarities to the previous findings as the LDG expressed no dissatisfaction with their clinical placement experience.

Figure 8: Satisfaction with placement experience



The relationship between the perceived levels of therapeutic commitment, role competency and role support and satisfaction with clinical placement was investigated using Spearman's rank order correlation test. Table 13 presents the findings for each scale.

Table 13: Spearman's correlation between scales and satisfaction with placement

Spearman's rank order correlation test	Therapeutic Commitment Scale	Role Competency Scale	Role Support Scale
Satisfaction with placement	r_s =0.21 (p=0.001)	r_s =0.35 (p=0.001)	r_s =0.41 (p=0.001)

There was a moderate strength correlation between role competency and role support and the satisfaction rating students had with placement experience. There was a small correlation with therapeutic commitment and satisfaction with placement experience.

4.14.1 Comparison of scales and placement experience variable

The group of students who reported that they had the opportunity to provide care for someone with a learning disability whilst on placement presented the highest mean score for therapeutic commitment (*M*=63.87, *SD*=9.90), role competency (*M*=56.98, *SD*=9.48), and role support (*M*=23.14, *SD*=5.43). The lowest mean score for role support (*M*=19.12, *SD*=5.91), and role competency (*M*=51.12, *SD*=8.56) was indicated by the group who did not know if they had this experience in placement. The lowest mean score for therapeutic commitment (*M*=57.76, *SD*=9.03) was with the group who had not had the opportunity in clinical placement.

Application of ANOVA tests reported that there were significant differences between the groups in all three scales. Post-hoc comparisons using Tukey HSD test indicated the mean score for the group with placement experience was significantly different from the group who had no experience in all three scales at $p<0.05$. Furthermore, the therapeutic commitment and role competency scales the effect size was (d=0.64) and (d=0.56) suggesting a moderate effect, for the role support scale (d=0.37) suggesting a small effect size. The group who were unsure did not significantly differ from the group who had, and the group who had no clinical placement experience in all three scales.

Table 14: Relationship between scales and placement experience

Placement experience	Therapeutic Commitment			Role Competency			Role Support		
	Mean	*SD*	95% CI	Mean	*SD*	95% CI	Mean	*SD*	95% CI
No	57.76	9.03	55.22-60.30	51.60	9.87	48.85-54.34	21.13	5.39	19.63-22.63
Yes	63.87	9.90	62.80-64.94	56.98	9.48	55.95-58.00	23.14	5.43	22.55-23.72
Unsure	59.12	8.46	52.05-66.20	51.12	8.56	43.97-58.28	19.12	5.91	14.18-24.07
ANOVA	$F(2,387)=9.27$, $p=0.001$, $d=0.64$			$F(2,387)=8.32$, $p=0.001$, $d=0.56$			$F(2,391)=4.91$, $p=0.008$, $d=0.37$		

4.15 Validity and reliability of learning disability perception questionnaire

To ensure the output from any study is fit to be applied to practice it is paramount the tool is tested for validity and reliability (Parahoo 2014). The Mental Health Problems Perception Questionnaire (MHPPQ) from which the LDPQ is adapted from had been psychometrically tested and was proven to be both valid and reliable (Lauder et al. 2000; Angus 2001). The modified LDPQ tool required also to be tested for validity and reliability. Traditional psychometric assessments were used to test for validity and reliability (Nunnally and Bernstein, 1994; Streiner and Norman 2008); however, the contemporary view with regards to evaluating healthcare measures is to apply the Consenus-based Standards for the selection of health measurement Instrument (COSMIN) (Mokkink et al. 2010, Polit and Yang 2016).

4.16 Reliability

Reliability is seen as the 'consistency between an instrument and the measures it produces' (Krabbe 2017 p135) with the principle being, less error, the more reliable it is (Polit and Yang 2016). It concerns itself with three main areas; reliability, internal consistency and measurement error (Mokkink et al. 2010; Polit and Yang 2016). In this study, reliability was only tested using internal consistency. Cronbach coefficient alpha measure was used to test the reliability by examining internal consistency of the scales. This may be seen as a limitation as this approach does not meet with COSMIN standards (Mokkink et al. 2010, Polit 2015) due to the study design not accommodating the test-retest of the tool with parameters measured using intraclass correlation coefficient or standard error of measurement (Polit 2015). However, a future application of the instrument by the researcher would allow intrarater reliability to be measured and meet the criteria of the guidelines, providing a better picture of whether or not the tool would provide a consistency and stability (Polit and Yang 2016).

4.16.1 Internal consistency

For the tool to be seen as consistent, its internal reliability required to be tested. This was achieved by calculating Cronbach's alpha coefficients for each scale within the instrument. The alpha coefficients for the therapeutic commitment, role competency and role support scales as they were originally constructed are as follows 0.91, 0.89

and 0.91 respectively. From these observations, it could be argued that all scales demonstrate internal reliability of a sufficient level based on the typical alpha threshold for a new tool (Nunnally and Bernstein 1994). This is an improvement from the original study it was used in where the alpha coefficients reported were 0.74, 0.88 and 0.87 (Brown 2008). Evidence provided implies the LDPQ is reliable; this is a necessity to achieve validity (Krabbe 2017).

4.17 Validity

Validity provides assurance that an instrument measures what it was designed to. It is not gained in one process of measurement; it is built-up through time with repeated measures (Strauss and Smith 2009) and does not provide a definite answer but instead an extent to which an instrument is valid (Streiner et al. 2015). There are varying types of validity; content/face, criterion, construct and cross-cultural (Polit and Yang 2016). In this study content and construct validity were observed.

Correlations between the three scales of the LDPQ were calculated using Person's product moment correlation coefficient. This resulted in positive, strong correlations being observed between therapeutic commitment and role competency (r=0.76, P<0.01) and between role competency and role support (r=0.55, P<0.01). A respectable amount of variance was observed between the therapeutic commitment and role support scales (r=0.43, P<0.01) (Pallant 2010). These results further support the validity of the tool as they are similar to those found in the researcher's previous study presented in Table 15. These correlations are also in the same direction as the MHPPQ (Angus et al. 2001) and as anticipated by the theoretical model supporting the LDPQ, as a result contributing to its validity.

Table 15: Comparison of Pearson's product moment correlation between scales

Constructs	Current LDPQ study	Previous LDPQ study
Role competency & role support	r =0.55, P<0.01	r =0.59, P<0.01
Therapeutic commitment & role competency	r =0.76, P<0.01	r =0.69, P<0.01
Role support & therapeutic commitment	r =0.43, P<0.01	r =0.45, P<0.01

4.17.1 Construct validity

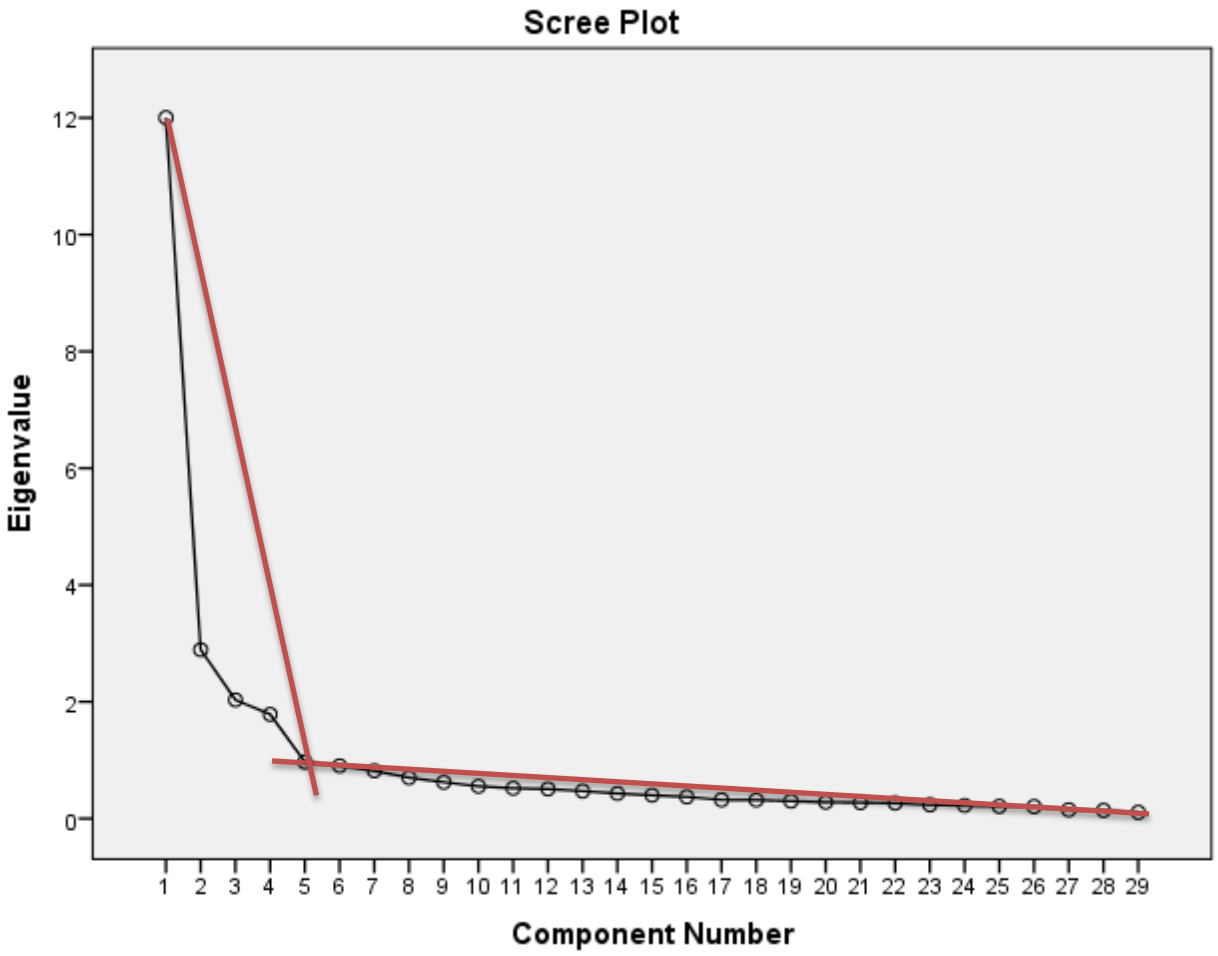
Whilst addressing the structural validity of the LDPQ exploratory factor analysis was utilised. The two main concerns when using factor analysis are firstly the sample size, then strength of the relationships between the variables. This study had a reasonable sample (n=398) which was required to undertake exploratory factor analysis (Gorsuch 1983) and met the 10 responses to one item rule (Stevens 1996). Initially, the correlation matrix was examined to test the strength of the intercorrelations between the statements were above 0.3 (Tabachnick and Fidell 2001). The next step was to ensure there was sufficient correlation of the data to determine if factor analysis was appropriate (Pett et al. 2003). As all items strongly correlated, no items were dropped initially. Bartlett's test of sphericity was significant, and the study assumptions were met for factor analysis ($p<0.001$) (Pallant, 2010). The Kaiser-Meyer-Olkin statistic suggested the sample size is sufficient relative to the number of items in the LDPQ scale, the value was marvellous at 0.9, exceeding the recommendation value of 0.6 (Kaiser 1974). Additionally, the Measures of Sampling Adequacy statistics specify that the correlations among the individual items are strong enough that the correlation matrix is factorable (0.86-0.97) (Pett et al. 2003). These results indicated the data set was adequate for initial factor extraction.

Principal Component Analysis method (PCA) was adopted to condense the variance to produce individual components (Nunnally & Bernstein, 1994), although some debate exists whether PCA should be seen as a method in its own right or described as part of the umbrella term 'factor analysis' (Yong and Pearce 2013). Following the extraction of components rotation is known to extract maximum variance across the variables and is simpler to interpret (Tabachnick & Fidell 2007). Varimax rotation was chosen as it was believed from previous studies using a similar theoretical framework that the components were not correlated (Lauder et al. 2000, Angus et al. 2001), therefore required an orthogonal approach.

Following extraction and rotation techniques, only components were retained if they had an Eigenvalue greater than 1 (Kaiser 1960). Initial Eigenvalues identified a 4-component solution (12.0, 2.89, 2.03, and 1.78) which accounted for 64.5% of the variance. Results for structural validity are determined as positive if factor analysis explains at least 50% of the variance (Terwee et al. 2007).

The scree plot (Figure 9) was examined to assess the number of components evident from the point of inflexion indicated by the connecting point of the two red lines suggesting that 4 components were present (Catell 1966).

Figure 9: Scree Plot



Field (2009) suggests both Kaiser's criterion and Catell's scree test tend to overestimate the number of components extracted, hence parallel analysis was the third test used to support the decision of how many components to retain. Horn (1965) suggests comparing the size of the eigenvalues to those from a similar sized randomly generated data set. Four components again were retained as they were of greater value than the random data (Table 16).

Table 16: Comparison of eigenvalues from PCA and criterion values from parallel analysis

Component Number	Actual eigenvalue from PCA	Criterion value from parallel analysis	Decision
1	12.003	1.5335	Retain
2	2.892	1.4570	Retain
3	2.032	1.4059	Retain
4	1.785	1.3544	Retain
5	0.970	1.3111	Reject

Table 17 presents the component loadings following rotation. A four-component solution was then sought from this information. All items loaded greater than 0.4 on at least one component and some loaded strongly on two components (Items 14 & 24). No items had weak loadings on all components.

Table 17: Component loadings following Varimax rotation

Item No.	Component 1	Component 2	Component 3	Component 4
1	0.80			
29	0.77			
3	0.75			
25	0.72			
2	0.71			
12	0.69			
15	0.65			
14	0.65	0.41		
4	0.63			
28	0.62			
24	0.59	0.41		
23	0.43			
22		0.85		
21		0.85		
19		0.75		
20		0.75		
17		0.70		
11		0.69		
13		0.66		
18		0.65		
16		0.47		
10			0.85	
9			0.85	
8			0.84	
26			0.74	
27			0.74	
5				0.86
6				0.85
7				0.76
Eigenvalues	6.49	5.74	3.91	2.56
% of variance	22.39	19.80	13.49	8.84

The theoretical framework scale has 29 items (Appendix 10) which represents three different constructs as per Table 18 and the output from PCA did not load the items to the components as expected.

Table 18: Items related to Constructs in theoretical framework compared to output from Principal Components Analysis

Component	Items in Theoretical Framework	Component Items following PCA
1	1, 2, 3, 4, 5, 6, 7, 14, 15, 20, 28, 29	1, 2, 3, 4,12,14, 15, 23, 24, 25, 28, 29
2	11, 12, 13, 16, 17, 18, 19, 21, 22, 23, 24, 25	11, 13, 14,16, 17, 18, 19, 20, 21, 22, 24
3	8, 9,10, 26, 27	8, 9,10, 26, 27
4		5,6,7

- Loaded on 2 components

- Loaded to different components than theoretical framework

The four components then required to be assessed for reliability to ensure they were free from measurement error (Pedhazur & Schmelkin 1991). In order to evaluate and refine the components, firstly they were required to be examined for theoretical consistency (Pett et al. 2003). Two items (14 & 24) doubled loaded onto two components, Hair et al. (1995) state the importance of maintaining theoretical coherency when placing an item, therefore item 14 was added to component 1 and item 24 was added to component 2. With the inclusion of these items saw an increase in reliability of the components with component 1 Cronbach coefficient alpha changing from 0.919 to 0.923 and component 2 Cronbach coefficient alpha changing from 0.911 to 0.913. During this process however, it was noted in component 1 that the mean score of 5.3 for item 23 was high. The scale range for the items was 1 to 7; all the means were in the middle to high range (3.7 to 5.3) with standard deviations over 1. Concerns of ceiling effects with this item led to it being deleted (Pett et al. 2003).

As items (12, 20 and 25) that did not load in line with the theoretical constructs, further consideration of their meanings was required to decide if they should remain within the component. Component 1 had the inclusion of items 12 and 25 that were expected to load to therapeutic commitment construct. Items 12 and 25 read: -

- 12 – I feel that I am able to work with patients with learning disabilities as effectively as other patients who do not have learning disabilities.
- 25 – On the whole, I am satisfied with the way I work with patients with learning disabilities.

Reviewing all the item statements in component 1, it looked like it was representing role adequacy. It could be argued that both statements are fit with the definition of role adequacy (a practitioners' sense of self-efficacy in responding to patients' problems) (Shaw et al. 1978) therefore were retained.

Item 20 loaded to component 2 instead of 1. It read: -

- 20 – Caring for people with learning disabilities is an important part of a general (adult) nurse's role.

On review this statement was poorly phrased, the words 'general and adult' required to be deleted in any future use of this tool. Component 2 content supports the therapeutic commitment construct which was developed from 3 subscales, one of which is task specific self-esteem meaning the nurse's sense of their value or worth placed on their role (Blascovich & Tomaka 1991). It could be suggested that Item 20 fits with this definition hence remains as part of the component 2.

Following these assessments, PCA was computed on all four components to establish if they contained more than one component. All components were observed to have only one component present. Cronbach's alphas were calculated to ensure internal consistency for each new component. The results were 0.928, 0.913, 0.910 and 0.843 respectively.

To ensure the survey tool could be completed in a reasonable period of time in the future and to produce a tool that is valid and reliable, components were refined through item reduction. A process of multiple loading established that when some items were deleted the reliability of the tool was either improved or made a negative contribution, however the reduction was small (Table 19)

Table 19: Refining the components - Cronbach's Alpha coefficient scores

Component	Items deleted	N/α before items removed	N/α after items removed	Gain in α
1	28	N=10, 0.928	N=9, 0.922	-0.006
2	16 & 24	N=10, 0.913	N=8, 0.912	-0.001
3	26 & 27	N=5, 0.910	N=3, 0.918	+0.008
4	none	0.843	-------	

From these results, it could be argued that all scales demonstrate internal reliability of adequate level based on the typical alpha threshold for a new tool (Nunnally 1978).

To name the components the theoretical framework the survey instrument was based upon was revisited. It could be suggested that during PCA, the role competency scale was made up from two subscales: role adequacy and role legitimacy was split into two individual components. Component 1 aligned with the role adequacy construct, whereas the new component 4 aligned with the role legitimacy construct. From this comparison, components were labelled: 1 - role adequacy, 2 - therapeutic commitment, 3 - role support and 4 - role legitimacy (Table 20).

Table 20: Final component name and items

Component	Items for Future Scale
Role adequacy	1, 2, 3, 4, 12, 14, 15, 25, 29
Therapeutic commitment	11, 13, 14,17,18, 19, 20, 21, 22
Role support	8, 9,10, 26, 27
Role legitimacy	5,6,7

4.18 Content validity

Content validity was used here is to evaluate if the survey items and questions represent therapeutic commitment, the theory the LDPQ is based upon (Newman et al. 2013) and has two elements to it, development and judgement quantification (Lynn 1986). As the quantitative measure (Section B of LDPQ) was previously modified as described in Section 3.10.3 using an expert panel, the judgement quantification stage was undertaken. To achieve this, a panel of experts were consulted (Stewart et al. 2005). Debate exists on the required number of panel experts (Lynn 1986; Kubany et al. 1995; Polit et al. 2007). Lynn (1985) suggests five experts would suffice and were chosen from different vocational areas all relevant to the study (Grant and Davis 1997). They were all nursing professionals, two learning disability nurses offered expertise on their area of practice; practice education facilitator, practice development facilitator and higher education lecturer provided expertise on skills and knowledge development, provision of role support in clinical placement from practice and university perspectives and finally, all of them on the pre-requisites to developing therapeutic relationships. The panel was made of specialists and non-specialists to allow perspectives from both viewpoints which reflected the sample population.

As sections of the LDPQ were at different stages of development, there were three stages to this. First, the panel were given published papers on the development of the MHPPQ (Lauder et al. 2000; Angus et al. 2001) and an information sheet to

understand which statement aligned to each scale and subscale besides definitions of the scales and subscales (Appendix 7). They were then asked to review the established 29 statements and comment on their content and applicability (Grant and Davis 1997). Due to difficulties in arranging a meeting, communication between all panel members and the researcher occurred via email so everyone was aware of and discuss each other's views. They were then asked to evaluate the eight open-end questions and finally the overall survey tool. Content validity is a subjective process that can be strengthened with the use of standardised criteria to evaluate it within (Lynn 1985). It could be argued this study would have benefitted from using a Content Validity Index to rate the relevance of statements within the LDPQ scales by the expert panel, improving the evidence of content validity (Polit et al. 2007).

4.19 Summary of findings

These analyses have explored the perceptions of final year student nurses' therapeutic commitment to people who have a learning disability. The results obtained have addressed the first two research questions, thus providing an insight into the perceptions of the sample population and examining the differences between the NLDG and LDG. Analysis of the data set has highlighted the following interesting findings and supports the first hypothesis that final year student nurses on the whole believe they are therapeutically committed to people with a learning disability.

This is evident as final year student nurses in this sample reported moderate to high levels of therapeutic commitment, role competency and role support. Interestingly, males perceive higher levels of role competency than females.

Student nurses who had experience working with people with learning disabilities perceived statistically significant higher levels of therapeutic commitment and role competency than those with no work experience or those who were unsure if they had work experience. Additionally, those who had experience working with people with learning disabilities scored significantly higher in the role support scale than those who were unsure if they had any experience.

Furthermore, student nurses who had a personal experience with people with a learning disability scored significantly higher on all three scales than those who reported to have no personal experience. When exploring if student nurses received education on learning disabilities within their pre-registration nursing curriculum, student nurses who did, scored higher on all three scales, however the differences

were not significant. Likewise, student nurses who had an experience working with a patient with a learning disability whilst on clinical placement scored higher on all three scales than those with no experience; furthermore, the differences were statistically significant.

The second hypothesis suggests that the LDG which consists of learning disability nursing students would perceive higher levels of therapeutic commitment than the NLDG that consists of adult and mental health student nurses. The following results support this hypothesis.

LDG reported higher levels of therapeutic commitment, role competency and role support than the NLDG, all of which were significant with a large effect and are a necessary prerequisite for effective interventions with patients. When exploring the therapeutic commitment, LDG scored significantly higher on motivation, expectation of work satisfaction and task specific self-esteem subscales than the NLDG with a large effect. This suggests LDG showed a greater predisposition to working therapeutically with people who have a learning disability than NLDG by indicating higher levels of motivation to work with this patient group. Also, perceiving greater levels of self-esteem, as well as greater expectations of feeling satisfied when working with people with a learning disability.

When considering role competency, LDG scored significantly higher on role legitimacy and role adequacy scales than NLDG, indicating that LDG perceived working with people with a learning disability is a legitimate part of their role and they have the necessary skills to fulfil it, greater than the NLDG. And finally, focusing on role support and which group could access specialist support and gain advice more readily, LDG scored statistically higher than NLDG.

Chapter five: Presentation of results – qualitative analysis

5.1 Introduction

With a convergent mixed methods approach being used within this study, the quantitative findings have been reported first due to their weighting. This chapter will provide an overview of the thematic analysis stages and report the results that originate from participants having answered six open ended questions within the questionnaire as discussed in Section 3.10.3. From the analysis, three deductive themes were found: therapeutic commitment; role competency; and role support directly relating to the theoretical framework of therapeutic commitment. Within each theme, it was commonly identified that various components influenced the constructs of therapeutic commitment which will be presented first, followed by role competency and finally role support as illustrated in Figure 12.

5.2 Stages of thematic analysis

Braun and Clarke (2006) have clearly defined their thematic analysis model which outlines a series of phases that were completed to identify the final themes. An illustrative narrative is provided to bring a full account of each theme with data extracts to provide an example of the interpretations being claimed (Braun and Clarke 2013).

5.2.1 Stage one and two

In stage one, each question response from Section C of the LDPQ was initially entered verbatim into an Excel spreadsheet and then into QSR NVivo 11 software package as it helped to organise the large amount of data. Leading to stage two where through the process on data entry, the researcher started to become familiar with the data and was able to identify some initial codes/themes which were noted. Reading and re-reading the data was a lengthy process. First observations included participants seeing people with learning disabilities as the same as everyone else, the need to empathise with people who have learning disabilities and students' observations of poor patient care. At this point, the researcher had a feeling of annoyance with what she was reading and starting to identify in the data. This was mainly due to the comments that captured the perception that people with learning disabilities were the same as everyone else,

so should be treated in the same way. She recognised that her belief is that everyone is different with or without a learning disability and should be cared for as they wish to meet their needs. Braun and Clarke (2013) comment that it is normal for a researcher to identify with what is significant to them. This was the first time the researcher had to take a step back and reflect on her own position, then review what she was identifying in the data. She was looking for areas she wanted to see and not fully listening to the data.

5.2.2 Stage three

The next stage was to generate initial codes. This was achieved by completing coding of the whole data set. A deductive approach was utilised and stemmed from the theory of therapeutic commitment using the central concepts of motivation, work satisfaction, task specific self-esteem, role legitimacy, role adequacy and role support to explore the entire dataset (Saldana 2015; Braun and Clarke 2013) so an understanding of what components influenced therapeutic commitment could be established. All of the data were appraised, identifying components that influence the individual central concepts. Phrases or single words that related to the central concepts were coded to it. These were data driven and semantic codes which reflected and mirrored the participants' language. At times some phrases were coded to more than one concept. On occasions, some interpretation by the researcher was required. Notes were taken to record the researcher's thoughts and ideas which later supported the development of themes. The initial codes were named 'attitudes', 'care delivery', 'improving outcomes', 'legitimacy/responsibility', 'motivation', 'personal experience', 'placement experience', 'pre-registration education', 'relationship development', 'reasonable adjustments', 'professional role', 'people with learning disabilities characteristics', 'work satisfaction', 'self-esteem', 'skills and knowledge', 'support', 'treating everyone as an individual' and 'nurses' values'.

5.2.3 Stage four

Stage four saw all codes being re-examined to see if their content addressed the research question leading to some being joined together as they were representing the same idea. This process found the researcher going back and forth into the data set to check and confirm meaning to ensure the content was coded appropriately. Codes then began to be sorted into potential themes based on the central concepts being

explored; the researcher took time to remind herself of the research questions being asked to focus the analysis appropriately as some codes were not relevant. The outcome of this saw the codes ‘legitimacy/responsibility’, ‘motivation’, ‘work satisfaction’ and ‘self-esteem’ being revisited. These were the core concepts; some participants had discussed them but not the components that influence them so were decoded. If they did discuss the components that influenced, they were then recoded. It became apparent by rereading the codes that themes were emerging. In particular, the role of caring the student perceived they had, gratitude the student received and being challenged by the role they were undertaking were actual areas being discussed.

The code named ‘care delivery’ contained some data that did not answer the research question therefore was decoded. Other data talked about the participant’s role of caring for others so was recoded to ‘role of caring’. Students discussed the development of their relationship with the patient affecting their therapeutic commitment, so this code remained the same. At this stage the following themes were appearing relating to the components that affected only therapeutic commitment; ‘experiencing achievements’, ‘gratitude’, ‘improved outcomes’, ‘role of caring’, ‘being challenged’ and ‘relationship development’.

From the remaining codes; ‘attitudes’, ‘treating everyone as an individual’, ‘reasonable adjustments’, ‘professional role’, ‘personal experience’, ‘placement experience’, ‘people with learning disabilities characteristics’, ‘pre-registration education’, ‘skills and knowledge’, ‘support’ and ‘nurses’ values’. Further exploration took place to understand more about what they were representing and saying. The ‘attitudes’ code mainly discussed discrimination and equality and linked well with the rights of people with learning disabilities. Students also discussed making reasonable adjustments to the way they delivered care in order to meet an individual’s needs which linked to providing equity. A major part of the researcher’s role as a learning disability nurse has been to ensure people with learning disabilities rights are met so she became concerned that her interpretation of this potential theme was reflecting what she feels others should believe and behave in line with. It also became apparent that when students were discussing their professional role that they believe they have a duty to care and people with learning disabilities have the right to receive effective care. This potential theme held components that influenced the students’ role competency and therapeutic commitment.

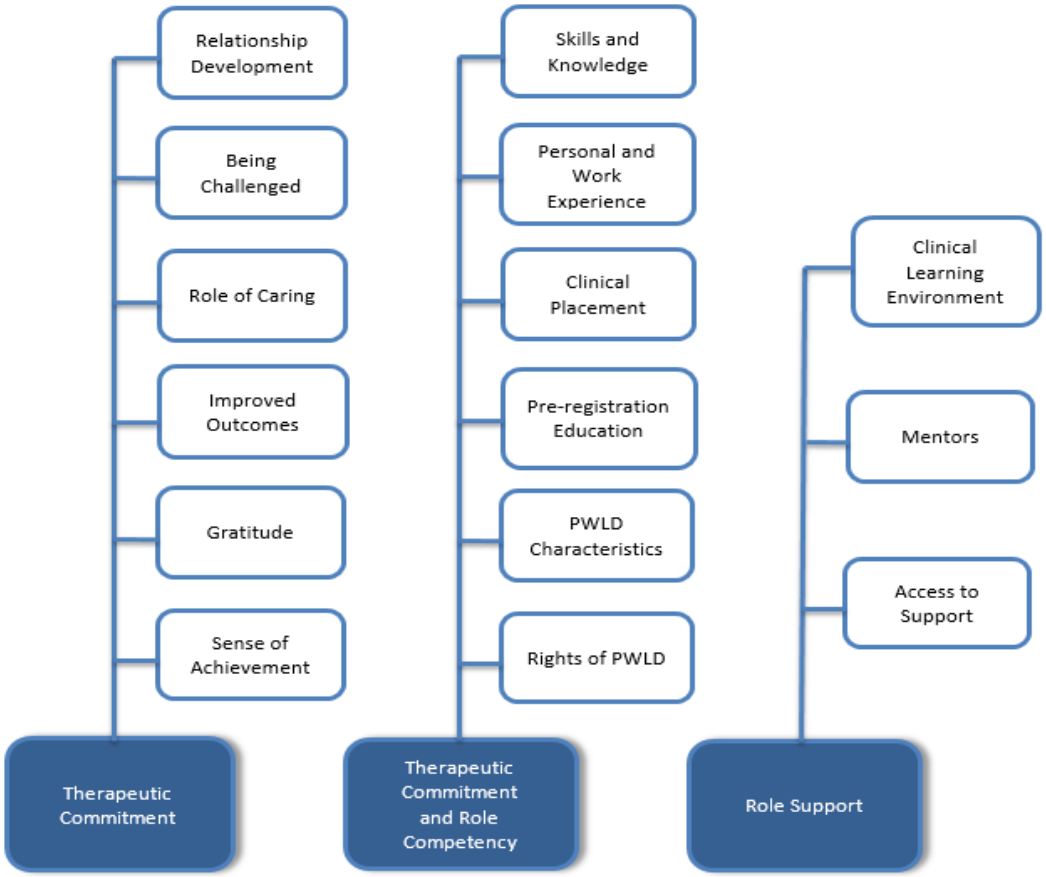
‘Nurses’ value’, ‘treating everyone as an individual’ and some of the ‘attitudes’ code were recoded to represent the ‘characteristics of a nurse’. Students talked about what they believed were the appropriate and inappropriate characteristics to have when caring for people with learning disabilities. This initially became a potential theme representing components that influence role competency and therapeutic commitment. However, when the researcher was looking across the data set it became apparent that the ‘treating everyone as an individual’ code sat better with ‘rights of people with learning disabilities’ as it was discussed as a way of not discriminating. This left the ‘nurses’ characteristics’ code. It contained many singular words like empathy, person centred, respect, compassion, adaptable, patience. There were limited actual comments or phrases in relation to nurses’ characteristics. At this point the researcher decided that there was insufficient information to continue having this as a theme. This was disappointing to the researcher as she expected individuals’ characteristics to have an effect on therapeutic commitment.

The largest code was ‘people with learning disabilities characteristics’. Many students discussed how they perceived someone with a learning disability as a component that influenced their role competency and therapeutic commitment. This was reported both positively and negatively and reflected the researcher’s reality as nurses she worked with clinically, anecdotally conveyed similar views. Therefore, the researcher’s previous experience supported the development of this potential theme.

This left the following codes to be appraised; ‘personal experience’, ‘placement experience’, ‘pre-registration education’, ‘skills and knowledge’ and ‘support’. They all had similarities and initially the researcher felt they could be a potential theme named ‘learning opportunities’ as they all aligned with learning opportunities the student experienced. However, having reread the contents of the codes again, they were discussing components that influenced different core concepts. For example, the code ‘clinical placement’ and ‘pre-registration education’ had comments that reflected the students’ experience but others discussed the support they did or did not receive when providing care to a patient with a learning disability, so the content of these codes was recoded to ‘support’ where appropriate. The code ‘skills and knowledge’ held data on skills that student nurses perceived should be used to care for people with learning disabilities, however in the main students provided a list of skills with little information or comment on why they were important. For this reason, the actual skills themselves were decoded. This left potential themes of - ‘pre-registration education’, ‘placement experience’, ‘skills and knowledge’ and ‘pre-registration education’.

The last code to be reviewed was ‘support’. It had additional comments as previously discussed which allowed the researcher to review it and see three different elements to it. First of all, students discussed support they were able to access, then the mentors who supported them to provide care to patient with learning disabilities and finally, the components that influenced the clinical learning environments they were in. The comments all aligned to the central concept of role support. There were now a number of candidate themes (Braun and Clark 2006) as shown in thematic map Figure 10.

Figure 10: Candidate themes thematic map

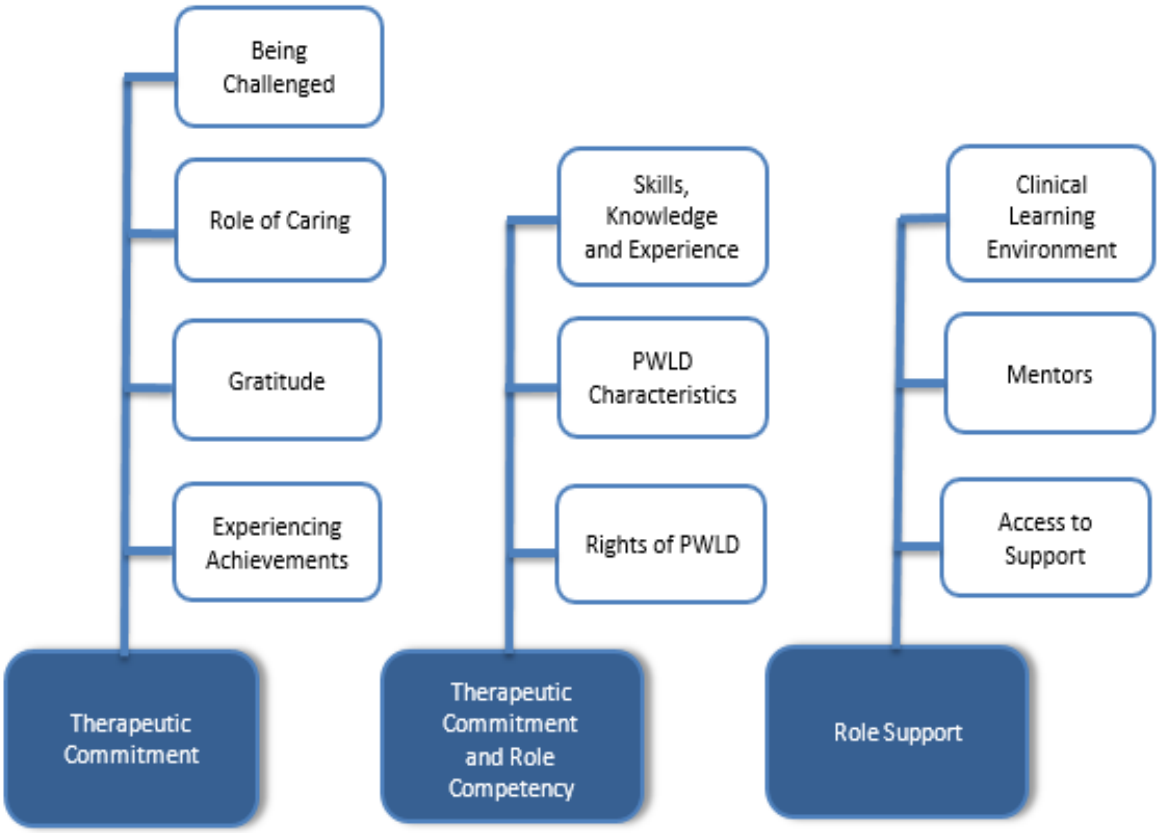


5.2.4 Stage five

Stage five moved on to the potential themes being reviewed and further refined. Braun and Clarke (2013) view this process as an opportunity to assess the quality of the themes being suggested in Figure 10. Again, the researcher checked across the themes for similarities to ensure they could not be further refined. She read all of the coded data for each theme to ensure clear patterns existed. Also, meanings of the codes in the dataset were checked to ensure they have been accurately coded and linked to the theme with consistency. This resulted in 'improved outcomes' and 'relationship' being merged with 'sense of achievement'. The 'improving outcomes' code was recoded to 'sense of achievement' as the participants spoke about improving their patients' wellbeing as motivating and satisfying as something they have achieved for their patient. Similarly, the 'relationship development' code talked about the how the students felt having developed a relationship with a patient with a learning disability. The other themes that related to the components that solely influenced therapeutic commitment remained the same.

When reviewing the potential themes that aligned with role competency and therapeutic commitment there was a lot of overlap between 'pre-registration education', 'placement experience' and 'skills and knowledge'. The content of all of these potential themes were all related to either, skills, knowledge or experience of the student that influenced their role competency or therapeutic commitment to work with people with learning disabilities. The researcher decided at this point to join them into one theme. This resulted in a potential thematic map as illustrated in Figure 11 and the researcher had to consider if this new map truly represented the story being told by the data.

Figure 11: Draft potential thematic map



The final action of this stage was now to consider and check the new themes with the whole data set. This occurred after a period of time away from the data. This process once again led the researcher to make further changes. When re-reading the therapeutic commitment theme, it was clear that the subthemes previously described overlapped with each other. They all were representing the students' perception that their nursing care made a difference to the wellbeing of their patient which then influenced the students' feelings of work satisfaction, motivation and self-esteem hence they were combined to produce a new subtheme titled 'making a difference'.

Moving onto the therapeutic commitment and role competency theme review; when checking if the themes represented the data it became apparent that the theme 'people with learning disabilities characteristics' was on the whole related to therapeutic commitment and in parts role competency. The researcher decided at this

point to truly reflect the data; it should be a subtheme of therapeutic commitment. Similarly, with ‘rights of people with learning disabilities’ subtheme in the main corresponded to therapeutic commitment, therefore was moved to that theme. Reading the contributing data to this subtheme made the researcher reflect on its meaning. Although it did discuss the ‘rights of people with learning disabilities’, it became obvious that what students were actually commenting on was the attitudes they perceived a nurse should have to care for people with learning disabilities. Continuing to read the whole dataset, the researcher re-engaged with the data on nurses’ values and qualities which they had previously discarded. To answer the research question posed it was important to recognise this pattern in the data and along with the ‘nurses’ attitudes’, therefore they were joined together a new subtheme called ‘nurses characteristics’.

The changes in these sub themes impacted on the role competency theme. It left one subtheme titled ‘skills, knowledge and experience’. This was also reviewed, and the decision was to split it into two subthemes, ‘skills and knowledge’ and ‘experience’. The reason for this was that they were representing different aspect of the data; skills and knowledge linked well together and although experience influenced skills and knowledge, the splitting of the subtheme allowed this to be more apparent. Role support subtheme was reviewed and remained the same.

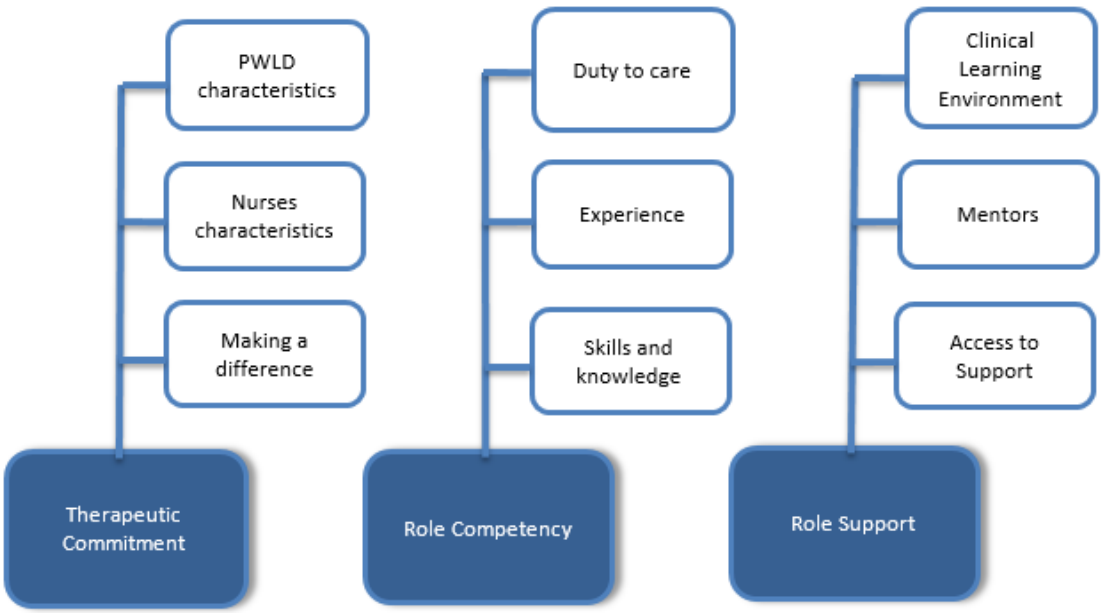
5.2.5 Stage six

This is where the final themes are defined and named (Braun and Clark 2006). However, at the writing up stage, it was noted that an element of the ‘nurses’ characteristics’ subtheme describing the nurses’ duty of care was inappropriately placed and should have been theoretically linked with the role competency theme not therapeutic commitment, a new sub theme was created. All the themes were identified at a sematic level and were based on the explicit meaning of the data. Each theme is defined in Table 21. The final themes that emerged from the data are illustrated in a thematic map presented in Figure 12.

Table 21: Definitions of themes

Theme	Definition
Making a difference	To do something that helps people with learning disabilities which causes a change in the student nurse
People with learning disabilities characteristics	Features or qualities perceived by student nurses to belong to a person with a learning disability.
Nurses' characteristics	Attitudes, values and qualities student nurses perceive are required to care for patients with learning disabilities
Skills and knowledge	Various skills and knowledge that the student nurse has expressed
Experience	A student nurses' personal participation with someone with a learning disability
Duty to care	Student nurse's professional responsibility to provide care
Clinical learning environment	An area where a student nurse should develop skills and knowledge whilst under the supervision of a mentor, providing the opportunity to also practice their professional role.
Mentors	A registered nurse who supervises and assesses student nurses
Access to support	Availability of help and advice from a specialist for the field of learning disability

Figure 12: Final identified themes and subthemes from thematic analysis



5.2.6 *Stage seven*

In this final stage, the formal writing of the findings chapter commenced. From the researcher's notes that have been taken during the process of coding and developing themes, the foundations of the analysis and interpretation were built. Each point made from the interpretation of the themes needs to be represented by an extract from the data. Careful consideration was required to be given to extracting the most descriptive pieces of data that illuminated the analysis of the findings (Nieswiadomy and Bailey 2017).

5.3 Interpretation of themes

The process in which the themes were established has been discussed. The researcher was conscious of ensuring her interpretations were originating from the data and not her clinical experience. The identified themes will now be discussed and interpreted.

5.4 Therapeutic commitment

Developing a therapeutic relationship with a patient is key to any nurses' role to ensure a positive patient outcome. Nurses need to have the commitment to do this. Therapeutic commitment is the nurses' willingness to effectively work therapeutically with their patient (Lauder et al. 2000). It is created from different but related constructs of motivation, expectation of work satisfaction and task specific self-esteem. Respondents believed that making a difference to their patients' wellbeing, a nurse's individual characteristics and people with learning disabilities' individual characteristics influenced their motivation, work satisfaction and belief in themselves when caring for people with learning disabilities. These three components are illustrated as subthemes of therapeutic commitment.

5.4.1 Making a difference

Within this first subtheme, students in both NLDG and LDG commented on their experiences of caring for people with learning disabilities and the impact this had on them. It was clear from the responses that when students perceived their nursing care made a difference to patients by improving their wellbeing; this in turn had an influence on them as an individual and a practitioner. This was evident from students feeling

gratification, changing their views or having more confidence from the episode of care. Two things that emerged clearly from the data were that these feelings were then reinforced by the gratitude they received from patients for the care they delivered or if the student perceived the episode of care was problematic for them to achieve.

Many students in both groups discussed how their nursing intervention resulted in them feeling rewarded which links directly with work satisfaction -

> *The reward you feel when your patient achieves something, the look on their face – P41 (NLDG student)*

> *It's hard to put into words what I enjoy about this kind of work, but often its little things like making an unsettled patient settled or getting a smile from a challenging patient that makes it so rewarding – P154 (LDG student)*

Some students from both groups reflected that they gained greater work satisfaction if the task they were undertaking provided them with a challenge.

> *I find it rewarding and enjoy the challenge as they are sometimes un-cooperative, therefore, I have to build relationship and try harder for them to co-operate which is rewarding at the end when you know they trust you – P286 (NLDG student)*

> *I enjoy the varying abilities, the continual challenges and how people with learning disabilities are full of surprises! - P347 (LDG student)*

Some students in both groups described when they have successfully delivered care the consequence was that their confidence or task specific self-esteem is increased –

> *I like working with people with learning disabilities because there are many health needs and areas to improve on in services and health related issues. This makes me feel valued as a nurse and makes me feel I am making a difference in improving people with (LD) general life and wellbeing – P338 (LDG student)*

> *It can be a challenge although can boost confidence if the patient is satisfied or their quality of life is improved – P379 (NLDG student)*

Whereas, some students for NLDG reported that not being able to deliver care affecting their confidence –

> *I feel I should know some more about learning disabilities to aid my confidence – P171 (NLDG student)*

As these examples indicate a large about of students from both groups related to being motivated by improving wellbeing of their patient when delivering care –

> *I want to make a difference in their quality of life and the barriers they can face throughout the different transitional periods they go through – P151 (NLDG student)*

> *The thing I like the most about working with people with learning disabilities is I feel like I am actually making a difference – P353 (LDG student)*

For a significant number from the NLDG however, they were motivated by the role of caring as a whole; they did not have an increased desire to care for people with learning disabilities -

> *I feel just as willing to help someone with LD's as I would someone without – P258 (NLDG student)*

> *It can be a rewarding process - as is caring for any patient - that allows you to connect with your patient and provide patient centred care - P319 (NLDG student)*

The receipt of gratitude from patients with learning disabilities also influenced many students' levels of task specific self-esteem, motivation and work satisfaction. Here is a sample of their responses –

> *Some patients know that they have a disability so appreciate your help. It makes me think I know what I'm doing is good - P 85 (NLDG student)*

> *I personally feel they are very grateful for your care, this is an aspect that I like as it encourages me that what I'm doing is worthwhile – P60 (NLDG student)*

> *They are grateful that you are working with them, and give a sense of achievement – P136 (LDG student*

5.4.2 Nurses' characteristics

In the second subtheme a high volume of students from both LDG and NLDG, referred throughout the data to the attitudes, values and qualities they held that influenced how they perceived and cared for people with learning disabilities. Possessing these attitudes, values and qualities would influence the students' therapeutic commitment to this patient group.

Discrimination was a dominant feature in the data. The majority of students believed care should be delivered in a non-discriminatory, non-judgemental and unprejudiced way. From both groups, students highlighted causes of discriminatory practice.

> *I feel that general stereotypes surrounding learning disabilities ultimately impacts on the care these people receive. I feel people are often misunderstood and as a result are not treated in a dignified manner like everyone deserves to be as a result of their learning disability – P139 (LDG student)*

> *I feel that people don't understand enough about learning disabilities which can cause them to discriminate against people who are different – P65 (NLDG student)*

Students offered ways to view people with learning disabilities and improve the care they provide -

> *Not being judgemental or afraid of people with learning disabilities means that I can form relationships with patients and work well with them – P154 (LDG student)*

> *Own values should be put aside and the proper care should be given to suit individuals – P218 (NLDG student)*

Linked to discrimination was the concept of labelling, whereby being known to have a learning disability causes you to be discriminated against was discussed by some of the NLDG, however no students in the LDG highlighted labelling as part of discrimination.

> *It's about the person, not the disability. They should not be defined by what condition/disability they have - P282 (NLDG student)*

Another common perspective linked to the rights of people with learning disabilities was ensuring equality. The majority of students from both groups expressed the view

that people with learning disabilities should be treated the same as everyone else in society. As these examples indicate –

> *I feel that they are entitled to exactly the same legal, medical, health and social rights and opportunities as everyone else, and that I will do everything I can as an LD nurse to further this aim – P150 (LDG student)*

> *They have as much right to healthcare and being treated as any other patient – P133 (NLDG student)*

Conversely, students from the LDG outweighed the NLDG when recognising that although people with learning disabilities should be treated equally, they also may have additional individual needs which require to be met –

Some of the students in the LDG highlighted the need to practice positive discrimination to ensure appropriate care is given.

> *I believe they should be positively discriminated against so they are treated equally – P348 (LDG student)*

> *I feel that they are no different from other patients, however, may require additional care – P310 (NLDG student)*

In order to provide equal care, often reasonable adjustments are required to meet an individual's needs (Marsden and Gilles 2017). A number of students from both groups described what they do to make reasonable adjustments to care they deliver to people with learning disabilities in order to ensure that their individual needs are met -

> *It also allows different aspects of care to be considered and care delivery to be modified to fit the individual – P134 (LDG student)*

> *They are the same as other people but require more time and understanding – P254 (NLDG student)*

Student nurses believed that a nurse required certain qualities to provide care for a person with learning disabilities. The main qualities found were respect, dignity, compassion, empathy and understanding, a sense of humour, patience and caring. Participants from both groups were in agreement.

> *A cheerful disposition, a sense of humour, patience, persistence, understanding - P396 (NLDG student)*

Knowing they are no less than us and giving dignity and respect – P46 (NLDG student)

The nurse should be compassionate and empathetic. They must be very caring and understanding – P162 (NLDG student)

I have the care, compassion, knowledge and understanding to be competent in my role – P352 (LDG student)

5.4.3 Characteristics of people with learning disabilities

The third subtheme explored was the characteristics of people with learning disabilities and the effect these had on the student nurses' therapeutic commitment while providing care. Some students described people with learning disabilities as unique individuals –

Different conditions, demographics and life situations makes each person with learning disabilities unique – P261 (NLDG student)

They have got their capacities and strengths that should not be ignored and taken into account – P122 (NLDG student)

Many of the LDG and around half of the students in the NLDG generalised about attributes of people with learning disabilities that would have a positive influence on their therapeutic commitment which included their openness and honesty and having fun -

I love their honesty with no "social safety catch". People with LD tend to say what they are thinking / feeling – P168 (NLDG student)

They got a sense of humour, honest group of people - P339 (LDG student)

Some students from the NLDG commented that people with learning disabilities can display behaviours that challenge and are unpredictable. This was seen to have a negative effect on their therapeutic commitment.

You don't always know what to expect from their behaviour so the challenge of dealing with varied situations. – P64

I can be unsure of their unpredictability but in general like working with them – P8

Another component that has a negative effect on students' therapeutic commitment from the NLDG was the type of condition or disability and the severity of disability a person with a learning disability had -

> *Mild learning disabilities I've - no problem, I find more profound people with learning disabilities harder to care for, I'm not comfortable – P67*

> *I would like to feel confident in caring for people with learning disabilities but sadly I don't. Some patients have very complex health needs and I feel I don't have the right communication skills at times in caring for those with learning disabilities – P35.*

> *I feel slightly nervous around people who have autism. – P82.*

> *This patient group have specialised care needs and when mental health issues are factored in, it can become difficult to adapt your care strategy. – P78.*

Some NLDG students described when there were issues with communication that may cause them to feel less therapeutically commitment towards their patient -

> *It really depends on the disability. If I can't understand what they say or feel they don't understand what I say, that's hard. Also if very distressed, I have found it hard not to understand what they need, if they are comfortable, if they understand why I have to move them. So that can feel awkward and upsetting. – P382.*

5.5 Role competency

The second theme reports the factors that influenced role competency. Role competency encompasses two constructs, role legitimacy and role adequacy (Lauder et al. 2002). It is paramount that student nurses from all fields of practice believe it is their responsibility to care for people with learning disabilities and have the essential skills, knowledge and experience to aid them in achieving this.

5.5.1 Skills and knowledge

From exploration of the data, the first subtheme was identified as a factor that may have an influence on a student's role competency was the skills and knowledge they

perceive they possessed. The entire LDG group felt they were developing the necessary skills and knowledge. On the other hand, many of the NLDG indicated that they did not feel they had the necessary skills and knowledge to provide effective care as a different knowledge base and skill set is required -

> *I feel that I will be equipped with the skills to make a difference to people who even now are faced with continual barriers – P152 (LDG student)*

> *Although having general adult skills still apply I wouldn't feel fully competent if issues directly related to the particular disability arose out with my skill area – P133 (NLDG student)*

Whereas, some participants from the NLDG perceived that the skills and knowledge gained within the adult and mental health fields of nursing education were adequate to provide care for people with learning disabilities and many note core skills are transferable.

> *Same skills in adult/mental health can be applied to any human. Nursing is universal, same skills different group – P167*

> *My basic adult training makes me competent to care for this group, as all nursing skills are transferrable – P355*

Many students in the NLDG indicated they did not have the belief they could care adequately for people with learning disabilities due to students' lack of knowledge, skills and experience making them lack in self-confidence -

> *I feel quite nervous and uncomfortable around people with learning disabilities but this is due to a lack of knowledge around this area – P50*

> *As times I feel out of my depth as I feel I am not experienced enough when it comes to caring for some people with learning disabilities – P303*

Some students from the NLDG specified although they lacked knowledge and skills they were motivated to learn and provide care -

> *Actually don't feel "competent" just willing to try and be inclusive. - P399*

And a small number of students described their dissatisfaction with their work with this group due to their lack of skills -

Only worked with one patient and found it frustrating rather than rewarding at my lack of skills to help them appropriately- P115

However, with experience some students in NLDG report a growth in their confidence –

At first I found it daunting, but the more time I have spent the more at ease I have felt and the more confident I have become in my abilities – P 110.

A few students recognised that to be a competent practitioner took more than skills and knowledge but to have values-based competency also –

I think an individual is competent to work with people with learning disabilities if they have the capacity to see the person's potential and to desire to help them to achieve their potential – P152 (LDG student)

The majority of students in both groups identified the actual skills they perceived as necessary to provide care for people with learning disabilities. These skills were wide ranging and effective communication skills were seen to be of great importance.

Communication skills are vitally important, as is the ability to understand a range of emotions and behaviours and what they can mean in terms of a nursing assessment – P316 (NLDG student)

Understanding the individual's needs and adapting the way the student delivers care was another key area reported by students. Students from both groups gave examples from nursing practice where they have made reasonable adjustments to the care they provided to ensure their patient with learning disabilities needs are met.

Effective communication with patient & relatives / carers. Modify care delivery to suit individual e.g. drug administration, aiding mobility. Knowledge of co-morbidities that may be masked by primary disability – P134 (LDG student)

Flexibility to solving a patients problems or difficulty (sometimes thinking "outside the box" and considering perhaps something which may not have routinely been done before. – P155 (NLDG student)

Around half NLDG students highlighted they were deficient in skills and knowledge to support them to manage a patient's behaviour when it presents as a challenge to them.

Specific training, ability to understand where behaviour comes from and its triggers – P124

On the contrary, some NLDG students and many LDG students recognise the additional skills pertaining to meeting the care needs of people with learning disabilities including understanding and being able to recognise diagnostic overshadowing.

People inc (including) *nurses need to be aware of physical & mental health issues which can be masked by symptoms of LD – P168 (NLDG student)*

Pre-registration education

Opportunities to develop knowledge and skills about caring for people with learning disabilities within the pre-registration undergraduate programme they were studying was an influencing factor for students within both groups.

Nearly all students in the LDG acknowledged that their current programme of study had supported them to continue to develop knowledge and skills.

Working towards a degree in Learning Disability nursing and the skill base I have gained throughout university and working with people with an LD in the past and present time – P143

With the NLDG, their views were divided with a few students commenting that they had an opportunity to learn about delivering care and this made them competent to fulfil the role -

Within my university course, we have had various lectures and online packages which have provided me with appropriate communication skills and understanding of people with learning disabilities – P159

Some acknowledged they received education, but it did not fulfil their needs as a learner -

Some but not enough - I would say I don't feel we have been fully equipped at university with the knowledge on how to care for this group but the opportunities I have had, have grown my confidence in this area – P31

Many students in NLDG highlighted the lack of opportunities they had -

I feel for adult general nurses, it is a big issue and grey area. Although the university offers a LD course, I find a lack of training is given to the adult branch, therefore, I do not feel confident in practice as I would caring for a patient without LD – P367

Some of those who stated they received no education were able to recognise the transferable skills they possessed, however describe that people with learning disabilities care needs may differ and additional skills and knowledge may be required. -

Beyond basic nursing assessment/prioritising skills and basic human compassion and empathy, I do not feel that I have been educated on nursing skills particular to patient with learning difficulties. For example, how to deal with behavioural changes or physiological symptoms related to learning disability - P308

I would definitely benefit from further training in regards to communication and challenging behaviour as I genuinely want to offer the best care I can for people with learning disabilities – P358

Many of the students within the NLDG expressed their desire to have more education and provided justification aligned to current policy.

I think it is shocking that we no longer get lectures on LD. Especially as we are adult nurses, the NHS is becoming less about the hospital and more about community care. Nurses will have more interaction with this group and should be able to treat these patients with the same levels of care as everyone else – P280

5.5.2 Experience

This experience subtheme encompasses the students' clinical placement, personal and work experiences and how these learning opportunities have been seen to influence the students' role competency towards people with learning disabilities. Some students from both LDG and NLDG described the learning they gained from generally having contact with people with learning disabilities –

I have generally found that they respond very well to me. They can present unique challenges and also teach us a lot about their wants and needs……

They have taught me a lot about myself and completely altered my perception of people with learning disability – P76

The one person who I knew had LD was pivotal in changing my opinions about how I nursed, communicated and made me challenge my perceptions – P 169

Personal and work experiences

Some students shared their personal experiences of having a family member with a learning disability which has given them the competence to provide care to this group -

As a member of my family has learning disabilities I feel I have the skills to support patients with learning disabilities – P13

Other students shared the values they hold from having a family member with learning disabilities which align well with being therapeutically commitment to this patient group.

I have a close family member with a learning disability and as a result don't view individuals with learning disabilities as anything other than an individual person who may require more help with some tasks. I feel they often are a valuable part of society and in general have the same feelings and emotions as everyone else- a fact which I find is often overlooked. – P93

Working with people with learning disabilities was discussed by students from both groups in either a paid or voluntary capacity. In the NLDG, students discussed that their skills and knowledge, as well as confidence grew through their work opportunities and how this translates to their current roles -

From previously working with service users with learning disabilities I have built up communication skills including Makaton, increased knowledge of how body language can be used. Also confidence, I don't shy away from people with LD – P183

I have worked with individuals with LD in the past so feel confident in working with them in the healthcare sector. Good communication, patients, caring, understanding of their disability and how it affects their life – P215

Notably, many students in the LDG also made it known that their pre-registration course has continued to build upon the skills and knowledge they have developed from their previous work experience with people with learning disabilities -

I enjoy working with this group and pre-university worked as a support assistant for people with LD. This course has enabled me to add an academic and theoretical framework to the interactive skills I have learned while "on the job" – P150

Clinical placements

There was a distinct pattern in the data relating to the experience students gained during clinical placements and the effectiveness of the clinical learning environment. This in turn had an impact on their therapeutic commitment. Many students from both groups indicated that having a placement was beneficial to them and their individual development as a nurse.

From the LDG, one student reflected on the opportunities placement gave her to improve her practice -

My last 2 years of training experiences different placements, reading most relevant research, literature about this client group and working to best practice guidelines – P148 (LDG student)

Some students from the NLDG described the benefits of a clinical placement with people with a learning disability -

I have experience of working with patients with a learning disability whilst on a spoke placement. I found this to be extremely rewarding and feel it has made an impact on improving my practice – P7 (NLDG student)

However, many from the NLDG expressed the views that more placements were required -

I don't think we are given enough hands on practical experience as adult nurses, and I believe in order for adult nurses to be efficient in caring for people with learning disabilities we should have more practical placements in areas that care for this group of patients/service users – P284 (NLDG student)

A few students recognised the learning opportunities from engaging with carers.

Seeing how carers support them also is beneficial in my learning – P46 (NLDG student)

5.5.3 Duty to care

The Nursing and Midwifery Council stipulates that that all nurses must be able to respond to the care needs of people with learning disabilities (NMC 2010). As these examples indicate, students expressed the view that as a nurse they have a duty to care towards people with learning disabilities and a legitimate part of their role. All of LDG and the majority of NLDG participants agreed with this direction and see their professional role as a duty of care –

> *As a LD student nurse it is a fundamental role for me, however, all nurses may encounter people with LD, therefore, should have appropriate skills – P147 (LDG student)*

> *Yes, as nurses we have a duty of care towards everyone and this should be non-discriminatory – P316 (NLDG student)*

Some recognised that people with learning disabilities could be their patient in any healthcare setting; therefore, they would be responsible for their care -

> *I feel that it is important for adult nurses to have an understanding of patients with LD as you meet them in all health care environments – P270 (NLDG student)*

Notably however, a few of the students from the NLDG felt it was not their responsibility to provide care for this group –

> *Not really because they have their own branch of nursing – P101 (NLDG student)*

> *It is not something I wish to do on a daily basis, hence the Adult Nursing degree – P210 (NLDG student)*

And a small number of NLDG students felt that learning disability nurses could provide better care than they could and were confused about learning disability nurses roles –

> *It should be part of your job but specialist services would be able to deal with disability needs better – P294 (NLDG student)*

> *LD is classed by some people as being a mental health issue so MHN's* (mental health nurses) *are required to know how to work with them, but LDN's* (learning disability nurses) *are there for this reason – P224 (NLDG student)*

5.6 Role support

Role support for the purposes for this study is defined as the perceived access to the specialist support the student nurse had in order to assist them to meet the needs of a person with a learning disability (Lauder et al. 2000). The participants are student nurses and are mentored by a registered nurse; therefore, acknowledgement has been given to the supervision from the mentor to access specialist support which is an additional factor that may influence therapeutic commitment.

5.6.1 Access to support

Access to support from speciality learning disability staff was a way some participants in NLDG thought would enable them to provide a better level of care -

> *If I felt unsure of how to proceed with a patient I would ask a colleague from LD Liaison Nurse for advice. – P356 (NLDG student)*

> *I am willing to listen, observe and learn from the professionals in this field and use my gained knowledge to offer my best care – P341 (LDG student)*

Whereas a small number of students in NLDG believed it was the role of the learning disability nurse to provide the care within the general healthcare setting -

> *…… otherwise moderate / severe learning disabilities should receive specialised care from trained learning disability nurses – P125 (NLDG student)*

> *Yes to a certain level. Severe autistic patients may benefit from a more specialised nurse that just an adult nurse – P266 (NLDG student)*

5.6.2 Mentors

Students from both groups recognised that they require seeking support from a mentor when they feel unable to complete care delivery by themselves -

> *I don't feel very confident in caring for this group alone, but would feel happy to ask for advice from a more experienced nurse/carer or a family on a person's abilities – P298 (NLDG student)*

A key factor that influenced the student nurses' perceptions of caring for people with learning disabilities were the attitudes and behaviours of their mentors and their

experiences within the clinical learning environment. Some students in the NLDG indicated the importance of having a mentor who was competent in caring for people with learning disabilities -

> *I enjoy working with more experienced staff and how they deal with patients with LD. I felt more satisfied – P9 (NLDG student)*

Others from the NLDG described poor learning experiences that influenced them -

> *I also find some staff members to be very negative in their approach to individuals and I think this should be addressed especially if these staff members are mentoring students. They need to show understanding and not scared to deal with individuals – P362 (NLDG student)*

> *On one ward, however, I was working with a senior nurse who seemed very uncomfortable working with a patient with learning disabilities. She was abrupt and dismissive towards this patient and appeared to avoid working with this patient where possible. I felt this was very negative and felt the patient had been seriously let down by this lack of effort and compassion – P157 (NLDG student)*

5.6.3 Clinical learning environments

Finally, some NLDG students discussed the factors that influenced less effective care within their clinical learning environment and in turn may affect their therapeutic commitment-

> *However, many mentors on placement don't feel they have the time to adequately support patients or their students when learning disabilities is recognised – P362 (NLDG student)*

> *I feel they have difficulties being seen or heard as an individual within healthcare in a busy setting it might be easy to avoid or see to other patients, as often those with learning disabilities are quiet and uncomplaining – P399 (NLDG student)*

In addition, some NLDG students perceived that mentors had additional learning needs themselves to care for people with learning disabilities.

Sometimes do not receive best of care due to staff not being appropriately trained – P115 (NLDG student)

5.7 Quality of qualitative data

To demonstrate the quality of the qualitative element of this study, the researcher will consider the interpretation of the findings within this chapter by examining its rigor, credibility and trustworthiness. Firstly, according to Cresswell (2009) the idea of validity and reliability as used in quantitative research greatly differs in qualitative research. Guba and Lincoln (1994) advocate that alternatively trustworthiness and authenticity should be assessed. However, Rolfe (2006) argues the fact that there is no one overall method or methodology that encapsulates qualitative research; therefore, it is difficult to develop agreed criteria to measure its quality.

Rice & Ezzy (1999) state to achieve rigor, the process to interpret the data must be offered with the use of the participants own words to illustrate the findings. Patton (2002) proposes this approach improves the face validity and credibility of the research. Rigor in this study is evidenced by the detailed reflections of the analytical process the researcher undertook (Fereday and Muir-Cochrane 2006). Reflexivity is seen to provide rigor in studies and establish credibility (Holloway and Freshwater 2007) by the researcher identifying and acknowledging constructs that have intentionally or unintentionally impacted on the findings (Guba and Lincoln 2005). The researcher in this study has offered insights and reflections on her influences throughout. Triangulation was achieved by examining the consistency of different data sources from within the same method, by comparing participants with different views (Patton 1999). Furthermore, as this is a mixed method study the findings from the qualitative analysis were triangulated by convergence with those from the quantitative approach increasing its credibility (Creswell 2009).

However, other methods of evidencing validity could have enhanced this study. One such method is the utilisation of respondent validation where your findings are shared with the participants to ensure their accuracy (Robson 2002). Due to the study design being of a convergent nature, it was not possible to share the findings with the student nurses who participated in the study, as the data was collected in one phase then analysed at a later time. During this time period, the student nurses who participated would have completed their studies and been practicing as registered nurses. Due to this, they would be experiencing caring for people with learning disabilities from the

perspective of a registrant with different responsibilities and new clinical experiences in the role. It could be argued they would have reviewed the findings from a different lens than they originally held as a student nurse, therefore unable to accurately provide the necessary checks (Sandelowski 2010).

Furthermore, another method that may have been beneficial was to have other researchers independently code the data and collectively measure inter-rater reliability to determine the level of consistency in the coding (Yardley 2008). Due to the nature of a doctoral study this was not possible, data was coded by the researcher and shared with supervisors along with the findings.

5.8 Summary of findings

In summary, the participants' responses offered further insights into the factors that influenced the level of therapeutic commitment they perceived when considering providing nursing care to people with a learning disability. Three deductive themes where identified in the data and each had subthemes developed from factors that influenced the various constructs of therapeutic commitment. In the first theme, three factors were found to influence the students' levels of therapeutic commitment. Making a difference for themselves or their patient, nurses' characteristics and people with learning disabilities characteristics were all seen to increase their feelings of motivation, confidence and work satisfaction. Students related certain generalised characteristics of people with learning disabilities as factors that influenced their therapeutic commitment. In particular, from a positive perspective some students identified the individuals' uniqueness and found patients to be open and honest. From a negative perspective, therapeutic commitment was reduced depending on the type and severity of disability or condition the individual has.

Within the second theme, three factors were identified that influenced the students' role competency. The first subtheme was their professional duty to deliver care to people with learning disabilities influenced their role competency. However, a few students from NLDG did not feel it was their role as a non-learning disability nurse to provide care and some were confused about their role. The second and third subthemes identified centre on skills, knowledge and experience of students and how these influence as factors. Many students from NLDG did not feel competent to provide care, acknowledging they had a set of core skills that were transferable, however to provide care to some people with learning disabilities additional skills were

required. With regards to gaining of knowledge, some students from both groups indicated that their programme sufficed, providing them with competency. Others in the NLDG aligned the lack of education provision to their lack of competence and confidence. Students made association with experience and role competency. Those who had either family or work experience with this patient group perceived greater confidence as did those who had positive clinical placements.

The final theme was role support and student nurses indicated three factors that impacted on this. Many recognised they could access support for specialist services to assist them to make reasonable adjustments to the care they delivered in order to meet patients' needs. Conversely, some participants felt the specialist role should go beyond giving advice and that they should be providing the care. Students also gained support through their mentors and some students indicated they did not always have a positive role model in their mentor, also some reflected that busy clinical learning environments had a detrimental effect on people with learning disabilities care.

The findings go some way to enrich previous quantitative findings and expand understanding of how therapeutic commitment is experienced, influenced and demonstrated by the participants. However, there are limitations to this approach as all the data was collated at the one time via a self-administered survey, consequently responses were short, and this eliminated any opportunity to explore the findings in more depth (Robson 2002). In retrospect, this stage would have been better served by carrying out individual interviews or focus groups to allow deeper exploration.

Chapter six: Integration of quantitative and qualitative findings

6.1 Introduction

Mixed methods data analysis has a number of steps. First of all, with the convergent design of this study, both quantitative and qualitative data required to be separately analysed and validated before moving on to the integration of both sets of results (Onwuegbuzie and Teddlie 2003). In order to answer the mixed methods question posed in this study, the quantitative and qualitative analyses are merged allowing inferences to be drawn (Guetterman et al. 2015).

6.2 Integrated data analysis

The rationale for this mixed methods approach was to understand the model of therapeutic commitment from student nurses' perspectives, as well as, seek to discover any factors that influenced their perceptions, therefore requiring different approaches. The data from the qualitative findings was used to confirm the quantitative results that were produced. Figure 13, 14 and 15 are joint displays that present the merged quantitative and qualitative findings to provide a clear understanding of the outcomes of the analysis through a visual medium (Guetterman et al. 2015).

To integrate the findings firstly, the qualitative results were examined to establish if they confirmed the quantitative results. This was done by considering the results of the quantitative analysis of key concepts of the theoretical framework; namely therapeutic commitment, role competency and role support. Then the three qualitative main themes were examined to establish their sub themes married any of the quantitative results. For example, as demonstrated in Figure 13, when considering therapeutic commitment and the core concept of work satisfaction, the quantitative results report that NLDG perceive moderated levels of satisfaction whereas the LDG report high levels. These findings were then confirmed by the information in sub theme named 'Making a Difference'. Both these findings were then entered into the joint display. This process continued for all of the quantitative findings. The remaining qualitative findings offered new information about therapeutic commitment.

6.3 Interpretation of integrated findings

The information presented in Figure 13 contributed to answering the mixed method research question. The question aimed to examine if the qualitative and quantitative findings confirmed each other, hence strengthening their integrity, as well as expanding the understanding of the theory of therapeutic commitment from the initial quantitative phase of the study. This evidence confirmed the quantitative results in relation to student nurses' perceived levels of therapeutic commitment, role competency and role support. They inferred that final year student nurses overall are therapeutically committed when caring for people with learning disabilities, with learning disability student nurses perceiving greater levels than adult and mental health student nurses. Both sets of results agreed that learning disability student nurses perceived greater work satisfaction caring for this patient group than the other two. Similarly, the results were consistent in the view that learning disability student nurses were more motivated to provide care and perceived greater task specific self-esteem when doing so than the other two groups of student nurses.

When considering role competency, the evidence presented was congruent in the view that learning disability nursing students saw caring for people with learning disabilities as a legitimate part of their role and indicated they have the necessary skills, knowledge and experience to fulfil it, whereas many adult and mental health student nurses did not to the same degree. Finally, the two sets of results were harmonious in reporting that learning disability student nurses perceived they could source specialist support and gain advice more readily than adult and mental health nursing students.

Having considered how the findings compared in relation to therapeutic commitment theory, this chapter will now report if the factors that were seen to influence therapeutic commitment from the quantitative analysis correspond to those found in the qualitative findings. As evidenced in Figure 14, results from both methodological approaches were congruent in identifying student nurses perceived the following factors influenced their therapeutic commitment; having previously worked with a person with a learning disability, having a personal experience, having the opportunity to care for a patient with a learning disability whilst on clinical placement and undertaking education on caring for people with learning disabilities.

Figure 15 presents the integrated data analysis that resulted in the creation of new knowledge relating to factors that influence therapeutic commitment. This new knowledge was not present in the quantitative results, instead were found in the

qualitative findings. From the new knowledge created, it is proposed that student nurses perceive receiving thanks for the care they provided, positively influences their therapeutic commitment. Equally important, the integrated results identified that finding the delivery of care a challenge positively influenced the student nurses' therapeutic commitment. Another key point generated was that many LDG and some NLDG student nurses believed that people with learning disabilities characteristics positively influenced their therapeutic commitment. Conversely, some NLDG student nurses perceived certain characteristic they associated with people with learning disabilities had a negative effect on therapeutic commitment.

And the last significant piece of new knowledge proposed was that many student nurses from both groups believed the attitudes and qualities held by a nurse contributed to the therapeutic commitment they perceived. The qualities included being caring, giving dignity and respect, being compassionate, being empathic and understanding, having patience and a sense of humour. Furthermore, they reported that having the attitudes of being non-discriminatory, non-judgemental and ensuring equality contributed to therapeutic commitment they perceived.

Finally, from the comparison of the integrated findings there were no incidences from the results disconfirming or disagreeing with each other.

Figure 13: Joint display of integrated data analysis confirming therapeutic commitment theory

Key Topic	Quantitative findings	Qualitative findings	Inferences/Mixed Method comparison
Work satisfaction	NLDG perceived moderate and LDG perceived high levels of work satisfaction. LDG (*M*=31.18, *SD*=2.37) perceived significantly higher levels of work satisfaction than NLDG (M=25.75, SD=4.04). *t*=-8.95, df=392, *p*=0.001, one tailed. CI 95%=-7.39 - -4.73, *d*=1.83	*'The reward you feel when your patient achieves something, the look on their face' – P41 (NLDG student)* *'It's hard to put into words what I enjoy about this kind of work, but often its little things like making an unsettled patient settled or getting a smile from a challenging patient that makes it so rewarding' – P154 (LDG student)* *'It can be a rewarding process - as is caring for any patient - that allows you to connect with your patient and provide patient centred care' - P319 (NLDG student)* <u>All from subtheme – Making a difference</u>	Confirmation – Some student nurses in both groups expressed satisfaction when caring for people with learning disabilities. However, some NLDG students perceived they did not gain satisfaction solely because they were caring for a patient with learning disabilities.
Motivation	NLDG perceived moderate and LDG perceived high levels of motivation. LDG (*M*=26.95, *SD*=1.43) perceived significantly higher levels of role legitimacy than NLDG (M=20.80, SD=3.48). *t*=-10.65, df=390, *p*=0.001, one tailed. CI 95%=-7.28 - -5.01, *d*=2.31	*'I want to make a difference in their quality of life and the barriers they can face throughout the different transitional periods they go through' – P151 (NLDG student)* *'The thing I like the most about working with people with learning disabilities is I feel like I am actually making a difference' – P353 (LDG student)* *'I feel just as willing to help someone with LD's as I would someone without' – P258 (NLDG student)* <u>All from subtheme – Making a difference</u>	Confirmation – Some student nurses in both groups were motivated to care for people with learning disabilities. Nonetheless, some student nurses in NLDG were no more motivated to work with people with learning disabilities than any other care group.

Task specific self-esteem	NLDG perceived moderate and LDG perceived high levels of task specific self-esteem. LDG (*M*=18.62, *SD*=2.10) perceived significantly higher levels of task specific self-esteem than NLDG (M=14.94, SD=2.68). *t*=-8.11, df=394, *p*=0.001, one tailed. CI 95%=-4.58 - -2.79, *d*=1.53	*'I like working with people with learning disabilities because there are many health needs and areas to improve on in services and health related issues. This makes me feel valued as a nurse and makes me feel I am making a difference in improving people with (LD) general life and wellbeing' – P338 (LDG student)* *'It can be a challenge although can boost confidence if the patient is satisfied or their quality of life is improved' – P379 (NLDG student)* *'I feel I should know more about learning disabilities to aid my confidence' – P171 (NLDG student)* All from subtheme – Making a difference	Confirmation – Some student nurses in both groups perceived positive task specific self-esteem whilst caring for people with learning disabilities, whereas some NLDG students expressed negative perceptions.
Role legitimacy	NLDG perceived moderate and LDG perceived high levels of role legitimacy. LDG (*M*=29.73, *SD*=2.78) perceived significantly higher levels of role legitimacy that NLDG (M=25.07, SD=3.73). *t*=-7.37, df=392, *p*=0.001, one tailed. CI 95%=-5.90 - -3.41, *d*=1.42	*'As a LD student nurse it is a fundamental role for me, however, all nurses may encounter people with LD, therefore, should have appropriate skills' – P147 (LDG student)* *'Yes, as nurses we have a duty of care towards everyone and this should be non-discriminatory' – P316 (*NLDG student*)* *'It is not something I wish to do on a daily basis, hence the Adult Nursing degree' – P210 (*NLDG student) All from subtheme – Duty to care	Confirmation – Some students from the NLDG and all from LDG perceived caring for people with learning disability is a legitimate part of their job, some of NLDG disagreed.

Role adequacy	NLDG perceived moderate and LDG perceived high levels of role adequacy. Student nurses in the LDG (*M*=41.38, *SD*=3.12) reported statistically significant greater levels of role adequacy than those in the NLDG (*M*=29.55, *SD*=6.37). *t*=-11.36, df=390, *p*=0.001, one tailed. CI 95%=-13.87 - -9.78, *d*=2.40	*'I feel that I will be equipped with the skills to make a difference to people who even now are faced with continual barriers' – P152 (LDG student)* *'Although having general adult skills still apply I wouldn't feel fully competent if issues directly related to the particular disability arose out with my skill area' – P133 (NLDG student)* *'Same skills in adult/mental health can be applied to any human. Nursing is universal, same skills different group' – P167 (NLDG student)* <u>All from subtheme – Skills and knowledge</u>	Confirmation – Some NLDG student nurses perceived lower levels of role adequacy than LDG student nurses.
Role support	NLDG perceived moderate and LDG perceived high levels of role support. Student nurses in the LDG (*M*=30.28, *SD*=3.06) reported statistically significant greater levels of role support than those in the NLDG (*M*=22.04, *SD*=5.10). *t*=-9.51, df=392, *p*=0.001, one tailed. CI 95%=-9.94 to -6538, *d*=1.96	*'I am willing to listen, observe and learn from the professionals in this field and use my gained knowledge to offer my best care' – P341 (LDG student)* <u>From subtheme - Access to support</u> *'I don't feel very confident in caring for this group alone, but would feel happy to ask for advice from a more experienced nurse/carer or a family on a person's abilities' – P298 (NLDG student)* <u>From subtheme - Mentors</u> *'On one ward, however, I was working with a senior nurse who seemed very uncomfortable working with a patient with learning disabilities. She was abrupt and dismissive towards this patient and appeared to avoid working with this patient where possible. I felt this was very negative and felt the patient had been seriously let down by this lack of effort and compassion' – P157 (NLDG student)* <u>From subtheme - Mentors</u>	Confirmation – Student nurses in LDG perceived they had greater ease of access to support when caring for a patient with learning disabilities than students from NLDG.

Figure 14: Joint display of integrated data analysis confirming the factors that students perceived influence therapeutic commitment

Key Topic	Quantitative findings	Qualitative findings	Inferences/Mixed Method comparison
Previous experience of working with people with learning disabilities	Student nurses who had experience working with people with learning disabilities (*M*=64.47, *SD*=10.04) reported significantly higher levels of therapeutic commitment than those with no experience (*M*=58.86, *SD*=8.32) or did not know if they had any (*M*=55.10, *SD*=7.74); *F*(2,337)=14.77, *p*=0.001 Student nurses who had experience working with people with learning disabilities (*M*=57.60, *SD*=9.72) reported significantly higher levels of role competency than those with no experience (*M*=52.08, *SD*=8.11) or did not know if they had any (*M*=48.60, *SD*=8.93); *F*(2,387)=15.01, *p*=0.001	Therapeutic commitment – *'From previously working with service users with learning disabilities I have built up communication skills including Makaton, increased knowledge of how body language is used. Also confidence, I don't shy away for people with LD* (learning disabilities)' – *P183 (NLDG student)* Role competency – *'I enjoy working with this group and pre-university worked as a support assistant for people with LD. This course has enabled me to add an academic and theoretical framework to the interactive skills I have learned while "on the job"' – P150 (LDG student)* <u>All from subtheme - Experience</u>	Confirmation – Working with people with learning disabilities increased students' therapeutic commitment and role competency.

Personal experience	There was a positive correlation between having a family member or friend with a learning disability and perceived levels of therapeutic commitment - *r*=-0.25, *p*=<0.01 and role competency *r*=-0.25, *p*=<0.01 Student nurses who had personal relationships with people with learning disabilities (*M*=66.66, *SD*=10.58) reported significantly higher levels of therapeutic commitment than those with no experience (*M*=61.31, *SD*=9.24); *t*(387)=5.06, *p*=0.001, one tailed. CI 95%=3.27 to 7.43, *d*=0.54 Student nurses who had experience working with people with learning disabilities (*M*=59.66, *SD*=9.71) reported significantly higher levels of role competency than those with no experience (*M*=54.55, *SD*=9.29); *t*(387)=4.96, *p*=0.001, one tailed. CI 95%=3.09 to 7.14, *d*=0.54	Therapeutic commitment – 'I *have a close family member with a learning disability and as a result don't view individuals with learning disabilities as anything other than an individual person who may require more help with some tasks. I feel they often are a valuable part of society and in general have the same feelings and emotions as everyone else- a fact which I find is often overlooked' – P93 (NLDG student)* Role competency – *'As a member of my family has learning disabilities I feel I have the skills to support patients with learning disabilities' – P13 (NLDG student)* <u>All from subtheme - Experience</u>	Confirmation – Having personal relationships with people with a learning disability increased student nurses perceived levels of therapeutic commitment and role competency.

Clinical placement experience	Student nurses who had an experience caring for a patient with learning disabilities on clinical placement (*M*=63.87, *SD*=9.90) perceived significantly higher levels of therapeutic commitment than those with no experience (*M*=57.76, *SD*=9.03) or did not know if they have had any (*M*=59.12, *SD*=8.46); *F*(2,387)=9.27, *p*=0.001 Student nurses who had an experience caring for a patient with learning disabilities on clinical placement (*M*=56.98, *SD*=9.48) perceived significantly higher levels of role competency than those with no experience (*M*=51.60, *SD*=9.87) or did not know if they have had any (*M*=51.12, *SD*=8.56); *F*(2,387)=8.32, *p*=0.001	Therapeutic commitment and role competency - '*I have experience of working with patients with a learning disability whilst on a spoke placement. I found this to be extremely rewarding and feel it has made an impact on improving my practice' – P7 (NLDG student)* '*I don't think we are given enough hands on practical experience as adult nurses, and I believe in order for adult nurses to be efficient in caring for people with learning disabilities we should have more practical placements in areas that care for this group of patients/service users' – P284 (NLDG student)* <u>All from subtheme – Clinical placements</u>	Confirmation – Having a clinical placement where the student nurse can provide care to a patient with learning disability increases their perceived levels of therapeutic commitment and role competency.

Educational opportunities	There was a difference in the levels of perceived therapeutic commitment between those who received education of learning disabilities (*M*=63.65, *SD*=9.43) and those who did not (*M*=61.45, *SD*=12.10) or were unsure (*M*=60.04, *SD*=7.83) although not statistically significant. *F*(2,387)=2.67, *p*=0.070 There was a difference in the levels of perceived role competency between those who received education of learning disabilities (*M*=56.73, *SD*=9.14) and those who did not (*M*=54.95, *SD*=11.72) or were unsure (*M*=53.38, *SD*=8.40) although not statistically significant. *F*(2,387)=2.18, *p*=0.115	Therapeutic commitment - *'I feel for adult general nurses, it is a big issue and grey area. Although the university offers a LD course, I find a lack of training is given to the adult branch, therefore, I do not feel confident in practice as I would caring for a patient without LD' – P367 (NLDG student)* Role competency - *'Beyond basic nursing assessment/prioritising skills and basic human compassion and empathy, I do not feel that I have been educated on nursing skills particular to patient with learning difficulties. For example, how to deal with behavioural changes or physiological symptoms related to learning disability' - P308 (NLDG student)* <u>All from subtheme – Pre-registration education</u>	Confirmation – Some students from the NLDG who did not receive any education on learning disabilities perceived a lower level of therapeutic commitment and role competency than those who have.

Figure 15: Joint display of integrated data analysis expanding understanding of factors that influence therapeutic commitment

Key Topic	Quantitative findings	Qualitative findings	Inferences/Mixed Method comparison
Receiving thanks	Student nurses overall reported moderate to high levels of overall therapeutic commitment - Whole population (*M*=141.71, *SD*=21.76), LDG (*M*=178.67, *SD*=10.56), NLDG (*M*=137.88, *SD*=18.86)	*'Some patients know that they have a disability so appreciate your help. It makes me think I know what I'm doing is good' - P 85 (NLDG student)* *'I personally feel they are very grateful for your care, this is an aspect that I like as it encourages me that what I'm doing is worthwhile' – P60 (NLDG student)* *'They are grateful that you are working with them, and give a sense of achievement' – P136 (LDG student)* All from subtheme – Making a difference	Expansion – The receipt of gratitude from patients with learning disabilities influenced some student's therapeutic commitment to care for them
Being challenged by the task of providing care to a patient with learning disabilities	Student nurses overall reported moderate to high levels of overall therapeutic commitment Whole population (*M*=141.71, *SD*=21.76), LDG (*M*=178.67, *SD*=10.56), NLDG (*M*=137.88, *SD*=18.86)	*'I find it rewarding and enjoy the challenge as they are sometimes un-cooperative, therefore, I have to build relationship and try harder for them to co-operate which is rewarding at the end when you know they trust you' – P286 (*NLDG student) *'I enjoy the varying abilities, the continual challenges and how people with learning disabilities are full of surprises!' - P347 (LDG student)* All from subtheme – Making a difference	Expansion – Finding it difficult to deliver care and then achieve the outcome the student planned contributed to some student's therapeutic commitment

Student nurses' perceptions of nurses' qualities necessary to be therapeutically committed to people with learning disabilities	Student nurses overall reported moderate to high levels of therapeutic commitment Whole population (*M*=141.71, *SD*=21.76), LDG (*M*=178.67, *SD*=10.56), NLDG (*M*=137.88, *SD*=18.86)	Qualities of a nurse – *'A cheerful disposition, a sense of humour, patience, persistence, understanding' - P396 (NLDG student)* *'Knowing they are no less than us and giving dignity and respect' – P46 (NLDG student)* *'The nurse should be compassionate and empathetic. They must be very caring and understanding' – P162 (NLDG student)* *'I have the care, compassion, knowledge and understanding to be competent in my role' – P352 (LDG student)* <u>All from subtheme – Nurses' characteristics</u>	Expansion – Some student nurses from both groups believed certain qualities (respect, dignity, compassion, empathy and understanding, a sense of humour, patience and caring) they had contributed to therapeutic commitment they perceived

Student nurses' perceptions of nurses' attitude necessary to be therapeutically committed to people with learning disabilities	Student nurses overall reported moderate to high levels of therapeutic commitment - Whole population (*M*=141.71, *SD*=21.76), LDG (*M*=178.67, *SD*=10.56), NLDG (*M*=137.88, *SD*=18.86)	Non-discriminatory attitude – *'I feel that general stereotypes surrounding learning disabilities ultimately impacts on the care these people receive. I feel people are often misunderstood and as a result are not treated in a dignified manner like everyone deserves to be as a result of their learning disability' – P139 (LDG student)* *'I feel that people don't understand enough about learning disabilities which can cause them to discriminate against people who are different' – P65 (NLDG student)* Non-judgmental attitude - *'Not being judgemental or afraid of people with learning disabilities means that I can form relationships with patients and work well with them' – P154 (LDG student)* *'Own values should be put aside and the proper care should be given to suit individuals' – P218 (NLDG student)* Ensuring equality - *'I feel that they are entitled to exactly the same legal, medical, health and social rights and opportunities as everyone else, and that I will do everything I can as an LD nurse to further this aim' – P150 (LDG student)* *'They have as much right to healthcare and being treated as any other patient' – P133 (NLDG student)* <u>All from subtheme – Nurses' characteristics</u>	Expansion – Some student nurses from both groups felt certain attitudes (non-discriminatory, non-judgemental and ensuring equality) they had contributed to therapeutic commitment they perceived

Student nurses' perception of positive and negative characteristics of people with learning disabilities	Student nurses in the LDG (*M*=178.67, *SD*=10.56) reported statistically significant greater levels of therapeutic commitment than those in the NLDG (*M*=137.88, *SD*=18.86). *t*=-12.76, df=380, *p*=0.001, one tailed. CI 95%=-47.07 to -34.50, *d*=2.67	*'They have got their capacities and strengths that should not be ignored and taken into account' – P122 (NLDG student)* *'I love their honesty with no "social safety catch". People with LD tend to say what they are thinking / feeling' – P168 (NLDG student)* *'They got a sense of humour, honest group of people'- P339 (LDG student)* *'I would like to feel confident in caring for people with learning disabilities but sadly I don't. Some patients have very complex health needs and I feel I don't have the right communication skills at times in caring for those with learning disabilities' – P35 (NLDG student)* *'I can be unsure of their unpredictability but in general like working with them' – P8 (NLDG student)* *'Mild learning disabilities I've - no problem, I find more profound people with learning disabilities harder to care for, I'm not comfortable' – P67 (NLDG student)* *'I feel slightly nervous around people who have autism' – P82 (NLDG student)* <u>All from subtheme – Characteristics of people with learning disabilities</u>	Expansion – Certain characteristics of patients (individual capacities and strengths, sense of humour, honesty) many LDG and some NLDG student nurses associated with people with learning disabilities, increased their levels of therapeutic commitment Particular characteristics (severity of learning disability and behaviours that challenge) some NLDG student nurses associated with people with learning disabilities, reduced their levels of therapeutic commitment

Chapter seven: Discussion

7.1 Introduction

In this chapter the research findings are summarised. The results are discussed in detail with reference to wider research and the emergence of new knowledge, in response to the following three questions:

1. Do final year student nurses perceive they are therapeutically committed to people with a learning disability?
2. Is there a difference between specialist (learning disability student nurses) and non-specialist (adult and mental health student nurses) perceived levels of therapeutic commitment?
3. What factors do final year student nurses believe influence therapeutic commitment?

This is then followed by a critique of the quality of the study and finally, recommendations are made for clinical practice and education, as well as future research.

7.2 Summary of key findings

In this study, final year student nurses' perceptions of therapeutic commitment to people with learning disabilities were explored. The results demonstrated that the therapeutic commitment model relating to the care of people with learning disabilities can be used for this means.

Integrated findings evidenced that final year student nurses believe they are therapeutically committed when caring for people with learning disabilities. Furthermore, learning disability student nurses are more therapeutically committed than adult and mental health student nurses. Learning disability nursing students perceived they were competent to provide care for people with learning disabilities, whereas some adult and mental health student nurses did not. Furthermore, learning disability nursing students reported they could access support and gain advice more readily than their adult and mental health peers.

Factors that significantly influenced therapeutic commitment and role competency perceived by all student nurses included having previously worked with a person with a learning disability; having a personal experience, having the opportunity to care for a patient with a learning disability whilst on clinical placement and undertaking education on caring for people with learning disabilities.

The findings also suggested that receiving thanks for the care they provided and finding the delivery of care a challenge influenced the student nurses' therapeutic commitment. Adult and mental health student nurses believed that people with learning disabilities characteristics influenced their therapeutic commitment. And finally, the attitudes and qualities held by the nurse contributed to the therapeutic commitment they perceived.

7.3 Emergence of new knowledge

This study provides invaluable insights into the predisposition student nurses have to engage in a therapeutic relationship with people who have learning disabilities. New knowledge has been found. Student nurses, who perceived they were competent in their role and knew where they could access support, were more likely to express a willingness to engage therapeutically with people who have learning disabilities. We now know that learning disability student nurses are more willing and able to engage in a therapeutic relationship than their adult and mental health peers. Other emerging new knowledge is in relation to the factors that influence student nurses' therapeutic commitment to people with learning disabilities. This study has shown that education on learning disabilities and contact with people with learning disabilities through either a social or work/education situation improves a student nurse's therapeutic commitment to their patient. We now understand that student nurses can be encouraged or deterred by the perceptions they hold about a person with learning disabilities individual characteristics which they use to assess if they are able to meet the person's needs.

The integrated findings supported the hypothesis that; final year student nurses believe they are therapeutically committed to people with learning disabilities. There is currently a dearth of research that has focused on adult and mental health student nurses' disposition to engage in therapeutic relations with people who have learning disabilities with some focusing on student nurses' attitudes. Studies have previously focused on attitudes and competence of healthcare staff in general healthcare settings

(Brown and Kalaitzidis 2013) but not if they are therapeutically committed. Parallels can be drawn to qualitative literature, whereby it is recognised a major consequence of a registered adult nurse not perceiving they have adequate skills and knowledge creates insecurities which in turn effects the development of a therapeutic relationship with a patient with learning disabilities (Sowney and Barr 2006; Flynn et al. 2015; Drozd and Clinch 2016).

Previous studies have claimed that nurses' attitudes to people with learning disabilities mirror that of the general public (Selvin 1995; Slevin and Sines 1996; McConkey and Truesdale 2000). It has been noted in recent times that the general public's attitude has become more positive (Scior 2011) similarly, it could be argued this study reports student nurses also share more positive views. The purpose of this study is to measure the therapeutic commitment of adult and mental health student nurses. This study used learning disability student nurses for comparison purposes. When considering the various components of therapeutic commitment, this study evidenced, as hypothesised that there were differences between both groups with adult and mental health reporting lower perceived levels of therapeutic commitment, role competency and role support than their learning disability counterparts.

Identifying if a student nurse is therapeutically committed to people with learning disabilities is new knowledge that helps us understand if they will have the ability to develop a therapeutic relationship that is necessary to provide person-centred care and factors that positively and negatively affect it. Also, the therapeutic commitment model can identify where the student perceives any deficits are, providing the opportunity to apply strategies to improve.

7.4 Therapeutic commitment

Ryan et al. (2016) found the achievement of effective patient centred care is dependent on the quality of therapeutic relationship between nurse and patient. Werner and Grayzman (2011) found students wanted to work with people with learning disabilities if they believe it would be beneficial, challenging and enjoyable. When considering the construct of therapeutic commitment in this study, student nurses perceived they would gain work satisfaction in their role of providing care for people with learning disabilities and this in turn increased their willingness to engage therapeutically with their patient. Bernal (2004) found student nurses enjoyed engaging with people with learning disabilities during placements. On the contrary

Lewis and Stenfert-Kroese (2010) identified that nurses feel dissatisfied and not confident. Some students from NLDG were indifferent about engaging in a therapeutic relationship to people with learning disabilities and perceived the role was no different than with any other patient group, aligning with previous studies that have shown that student nurses had a preference to care for people with physical disabilities rather than learning disabilities (Lewis and Stenfert-Kroese 2010; Mc Conkey and Truesdale 2000).

This study also found that student nurses were motivated to engage therapeutically with people with a learning disability. Having altruistic values influenced the students' therapeutic commitment. Prater and McEwen (2006) noted that one reason for choosing a nursing career is the desire to help others. Conversely however, some student nurses in this study were also motivated by the positive feedback in the form of gratitude they received. Rognstad et al. (2004) also found that student nurses views were not entirely altruistic, as they actively sought feedback from the patient in lieu of the care provided. The receipt of gratitude nonetheless will encourage and motivate to engage in the therapeutic relationship with people with learning disabilities. It is important to realise many people with learning disabilities will be unable to verbally provide feedback and healthcare practitioners often report issues with communication (Sowney and Barr 2006). It could be assumed when student nurses were recalling their experiences, the individuals they were engaging with had a mild to moderate learning disability. Communication is more complex, with the greater severity of learning disability, therefore creating challenges in building therapeutic relationships. It could be argued this group also have greater health needs and will access health care more often indicating the development of alternative and augmented communication skills are paramount.

Another factor that influenced the students' therapeutic commitment was to perceive the episode of care was problematic and challenging for them to achieve. Toode et al. (2011) agreed with this notion and noted that nurses are motivated and find satisfaction in nursing tasks they are uncertain of and require specific skills they may not have. It is argued that although providing care for people with learning disabilities can be challenging, student nurses should be given to opportunity with access to effective support, to find their own solutions in order to achieve a positive outcome. This process can increase the student nurses' therapeutic commitment if they perceived improvement in their confidence, work satisfaction and motivation.

7.5 Role competency

Providing care for people with learning disabilities is every nurse's business (Scottish Government 2012, NMC 2010). Cognition requires to be given to the fact that student nurses are at pre-novice level (Dreyfus and Dreyfus 1986) and may not perceive a level of competence due to this. A number of adult and mental health student nurses did not perceive that caring for people with learning disabilities was a legitimate part of their role. This was not consistent with a previous Canadian study focusing on nursing students' perception of people with learning disabilities, where nearly all of student nurses did perceive it was their responsibility (Temple and Murdoch 2012). In the United Kingdom, as there are four fields of practice there is often confusion about who is responsible for the care of adults with learning disabilities. People with learning disabilities can access all universal physical and mental health services. Role confusion can exist when registered learning disability nurses' roles are not understood by their peers (Donner et al. 2010). Some student nurses believed learning disability nurses should provide care to people with learning disabilities in acute care settings, in Slevin and Sines (1996) study nurses also believed this. This perception could be viewed as discriminatory or reflects the lack of confidence the student nurses have. This could account for some of the variance between the groups; nonetheless many adult and mental health students clearly recognised their professional role.

To fully engage in a therapeutic relationship with a patient the nurse must possess the necessary skills and knowledge (Crotty and Doody 2015). Many NLDG student nurses reported feeling incompetent, conversely some perceived that nursing skills were universal, and no additional or different skills or knowledge is required to provide care to people with learning disabilities. These views were similar to some registered adult nurses (Melville et al. 2005; Cooper et al. 2014). Temple and Mordoch (2012) found student nurses saw themselves as competent, reporting they believed the participants did not fully comprehend the needs of this group due to lack of exposure. Similarly, the students within this study may also be in the precarious position described as 'unconscious uncompetent', where they do not know, what they can know (Race 2004), therefore do not understand the deficits in their skills or knowledge base and the effect this can have on patient outcomes. People with learning disability have poor care experiences when nurses lack the necessary knowledge and skills which can impact on their wellbeing, safety and health (Bradbury-Jones et al. 2013) which can have severe consequences for individuals receiving care (Heslop et al. 2013). Studies have shown many non-specialist nurses feel uncomfortable caring for people with

learning disabilities (Sowney and Barr 2006; Lewis and Stenfert-Kroese 2010; Flynn et al 2016) which could lead to avoidance behaviours and that negatively impacts on the nurse patient relationship and delivering certain aspects of care (Baxter et al. 2000; Lewis and Stenfert-Kroese 2010). Schuengel et al. (2010) have shown that staff whose main role is to care of people with learning disabilities often experience stress which affects their ability to provide person centred care due to difficulties in communication and developing a therapeutic relationship and this is also reported by oncology nurses (Flynn et al. 2015). To develop a therapeutic relationship, the nurse must understand the patients' ability to take their part in it (Crotty and Doody 2015). Therefore, having the necessary communication skills are vital to effectively develop therapeutic relationships and provide person centred care as students highlighted (McCormack and McCance 2017).

7.6 Role support

In this study, role support is the support the student perceives they can access to help to effectively care for a patient with learning disabilities. This support could be from someone they viewed as more experienced; a mentor, parent or carer or a specialist from the learning disabilities field. It would be expected that student nurses would report high levels of role support given the mandatory supervision they receive whilst in clinical practice (NMC 2008) and support is crucial for a positive student learning experience (Warne et al. 2010).

The LDG reported high levels of support; the reasons for this could be two-fold, firstly due to the fact that their mentors were more likely to be learning disability nurses and secondly, they may be viewed as more experienced and competent practitioners in this field. However, this was not the case for NLDG who reported moderate levels. Some students perceived they could not access role support as their mentor was not therapeutically committed to this group. Perry (2009) argues that mentors are role models who students observe in practice to aid their learning. Learning can be intended or unintended (Gaberson and Oermann 2010) and students observe all practice, effective or poor. As many registered nurses report a lack of confidence, knowledge and skills when caring for people with a learning disability (Lewis et al. 2016) and it is well documented people have poor experiences in universal healthcare services (Michael 2008), undoubtedly student nurses will be observing poor practice and will have an effect on their professional socialisation (Price 2009). This includes

the acquisition of skills, knowledge, professional identity, and an understanding of the cultural norms and values that underpin practice that they may replicate to fit into the clinical environment (Malouf and West 2010) or highlight their concerns (Stacey et al 2011). The quality of any clinical learning environment is seen to be paramount to the development of competent and confident nurses (Murphy et al. 2012). In this study, the clinical learning environment itself was seen by the students to have an impact on mentors' willingness and ability to engage therapeutically with people with learning disabilities due to time constraints and the busyness of the clinical area. Roche et al. (2011) echoed this within a mental health context, finding that lack of time had a direct effect on therapeutic commitment. In order to learn how to engage therapeutically with people with learning disabilities on clinical placement, students require effective support from a competent mentor in a quality learning environment (Willis 2012).

Student nurses also reported accessing support from specialists from the field of learning disabilities. Learning disability liaison services are seen as an effective model to provide support in acute general hospitals to prevent inadequate care (MacArthur et al. 2015; Castles et al. 2013), although they are not established in all general hospitals. Their primary roles are to coach non-specialist staff when the liaison nurse is supplementing care at the point of delivery, advising on reasonable adjustments to ensure person centred care and provide formal education training programmes (Brown et al. 2010). Evidence shows the effectiveness of these services from the patient with learning disability and carers' perspective. Link nurses from community learning disability teams are also viewed as beneficial (Cartlidge and Read 2010; Hastings 2007). Roche et al. (2011) identified staff viewed supervision and coaching as a means of support but not one that improves role competency. It would be interesting to understand the views of non-specialist staff that use learning disability liaison nurse services in relation to how learning disability liaison services influence their therapeutic commitment towards people with learning disabilities.

Some families and carers perceive the expert knowledge and skills they hold are not recognised by healthcare staff (Mencap 2007), whereas others report they are often overly relied upon by non-specialist staff to assist in delivering care to people with learning disabilities (Backer 2009). Accessing families and carers for advice about the individual is another way of gaining role support that was not identified in this study. There is a need for student nurses to understand the role carers can have in developing a therapeutic relationship with their patient and being successful in delivering person centred care.

7.7 Factors that influence therapeutic commitment

In accordance with the initial aims of this study, factors were found that influenced therapeutic commitment. Student nurses who reported having a personal experience reported higher levels of therapeutic commitment and role competency. Conversely, Klooster et al. (2009) report having a family member with a learning disability did not improve students' attitudes. McConkey and Truesdale (2000) report nurses and therapists' confidence in caring for people with learning disabilities was increased if they had a personal experience out with their work situation. However, at the same time they report that having an experience in the workplace reduced nurses' confidence. This was a contradiction of the findings of this study where student nurses who had an experience with a person with a learning disability either through work or clinical placement perceived higher levels of therapeutic commitment and role competency than those who had no similar experience. However, Slevin (1995) found that having an experience with a person with a learning disability during a clinical placement improved a student nurse's attitude towards this group. Often adult and mental health student nurses do not get the opportunity to meet and engage with someone with a learning disability as part of their educational programme and when they do, it is more likely to be when the individual is unwell during a clinical placement. If they did have the opportunity, by seeing the individual in a positive light and emphasising their capabilities could result in increasing the NLDG student nurses' therapeutic commitment (Scior 2011). It is suggested that student nurses should have the opportunity to interact and engage with people with learning disabilities when they are well, out with a clinical environment so they can experience developing a relationship with them when the ill person with a learning disability is not experiencing the stress of a hospital or clinical environment.

Also undertaking education on people with learning disabilities increased the student nurses' therapeutic commitment and role competency. These findings were consistent with prior studies where education improved knowledge and confidence (Melville et al. 2005; Rose et al. 2012), whereas other studies report no improvement (Lewis and Stenfert-Kroese 2010). As hypothesised the LDG perceived greater levels of therapeutic commitment than the NLDG. However, it could be suggested that the LDG identified in the main they had received education on learning disabilities as is set by the NMC pre-registration education standards (2010) and core to the curriculum, however the curriculum the NLDG have undertaken may not have covered this, or in enough depth. In this study, some NLDG students reported a range of views on their satisfaction with educational experiences that mirrored recent reports (Spinks 2015).

The NMC (2017b) have reviewed their standards for pre-registration education. To ensure the quality of teaching within adult and mental health programmes, more detailed guidance on content, its delivery and how the students' knowledge is assessed pertaining to learning disability care is advocated. Furthermore, quality assurance processes currently in place require having a focus on this to ensure the learning disability content of curricula is transparent in education delivery. The findings of this study also have international nursing relevance. Out with the United Kingdom and Ireland, few countries have a learning disability nursing field of practice or specialist qualifications and the majority do not recognise the need to have standards or educational content relating to learning disabilities in all nursing programmes.

Student nurses in this study perceived people with learning disabilities had individual characteristics that increased or decreased their willingness to engage with them therapeutically. Both groups expressed stereotypical perceptions where positive generalisations that recognised individuality and assets like sense of humour were described. On the other hand, negative characteristic generalisations included behaviour that challenged the student and severities of the learning disability were expressed by NLDG. Comparable views have previously been reported when exploring healthcare professionals' attitudes (Pelleboer-Gunnink et al. 2017). The development of a therapeutic relationship relies on the nurse's understanding the individuals' unique behaviours and mannerisms (Crotty and Doody 2015) which may vary depending on how their learning disability and associated conditions have manifested. Depending on the severity of the learning disability, will affect the ability the individual has to form relationships (Jones and Donati 2009).
Other studies have reported nurses' anxiety and concern in relation to managing behaviours that challenge them (Sowney and Barr 2006; Merrifield 2011; Drozd and Clinch 2016). Often this is related to ineffective communication between both patient and nurse, that breaks down the trust they require to share in order to have a therapeutic relationship (Schuengel 2010), as well as the skills and knowledge the nurse has to effectively support the individual (Cartlidge and Read 2010). Additionally, health care professionals tend to overestimate individuals' ability to comprehend and communicate (Martin et al. 2012).

And finally, the attitudes and qualities held by the student nurse contributed to the therapeutic commitment they perceived. Students believed having non-judgmental and non-discriminatory attitudes, as well as treating people equally were necessary attributes to be therapeutically committed to them. Although students held these

attitudes they did not fully understand their application to practice. At times when working with people with a learning disability, NLDG student nurses perceived that treating everyone the same is the inclusive way and were frightened of discriminating by saying people were different (Sowney and Barr 2006). Student nurses reported they should treat everyone the same, as a way of providing equality and being non-discriminatory. This view does not consider that person-centred care is not about treating everyone the same. The student nurse requires understanding and assessing their patients' individual needs which are different than anyone else's, if not the patients' needs will not be met. There is a need for positive discrimination where reasonable adjustment is made to the delivery of healthcare to ensure equal and non-discriminatory practice (Marsden and Giles 2017).

Nurses require having the necessary attributes and characteristics to accompany skills and knowledge to provide care (Calman 2006). Student nurses saw respect, dignity, compassion empathy and understanding, patience and caring as characteristics essential to therapeutically engage with people with learning disabilities. All of these are interlinked (Department of Health 2010a) and align with the principles of nursing practice (RCN 2010) which could be assumed is part of their current educational programmes. However, to engage in a therapeutic relationship a student nurse requires being self-aware (McCormack and McCance 2010) and recognising if they apply the characteristics to practice. Interestingly, having a sense of humour was seen as an appropriate quality to possess. Studies have shown the exchange of humour between nurse and patient can help the therapeutic relationship between them, support communication exchanges, support the reduction in patients' anxiety and help the nurse manage difficult situations with various patient populations (Tatano Beck 1997) and to attempt to even out the power inequalities between the healthcare professional and patient (Scholl 2007). It is suggested in this study student nurses used humour to develop a relationship with their patient in a form of communication.

7.8 Limitations of research study

As a concurrent mixed method study utilising a fixed design, the data were collected at one stage. This can be seen as a limitation as the researcher was unsure what the quantitative analysis would show, therefore unable to adjust the qualitative approach to ensure a greater understanding of the quantitative findings. A flexible, sequential approach may have been more beneficial to allow for deeper exploration. Additionally,

using a set of open-ended questions requiring a written response to collect the qualitative data was restrictive. It produced short, descriptive comments that did not allow for in-depth exploration that could have been achieved if an alternative data collection method had been used like semi structured interviews or focus groups. In order to extrapolate the differences in views of the two groups, separate focus groups could have been used with vignettes, then analysed separately, producing two sets of distinct views. Nonetheless, if student nurses had been directly questioned about their commitment to people with learning disabilities, it would have been professionally challenging for them to respond from a negative perspective. Another limitation is the use of thematic analysis. Although it is flexible, this flexibility can lead to inconsistency and a lack of coherence when developing themes derived from the data, challenging the findings trustworthiness.

Caution should be taken when generalising the results of this study due to the low response rate. Findings may be generalizable to student nurses across the United Kingdom, as it took place in Scotland where student nurses access a NMC standardised undergraduate programme.

7.9 Potential for bias

The response rate in this study was low at 26.5%. The main reason for this was limited access to the study population. Access had to be gained through adult, mental health and learning disability university lecturers. It is suggested that some lecturers were not fully supportive of the study and did not feel the need to prioritise organising access for the researcher to meet the nursing students. The researcher however could have discussed these challenges further with the heads of school in an attempt to increase access. It is impossible to tell if access was granted to the researcher, if students would have engaged with the study. Those who were offered the opportunity to partake but declined was mainly due to timing issues. This creates bias in the study due to the number of non-responders; therefore, consideration requires to be given to the representativeness of the sample.

During the process of recruitment, gate keeping by a member of university lecturing staff and the researcher's presence at time of data collection may have introduced bias to the study, as students may have felt obliged to complete the questionnaire due to presence of both. Other future approaches to eliminate this would be to use postal surveys.

Also, for consideration, as a potential for bias, the participants as student nurses may have wanted to be seen as 'good nurses'. Social desirability bias may have led participants to score themselves higher than they truthfully perceived, portraying a positive image of themselves. Attempts were made to overcome this, initially the study proposed to not ask participants to complete a consent form, with consent being implied by the participant making an informed choice and completing the questionnaire. This was not approved by the ethics panel in one university. An alternative strategy was to ask the participants to leave their uncompleted or completed questionnaire in a box so there would be little chance of identification. For future use of the LDPQ, it would be beneficial to measure the impact of social desirability bias by incorporating a social desirability scale to the instrument (van de Mortel 2008).

Another factor that may have introduced bias to the study was that student nurses could have reported on the future skills/knowledge they expected to have rather than their present perception, or perceived they were not competent due to their undergraduate status. Additional instructions on the LDPQ, asking them to answer relating to how they felt today would potentially reduce this.

The final factor that could have introduced bias was the researchers influence on the research. As a novice qualitative researcher, she became familiar with how she influenced her research through her individual background and identity which was initially a challenge. Nonetheless, she quickly became cognisant that her knowledge, experience and values as a learning disability nurse were influencing her thinking and rationalising when establishing themes from the data. She had to reflect on her decisions and question if she were using prior knowledge, values or prejudices to interpret the data or was the is clearly evident. This reflexive stance throughout the process improves the quality of the research (Engward and Davis 2015).

7.10 Implications for practice and education

In a recent commentary in the literature, Northway (2017) makes a plea to the nursing profession to enact their professional responsibility to reduce the health disparities people with learning disabilities experience in healthcare. It is argued that this study provides a contribution by creating new knowledge regarding student nurses' willingness and ability to engage in a therapeutic relationship and the factors that influence it.

The findings from this study have implications for nursing practice because they help us understand how therapeutic commitment exists in nursing practice and what factors influence it. Attitudes, qualities and experiences have been identified that link to being therapeutically committed to a patient with a learning disability and factors that have a positive and negative effect. Identification of these factors in clinical practice and development of strategies to manage them will support nurses to engage in a therapeutic relationship, enhancing the delivery of effective care interventions resulting in positive outcomes for the patient, hence reducing health inequalities which aligns with Scotland's Nursing 2030 Vision (Scottish Government 2017).

The findings from this study have wider international relevance as globally this growing population continue to live longer (Maulik et al. 2011) and experience health inequalities (Scheepers et al. 2005, Krahn and Fox 2014). With the mounting recognition of the need to develop a nursing workforce with the necessary skills, knowledge and attitudes that enables them to be confident in delivering effective and inclusive care and to reduce harm to people with learning disabilities in universal health services (Michael 2008; Backer et al. 2009; Northway 2017), the implications for clinical practice and education are clear and in places well-rehearsed.

The first is the need for increased awareness and understanding of therapeutic commitment of adult and mental health nurses to people with learning disabilities and how this related to nursing practice in universal health services. International research indicates that people with learning disabilities have poor healthcare experiences as a result of non-therapeutic experiences; Australia (Iacono and Davis 2003; Webber et al. 2010; North America (Wilkinson et al. 2013) and Canada (Lunsky et al. 2011). These countries have a generic nurse qualification with no undergraduate specialised field for learning disabilities (Lewis et al. 2016). Many of the generic undergraduate programmes are seen to be inadequate to prepare adult and mental health student nurses as part of their curricula (Hahn 2003; Gardner 2012; Trollor et al. 2016). As the foundations of nurses practice are laid at the first stage of education (Beacock et al. 2015), pre-registration programmes need to be fit for purpose. The model of therapeutic commitment used in this study could be seen as part of the solution, to shape future curricula and competency frameworks. The findings in this thesis add weight to the continual arguments for higher education institution curricula to fully embrace the inclusion of knowledge, skills and experience of learning disabilities.

In the United Kingdom, Spinks (2015) also reports on the variation in the quantity and quality of learning disability pre-registration education in adult and mental health

programmes. Opportunities exist when student nurses have a positive predisposition to care for people with learning disabilities; this provides educators with an important foundation on which to continue developing the necessary skills, knowledge, experience and personal qualities necessary to provide effective person-centred care. In conjunction with emphasising that caring for people with learning disabilities is a legitimate part of any adult or mental health nurse role. Therapeutic commitment of student nurses can be increased by providing educational opportunities, both theoretical and experiential. Aligning with the recommendations from several policy and review documents (Michael 2008; Scottish Government 2012; Beacock et al. 2015), this study provides evidence to support the inclusion of learning disability care as an integral part of all pre-registration nursing curricula; in turn this may improve the experience people with learning disabilities have when accessing universal healthcare services. How this is achieved requires being well thought out. Theoretical delivery on learning disability alone will not suffice, as students require to be supported to understand people with learning disabilities needs in relation to every part of the adult and mental health curriculum and should be assessed on their knowledge. Clinical placements that engage in the everyday life of people with learning disabilities, out with health services may be disruptive for the individual, as student nurses frequently enter and leave their lives, with little benefit to them (Barksby 2014). With this in mind, innovative ways to manage this and provide student nurses the opportunity to meet and engage are required. Further work could also be done with individuals with learning disabilities who support clinical placements to be more involved in the process and ensure it is meaningful for them, for example co-produce learning outcomes, be part of the assessment of the student and evaluation process of the placement.

It is also recommended that people with learning disabilities co-design and deliver pre-registration curriculum for all nursing programmes, providing opportunity for educators and students to engage with individuals and appreciate the value and expertise they bring (Smith et al. 2016). This is an alternative learning opportunity for students and educators who may have little experience with this group themselves to influence their therapeutic commitment. From this study, it is suggested the curricula pertaining to learning disability care should include social model of disability, developing therapeutic relationships, providing person centred care, role of family and carers, augmented and alternative communication, consent, differing health needs, positive behaviour support, making reasonable adjustments to care in line with legislation, understanding the role of learning disability nurses and accessing learning disability services to gain specialist support and advice.

Kwiatek (2016) advocates for improvements to pre-registration education solely from an academic perspective, however it must be remembered that half of student education is in clinical practice. The challenge is for all nurses to flexibly, creatively and effectively deliver high quality care to people with learning disabilities accessing their services. Student nurses in this study had mentors who were unable to offer them the necessary support to provide effective care to their patient, impacting on their therapeutic relationship and ultimately patient care and student learning.

A plethora of recommendations echo the same message (Michael 2008; Backer et al. 2009; Hemm et al. 2015; Lewis et al. 2016) and highlight the need for all healthcare staff to be educated so they can be confident and competent when providing care to people with learning disabilities. This study supports this recommendation. As it has been established education on learning disabilities increases student nurses' therapeutic commitment and role competency, LDPQ could be used as measurement to test the effectiveness of an educational intervention with any non-specialist healthcare professionals. Again, as having contact with a person with learning disabilities increases therapeutic commitment, engaging or employing them to deliver education, co-produce learning opportunities and experiences in primary and acute general and mental health care settings enhance the development of skills, knowledge and attitudes (Tracy and Iacono 2008; Black and Roberts 2009; Bollard et al. 2012) and support staff to develop a therapeutic commitment to this patient group.

The model of therapeutic commitment to people with learning disabilities could apply to wider issues like the recruitment of nurses to clinical practice. The model could be used to understand the nurses' therapeutic orientation, skills and knowledge of people with learning disabilities in areas where they frequently attend, for example general practice. Furthermore, it could be used as an evaluation tool in universal healthcare services to explore staff views on caring for people with learning disabilities.

7.11 Implications for future research

There is a paucity of literature pertaining to person-centred care for people with learning disabilities out with the learning disability field. There is a need for more research into person centred care by adult and mental health nurses, how it is delivered and how they perceive it. This study provides an understanding of therapeutic commitment which is an essential predisposition held by a nurse before person centred care can be delivered. This study focuses on the student nurse perspective, which is only one side of the therapeutic relationship. Understanding

people with learning disabilities and their families' views of the therapeutic relationship and the care they experience is important. Brown et al. (2016) have considered operationalising person centred care from the perspective of the learning disability liaison service that supports adult nurses. Many have looked at hospital and care experiences (Gibbs et al. 2008; Fox and Wilson 1999; Hart 1998) but none have tried to understand what people with learning disabilities or their families view as person centred care provided by adult or mental health nurses. Howieson (2015) reported people with learning disabilities want to experience effective therapeutic relationships with adult nursing staff. McCance et al. (2008) advocate the need to understand what the patient view of caring is and use this to make changes to nursing practice. For that reason, we need to consider what people with learning disabilities understand of therapeutic commitment and their relationship with the nurse providing their care which will in turn contribute to the understanding of person centred care for this patient group.

People with learning disabilities care in acute hospital settings is enhanced when learning disability liaison nurses are part of the care team (McArthur et al. 2015), it would be interesting to evaluate this service using the LDPQ to measure the therapeutic commitment of adult nurses who use the liaison service and those who do not. It could be hypothesised that learning disability liaison services provide them with role support and education and coaching which would increase their role competence and in turn influence their therapeutic commitment towards people with learning disabilities.

The LDPQ is based on the theory of therapeutic commitment which is a pre-requisite to developing a therapeutic relationship with a person with a learning disability. Throughout this study person centeredness has played a key part as the aim of developing a therapeutic relationship with a patient. Future use of the LDPQ would benefit from additions to explore the process of care delivery and the care environment leading to a greater understanding of person-centred care to this patient population.

7.12 Conclusion

In conclusion, within this thesis the rationale for the mixed method study and the methodology used are described. This is the first study specifically focussing on the perceptions of final year student nurses' therapeutic commitment to people with learning disabilities. The use of the LDPQ as a tool that can generate data and provide

indicators that is useful in the development of a therapeutic relationship between a non-specialist student nurse and a patient with learning disabilities. Further understanding of therapeutic commitment can be explored to support the quantitative findings. The conclusions drawn in this thesis are significant for both practice and education and should improve the delivery of person-centred care to people with learning disabilities in universal health services. Furthermore, developing and using measures that can provide such insights into nursing practice is important in demonstrating effectiveness and identifying areas for improvement.

References

Adshead S, Collier E and Kennedy S (2015) A literature review exploring the preparation of mental health nurses for working with people with learning disability and mental illness Nurse Education in Practice 15 p103-107

Ailey S, Johnston T and Fogg L et al (2015) Factors related to complications among adult patients with intellectual disabilities hospitalized at an academic medical centre Intellectual and Developmental Disabilities 53 p114-119

Aldridge J (2006) The therapeutic relationship In M Jukes and J Aldridge (Eds) Person-centred Practices London: Quay Books

Albery IP, Heutston J, Ward J et al (2003) Measuring therapeutic attitude among drug workers Addictive Behaviours 28 p995-1005

Allison P (2002) Missing Data — Quantitative Applications in the Social Sciences Thousand Oaks: Sage Vol 136

Alborz A, McNally R and Glendinning C (2005) Access to health care for people with learning disabilities in the UK: mapping the issues and reviewing the evidence Journal of Health Services Research and Policy 10 (3) p173-182

Anderson P, Kaner E and Wuzke S (2003) Attitudes and managing alcohol problems in general practice: descriptive analysis based on findings of a World Health Organisation international collaborative study Alcohol and Alcoholism 38 (6) p597-601

Anderson P, Kaner E and Wuzke S (2004) Attitudes and managing alcohol problems in general practice: an interaction analysis based on findings of a World Health Organisation collaborative study Alcohol and Alcoholism 39 (4) p351-356

Angus N, Lauder W and Reynolds W (2001) Further testing of the mental health problems perception questionnaire Journal of Advanced Nursing 33 (5) p628-643

Aronson J (1994) A pragmatic view of thematic analysis The Qualitative Report 2(1) p1-12

Backer C, Chapman M & Mitchell D (2009) Access to secondary healthcare for people with intellectual disabilities: a review of the literature Journal of Applied Research in Intellectual Disabilities 22 p514-525

Balogh R, Brownell M and Ouellette-Kuntz H et al (2010) Hospitalization rates for ambulatory care sensitive conditions for persons with and without an intellectual

disability – a population perspective Journal of Intellectual Disability Research 54 p820-832

Bandura A (2001) Social cognitive theory: an agentic perspective Annual Review of Psychology 52 (1) p1-26

Bandura A (1977) Self-efficacy: toward a unifying theory of behaviour change Psychological Review 84 p192-215

Bandura A and Locke EA (2003) Negative Self-Efficacy and Goal Effects Revisited Journal of Applied Psychology 88 (1) p87–99

Barber C (2015) Caring for People with Learning Disabilities: a Guide for Non-specialist Nurses Banbury: Lantern Publishing

Barksby J (2014) Service users' perceptions of student nurses Nursing Times 110 (19) p23-25

Barker PJ, Jackson S and Stevenson C (1999) What are psychiatric nurses needed for? Developing a theory of essential nursing practice Journal of Psychiatric and Mental Health Nursing 6 (2) p273-282

Baxter P and Boblin S (2007) The moral development of baccalaureate nursing students: understanding unethical behavior in classroom and clinical settings Journal of Nursing Education 46 (1) p20-27

Beacock S, Borthwick R, Kelly J et al (2015) Learning Disabilities: Meeting Education Needs of Nursing Students London: Council of Deans

Beadle-Brown J (2006) Person-centred approaches and quality of life Tizard Learning Disability Review 11 (3) 4-12

Becker C and Pallin R (2001) Person-centred Planning Approaches: a Literature Review Persons with Developmental Disabilities http://www.qamtraining.net/docs/english/PersonCentered%20Planning%20Approaches.pdf (Accessed April 2017)

Bernal (2004) Mind the gaps Learning Disability Practice 7 (7) p30-33

Bernstein DA and Nash PW (2008) Essentials of Psychology 4th edition Boston: Cengage Learning

Biesta G (2010) Pragmatism and the philosophical foundations of mixed methods research In A Tashakkori and C Teddlie (Eds) Handbook of Mixed Methods in Social and Behavioural Research Thousand Oaks: Sage Publications

Binnie A and Titchen A (1999) Freedom to Practise: the Development of Patient-centred Nursing London: Butterworth Heimann

Black LA and Roberts P (2009) People with a learning disability as trainers: evaluation of a values based pilot training programme British Journal of Learning Disabilities 37 p129–137

Blascovich J and Tomaka J (1991) Measures of self-esteem Measures of Personality and Social Psychological Attitudes 1 p115-160

Bollard M, Lahiff J and Parkes N (2012) Involving people with learning disabilities in nurse education: towards an inclusive approach Nurse Education Today 32 p173-177

Bowler M and Nash P (2014) Professional boundaries in learning disability care Nursing Times 110 (21) p12-15

Boyatzis RE (1998) Transforming Qualitative Information: Thematic Analysis and Code Development Thousand Oaks: Sage

Boyton PM and Greenhalgh T (2004) Selecting, designing and developing your questionnaire British Medical Journal 328 (7451) p1312-1315

Bradbury-Jones C, Rattray J and Jones M (2013) Promoting the health, safety and welfare of adults with learning disabilities in acute care settings: a structured literature review Journal of Clinical Nursing 22 p1497-1509

Braun V and Clarke V (2006) Using thematic analysis in psychology Qualitative Research in Psychology 3 p77-101

Braun V and Clarke V (2012) Thematic analysis in H Cooper (Ed) APA Handbook of Research Methods in Psychology Washington: APA Books

Braun V and Clarke V (2013) Successful Qualitative Research London: Sage Publications

Briggs A, Clark T and Wolstenholme J et al (2003) Missing.... presumed at random: cost-analysis of incomplete data Health Economics 12 p377–392

Brown I (2007) What is meant by intellectual and developmental disabilities? In I Brown and M Percy (Eds) A Comprehensive Guide to Intellectual and Developmental Disabilities Baltimore: Paul Brookes

Brown JG (2008) MSc dissertation thesis: Adult Nurses Therapeutic Commitment towards Caring for People with a Learning Disability: Developing the Learning Disability Perception Questionnaire University of Dundee

Brown JG (2009) Concurrent Session: Therapeutic Commitment National Network for Learning Disability Nurses 27th Annual Conference Robinson College Cambridge University on 30th June 2009

Brown JG (2011) Concurrent session: The Challenges Faced by Learning Disabled Clients in General Health Services Florence Nightingale Inaugural Annual Conference Queen Elizabeth II Conference Centre London on 10th March 2011

Brown M, Chouliara Z and McArthur J et al (2016) The perspectives of stakeholders of intellectual disability liaison nurses: a model of compassionate, person-centred care Journal of Clinical Nursing 25 p972-982

Brown M, McArthur J and McKechanie A et al (2010) Equality and access to general health care for people with learning disabilities: reality or rhetoric? Journal of Research in Nursing 15 (4) p351-361

Brown S and Kalaitzidis E (2013) Barriers preventing high-quality nursing care of people with disabilities within acute care settings: a thematic literature review Disability and Society 28 p937-954

Bryman A (2011) Quantitative Data Analysis with IBM SPSS 17, 18, 19 Taylor Francis: London

Bryman A (2012) Social Research Methods 4th Ed Oxford: Oxford University Press

Bryman A (2008) Social Research Methods 3rd Ed Oxford: Oxford University Press

Bulmer Smith K, Profetto-McGrath J and Cummings JJ (2009) Emotional intelligence and nursing: an integrative literature review International Journal of Nursing Studies 46 (12) p1624-1636

Bush, RA and Williams RJ (1988) Generalist health and welfare workers' response to alcohol related problems: role legitimacy and the need for role support, an example from an Australian rural community Drug and Alcohol Dependence 22 p105-111

Caldicott Committee (1997) The Caldicott Report London: Department of Health

Calman L (2006) Patients views of nurses' competence Nurse Education Today 26 p217-725

Campbell M (2007) The importance of good quality services for people with complex health needs British Journal of Learning Disabilities 36 p32-37

Cartlidge D and Read S (2010) Exploring the needs of hospice staff supporting people with an intellectual disability: a UK perspective International Journal of Palliative Care 16 (2) p93-98

Cartwright AK (1980) The attitudes of helping agents towards the alcoholic client: the influence of experience, support training and self-esteem British Journal of Addiction 75 p413-431

Castles A, Bailey C and Gates B et al (2013) Experiences of the implementation of a learning disability nursing liaison service within an acute hospital setting: a service evaluation British Journal of Learning Disabilities 42 p272-281

Catell RB (1966) The scree test for number of factors Multivariate Behavioral Research 1 p245-276

Charmel P (2009) Building the business case for patient-centred care In S Frampton and P Charmel (Eds) Putting Patients First: Best Practices in Patient-centred Care 2nd Ed San Francisco: Jossey-Bass

Chessum C (2006) Interpersonal therapeutic relationships In M Jukes and J Aldridge (Eds) Person-centred Practices London: Quay Books

Chorwwe-Sungani G and Shangase N (2013) Therapeutic commitment of general nurses in dealing with mental health problems of people living with HIV/AIDS in Blantyre, Malawi Malawi Medical Journal 25 (4) p109-112

Clark C, Parker E and Gould T (2005) Rural generalist nurses' perceptions of the effectiveness of their therapeutic interventions for patients with mental illness Australian Journal of Rural Health 13 p205-213

Cooper M, Gambles M and Mason S et al (2014) How confident are nurses that they can provide good care? Learning Disability Practice 17 (2) p34-39

Cooper SA, Hughes-McCormack L and Greenlaw N et al (2017) Management and prevalence of long-term conditions in primary health care for adults with intellectual

disabilities compared with the general population: a population-based cohort study Journal of Applied Research Intellectual Disabilities 00 p1-14

Cooper SA, Henderson A and Jacobs M et al (2016) What are Learning Disabilities? How Common are Learning Disabilities? Scottish Learning Disabilities Observatory https://www.sldo.ac.uk/media/1610/what-are-learning-disabilities-how-common-are-learning-disabilities.pdf (Accessed December 2017)

Cooper SA, McLean G and Guthrie B et al (2015) Multiple physical and mental health comorbidity in adult with intellectual disabilities: population based cross-sectional analysis BMC Family Practice 16:110

Cooper SA, Melville C and Morrison J (2004) People with intellectual disabilities: their health needs differs and need to be recognized and met British Medical Journal 239 p414-415

Cooper SA, Morrison J and Melville C (2007) Improving the health of people with intellectual disabilities: outcomes of a health screening programme after one year Journal of Intellectual Disability Research 50 (9) p667-677

Costello A and Osborne J (2005) Best practices in exploratory factor analysis: four recommendations for getting the most from you analysis Practical Assessment, Research and Education 10 (7) p1-9

Cramm JM and Nieboer AP (2017) Validation of an instrument to assess the delivery of patient-centred care to people with intellectual disabilities as perceived by professionals BMC Health Services Research 17 p472

Creswell JW (2010) Mapping the developing landscape of mixed methods research In A Tashakkori and C Teddlie (Eds) Handbook of Mixed Methods in Social and Behavioral Research Thousand Oaks: Sage Publications

Creswell JW (2009) Research Design: Qualitative, Quantitative and Mixed Methods approaches Thousand Oaks: Sage Publications

Creswell JW and Plano Clark VL (2017) Designing and Conducting Mixed Methods research 3rd Ed Thousand Oaks: Sage Publications

Creswell JW and Plano Clark VL (2011) Designing and Conducting Mixed Methods research 2nd Ed Thousand Oaks: Sage Publications

Creswell JW and Plano Clark VL (2007) Designing and Conducting Mixed Methods research Thousand Oaks: Sage Publications

Critical Appraisal Skills Programme (2018) CASP Qualitative Checklist [online] Available at: https://casp-uk.net/wp-content/uploads/2018/01/CASP-Qualitative-Checklist-2018.pdf (Accessed May 2018)

Crotty G and Doody O (2015) Therapeutic relationships in intellectual disability nursing practice Learning Disability Practice 18 (7) p25-29

Deehan A, Taylor C and Strang J (1997) The general practitioner, the drug misuser, and the alcohol misuser: Major differences in general practitioner activity, therapeutic commitment, and 'shared care' proposals British Journal of General Practice 47 p705–709

Dellinger AB and Leech N L (2007) Toward a unified validation framework in mixed methods research Journal of Mixed Methods Research 1 (4) p309-332

Department of Health (2001) Valuing People: a New Strategy for Learning Disability for the 21st century London: HMSO

Department of Health (2012a) Compassion in Practice: Nursing, Midwifery and Care Staff Our Vision and Strategy https://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf (Accessed November 2017)

Department of Health (2012b) Transforming Care: A National Response to Winterbourne View Hospital: Department of Health Review Final Report https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf (Accessed June 2017)

Department of Health (2009) Valuing People Now: a New Three Years Strategy for People with Learning Disabilities London: HMSO

Department of Health and Social Security (1971) Better Services for the Mentally Handicapped London: HMSO

De Silva D (2014) Helping Measure Person-centred Care: A Review of Evidence about Commonly Used Approaches and Tools Used to Help Measure Person Centred Care London: The Health Foundation

De Vaus DA (2002) Surveys in Social Research 5th Ed Allen and Unwin: Crow's Nest

De Vet H, Terwee C and Mokkink L et al (2011) Measurement in Medicine New York: Cambridge University Press

Dewar B and Christley Y (2013) A critical analysis of compassion in practice Nursing Standard 28 (10) p46-50

Dillman DA, Smyth JD and Christian LM (2009) Internet, Mail and Mixed Mode Surveys: the Tailored Design Method 3rd Ed New Jersey: Wiley

Dinsmore AP (2011) A small scale investigation of hospital experiences among people with a learning disability on Merseyside: speaking with patients and their carers British Journal of Learning Disabilities 40 p201-212

Disability Rights Commission (2006) Equal treatment: Closing the Gap a Formal Investigation into Physical Health Inequalities Experienced by People with Learning Disabilities and Mental Health Problems Stratford upon Avon: Disability Rights Commission

Donner B, Mutter R and Scior K (2010) Mainstream in-patient mental health care for people with intellectual disabilities: service user, carer and provider experiences Journal of Applied Research in Intellectual Disabilities 23 p214-225

Doyle L (2015) Mixed methods In S Henly (Ed) Handbook of Advanced Quantitative Methods in Nursing Research Routledge International: London

Dreyfus HL and Dreyfus SE (1986) Mind over Machine: the Power of Human Intuition and Expertise in the Age of the Computer Oxford: Basil Blackwell

Drozd M and Clinch C (2016) The experiences of orthopaedic and trauma nurses who have cared for adults with a learning disability International Journal of Orthopaedic and Trauma Nursing 22 p13-23

Emerson E, Baines S and Allerton L et al (2011) Health Inequalities and People with Learning Disabilities in the UK Lancaster: Learning Disability Observatory https://www.ndti.org.uk/uploads/files/IHAL_2011_healthinequalityguidance.pdf (Accessed March 2015)

Emerson E and Baines S (2010) Health Inequalities and People with Learning Disabilities in the UK Lancaster: Learning Disabilities Observatory https://pure.strath.ac.uk/portal/files/7402206/vid_7479_IHaL2010_3HealthInequality2010.pdf (Accessed March 2015)

Engward H and Davis G (2015) Being reflexive in qualitative grounded theory: discussion and application of a model of reflexivity Journal of Advanced Nursing 71 (7) p1530-1538

Evardsson D, Sandman P and Rasmussen B (2008) Swedish language person-centred climate questionnaire – patient version: construction and psychometric evaluation Journal of Advanced Nursing 63 p302-309

Fabregues S and Molina-Azorin JF (2017) Addressing quality in mixed methods research: a review and recommendations for a future agenda Quality and Quantity 51 (6) p2847-2863

Fetters MD, Curry LA and Creswell JW (2013) Achieving integration in mixed methods designs – principles and practices Integrating mixed methods research in health services and delivery system research Health Services Research 48 (6) p2134-2156

Fereday J and Muir-Cochrane E (2006) The role of performance feedback in the self-assessment of competence: a research study with nursing clinicians Collegian 13 (1) p10-15

Field A (2009) Discovering Statistics Using SPSS Thousand Oaks: Sage

Finlay L (2002) Negotiating the swamp: the opportunity and challenge of reflexivity in research practice Qualitative Research 2 (2) p209-230

Finlay L and Gough B (2008) Reflexivity: a Practical Guide for Researchers in Health and Social Sciences London: John Wiley & Sons

Flynn S, Hulbert-Williams L and Bramwell R et al (2015) Caring for patients with intellectual disability: attitudes and care perceptions of UK oncology nurses European Journal of Oncology Nursing 19 p568-574

Forchuk C and Reynolds W (2001) Clients' reflections on relationships with nurses: comparisons from Canada and Scotland Journal of Psychiatric and Mental Health Nursing 8 p45-51

Foster T and Hawkins J (2005) The therapeutic relationship: dead or merely impeded by technology? British Journal of Nursing 14 (13) p698-702

Fox D and Wilson D (1999) Parents' experiences of general hospital admission for adults with learning disabilities Journal of Clinical Nursing 8 (5) p610-614

Francis R (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry London: The Stationary Office

Francis R (2010) The Mid Staffordshire NHS Trust Inquiry, Independent Inquiry into the Care Provided by Mid Staffordshire NHS Foundation Trust January 2005-March 2009 London: The Stationary Office

Gaberson KB and Oermann MO (2010) Clinical Teaching Strategies in Nursing 3rd Ed New York: Springer

Gardner MR (2012) Preparing nurses to care for people with developmental disabilities Nursing Clinics of North America 47 p517-527

Gawande A (2014) Being Mortal: Illness, Medicine and What Matters in the End London: Profile Books

Gibbs SM, Brown MJ, and Muir WJ (2008) The experiences of adults with learning disabilities and their carers in general hospitals: a focus group study Journal of Intellectual Disability Research 52 (12) p1061-1077

Gilbert P (2006) Social care services and the social perspective Psychiatry 5 (10) p341-345

Gill F, Stenfert-Kroese B and Rose J (2002) General practitioners' attitudes to patients who have learning disabilities Psychological Medicine 32 p1445-1455

Glasper A (2011) Every nurse needs to know about learning disabilities British Journal of Nursing 20 (8) p514-515

Glover G, Williams R and Heslop P et al (2017) Mortality in people with intellectual disabilities in England Journal of Intellectual Disability Research 61 (1) p62-74

Glover G and Evison F (2013) Hospital Admissions that should not Happen: Admissions for Ambulatory Care Sensitive Conditions for People with Learning Disabilities in England Improving Health and Lives www.improvinghealthandlives.org.uk (Accessed June 2015)

Gorman DM and Cartwright AK (1991) Implications of using the composite and short versions of the Alcohol and Alcohol Problems Perception Questionnaire (AAPPQ) British Journal of Addiction 86 (3) p327-334

Gorsuch RL (1983) Factor Analysis 2nd Ed Lawrence Erlbaum Associates: New Jersey

Grant JS and Davis LL (1997) Selection and use of content experts for instrument development Research in Nursing and Health 20 p269–274

Greene JC (2008) Is mixed methods social inquiry a distinctive methodology? Journal of Mixed Methods Research 2 (1) p7-22

Greene JC (2007) Mixed methods in social inquiry San Francisco: Jossey Bass

Guba EG and Lincoln YS (2005) Paradigmatic controversies, contradictions and emerging confluences In NK Denzin and YS Lincoln (Eds) The Sage Handbook of Qualitative Research Thousand Oaks: Sage Publications

Guba EG and Lincoln YS (1994) Competing paradigms in qualitative research In NK Denzin and YS Lincoln (Eds) Handbook of Qualitative Research Thousand Oaks: Sage Publications

Guest G, Bunce A and Johnson L (2006) How many interviews are enough? An experiment with data saturation and variability Field Methods 18 (1) p59-82

Guetterman TC, Fetters MD and Creswell JC (2015) Integrating quantitative and qualitative results in health science mixed methods research through joint displays Annals of Family Medicine 13 (6) p554-561

Guideline and Audit Implementation Network (GAIN) 2010 Guidelines on Caring for People with a Learning Disability in General Hospital Settings https://rqia.org.uk/RQIA/files/81/81662c46-b7bb-43a5-9496-a7f2d919c2a3.pdf (Accessed December 2017)

Hahn JE (2003) Addressing the need for education: curriculum development for nurses about intellectual and developmental disabilities Nursing Clinics of North America 38 p185-204

Hair JF, Black WC and Babin B et al (2010) Multivariate Data Analysis: a Global Perspective New Jersey: Pearson Prentice Hall

Hair JF, Anderson RE and Tatham RL et al (1995) Multivariate Data Analysis with Readings 4th Ed New Jersey: Prentice Hall

Halcomb E and Andrew S (2009) Mixed Methods Research for Nursing and the Health Sciences Hong Kong: Wiley-Blackwell

Hannon L and Clift J (2011) General Hospital Care for People with Learning Disabilities Chichester: Blackwell Publishing

Hart SL (1998) Learning disabled people's experience of general hospitals British Journal of Nursing 7 (8) p470-477

Hastings RP (2007) A survey of the learning disability service user's view of admission to an acute psychiatric ward The British Journal of Developmental Disability 104 p71-76

Heslop P, Blair P and Fleming P et al (2013) Confidential Inquiry into Premature Deaths of People with Learning Disabilities: Final Report Norah Fry Research Centre: Bristol

Hesse-Biber SN and Johnston RB (2015) The Oxford handbook of multimethod and mixed method research inquiry Oxford: Oxford Press

Hemm C, Dagnan D and Meyer TD (2015) Identifying training needs for mainstream healthcare professionals, to prepare them for working with individuals with intellectual disabilities: a systematic review Journal of Applied Research in Intellectual Disabilities 28 p98-110

Holloway I and Freshwater H (2007) Narrative Research in Nursing Oxford: Blackwell Publishing

Holloway I and Todres L (2003) The status of method: flexibility, consistency and coherence Qualitative Researcher 3 (3) p345-357

Horn JL (1965) A rationale and test for the number of factors in factor analysis Psychometrika 30 p179-185

Howieson J (2015) Experiences of acute hospital services among people with mild to moderate learning disabilities Learning Disability Practice 18 (9) p34-38

Hughes-Mc Cormack L, Rydzewska E and Henderson et al (2017) Prevalence and general health status of people with intellectual disabilities in Scotland: a total population study Journal of Epidemiol Community Health 72 p78-85

Iacono T, Bigby C and Unsworth C et al (2014) A systematic review of hospital experiences of people with learning disabilities BMC Health Services Research 14:505 p1-8

Iacono T and Davis R (2003) The experience of people with developmental disability in emergency departments and hospital wards Research in Developmental Disabilities 24 p247-264

Ingram-Broomfield R (2017) A nurses' guide to ethical consideration and the process for ethical approval of nursing research Australian Journal of Advanced Nursing 35 (1) p40-47

Institute for Medicine (2001) Crossing the Quality Chasm: a New Health System for 21st century Washington: National Academy Press

Jensen D, Kroll B and Groothoff JW et al (2004) People with intellectual disabilities and their health problems: a review of comparative studies Journal of Intellectual Disability Research 41 (5) p409-415

Joffe H and Yardley L (2004) Content and thematic analysis In D Marks and L Yardley (Eds) Research Methods for Clinical and Health Psychology London: Sage

Johnson RB and Onwuegbuzie AJ (2004) Mixed methods research: a research paradigm whose time has come Educational Researcher 33 (7) p14-26

Jones R and Donati M (2009) The therapeutic relationship in psychological therapy for individuals with learning disabilities: a review of existing literature Advances in Mental Health and Learning Disabilities 3 (1) p47-51

Juke M (2006) Person-centredness In M Jukes and J Aldridge (Eds) Person-centred Practices London: Quay Books

Jukes M and Aldridge J (2006) Person Centred Practices: A Therapeutic Perspective Quay Books: London

Kaiser H (1974) An index of factorial simplicity Psychometrika 39 p31-36

Kaiser H (1960) The application of electronic computers to factor analysis Educational and Psychological Measurement 20 p141–151

Kelly J (2007) Barriers to achieving patient-centred care in Ireland Dimensions of Critical Care Nursing 26 (1) p 29-34

King N (2004) Using templates in the thematic analysis of text In C Cassels and G Symon (Eds) Essential Guide to Qualitative Methods in Organizational Research London: Sage

Kirkley C, Bamford C and Poole M et al (2011) The impact of organisational culture on the delivery of person-centred care in services providing respite care and short breaks for people with dementia Health and Social Care in the Community 19 p438-448

Kitwood TM (1997) Dementia Reconsidered: the Person Comes First Bristol: Open University Press

Klooster PM, Dannenberg JW and Taal E et al (2009) Attitudes towards people with physical or intellectual disabilities: nursing students and non-nursing peers Journal of Advanced Nursing 65 (12) p2562-2573

Krippendorff K (2013) Content Analysis: An Introduction to its Methodology 3rd Ed Thousand Oaks: Sage Publications

Krabbe P (2017) The Measurement of Health and Health Status Concepts, Methods and Applications from a Multidisciplinary Perspective Academic Press: London

Krahn GL and Fox MH (2014) Health disparities of adults with intellectual disabilities: what do we know? What do we do? Journal of Applied Research in Intellectual Disabilities 27 p431-446

Kritsotakis G, Galanis P and Papastefaanakis E et al (2017) Attitudes towards people with physical and intellectual disabilities among nursing, social work and medical students Journal of Clinical Nursing 26 p4951-4963

Kwiatek E (2016) Supporting students to care for people with learning disabilities Learning Disability Practice 19 (3) p24-27

Larsson IE, Sahlsten MJ and Segesten K et al (2011) Patients' perceptions of barriers for participation in nursing care Scandinavian Journal of Care Sciences 25 p575-582

Lauder W, Reynolds W and Smith A et al (2002) A comparison of therapeutic commitment, role support, role competency and empathy in three cohorts of nursing students Journal of Psychiatric and Mental Health Nursing 9 p483-491

Lauder W, Reynolds W and Reilly V et al (2000) The development and testing of the mental health problems perception questionnaire Journal of Psychiatric and Mental Health Nursing 7 p221-226

Lauer E and McCallion P (2015) Mortality of people with intellectual and developmental disabilities from select US state disability service systems and medical claims data Journal of Applied Research in Intellectual Disabilities 28 p394–405

Leplege N, Gzil F and Cammelli M et al (2007) Person centredness: conceptual and historical perspectives Disability and Rehabilitation 29 (20) p1555-1565

Lewis P, Gaffney R and Wilson N (2016) A narrative view of acute care nurses' experiences nursing patients with intellectual disability: underprepared, communication barriers and ambiguity about role of caregivers Journal of Clinical Nursing 26 p1473-1484

Lewis S and Stenfert-Kroese B (2010) An investigation of nursing staff attitudes and emotional reactions towards patients with intellectual disability in a general hospital setting Journal of Applied Research in Intellectual Disabilities 23 p355-365

Lindsay P and Hoghton M (2016) Practicalities of Care for Adults with Intellectual and Developmental Disabilities In IL Rubin, J Merrick and DE Greydanus et al (Eds) Health Care for People with Intellectual and Developmental Disabilities across the Lifespan Cham: Springer

Locke EA (1976) The nature and causes of job satisfaction In MD Dunnette (Ed) Handbook of Industrial and Organizational Psychology Chicago: Rand McNally

Long T and Johnson M (2007) Research Ethics in the Real World: Issues and Solutions for Health and Social care London: Churchill Livingstone

Longo S and Scior K (2004) In-patient psychiatric care for individuals with intellectual disabilities: the service users' and carers' perspectives Journal of Mental Health 13 (2) p211-221

Lunsky Y, Tint A and Robinson S et al (2011) Emergency psychiatric service use by individuals with intellectual disabilities living with family Journal of Mental Health Research in Intellectual Disabilities 4 (3) p172-185

Lynn MR (1986) Determination and quantification of content validity Nursing Research 35 p382-385

Malouf N and West S (2010) Fitting in: a pervasive new graduate nurse need Nurse Education Today 31 (5) p488–93

Mansell J (2008) Learning disability policy and practice in the UK Tizard Learning Disability Review 13 (3) p12-14

Mansell J and Beadle-Brown J (2004) Person-centred planning or person-centred action? Policy and practice in intellectual disability services Journal of Applied Intellectual Disabilities 17 p1-9

Marsden D and Giles R (2017) The 4C framework for making reasonable adjustments for people with learning disabilities Nursing Standard 31 (21) p45-53

Marks DF and Yardley L (2011) Research Methods for Clinical and Health Psychology London: Sage Publications

Martin A, Connor-Fenelon M and Lyons R (2012) Non-verbal communication between registered nurses intellectual disability and people with intellectual disability: an exploratory study of the nurse's experience Journal of Intellectual Disabilities 16 (2) p97-108

MacArthur J, Brown M and McKechanie A et al (2015) Making reasonable and achievable adjustments: the contribution of learning disability liaison nurses in 'Getting it right' for people with learning disabilities receiving general hospital care Journal of Advanced Nursing 71 (7) p1552-1563

MacLean RN (2014) The Vale of Leven Hospital Inquiry Report Edinburgh: Scottish Government http://www.valeoflevenhospitalinquiry.org/Report/j156505.pdf (Accessed October 2017)

Maulik PK, Mascarenhas MN and Mathers CD et al (2011) Prevalence of intellectual disability: a meta-analysis of population-based studies Research in Developmental Disabilities 32 (2) p419–436

Mazurenko O, Bock S and Prato C (2015) Considering shared power and responsibility: diabetic patients' experience with PCMH care model Patient Experience Journal 2 (1) p61-67

Meadus RJ (2000) Men in nursing: barriers to recruitment Nurse Forum 35 p5-12

McCance TV et al (2008) Using the caring dimensions inventory as an indicator of person-centred nursing Journal of Clinical Nursing 18 p409-417

McConkey R and Truesdale M (2000) Reactions of nurses and therapists in mainstream health services to contact with people who have learning disabilities Journal of Advanced Nursing 32 (1) p158-163

McCormack B (2004) Person-centredness in gerontological nursing: an overview of the literature Journal of Clinical Nursing 13 p31-38

McCormack B and McCance TV (2017) Person-centred practice in nursing and healthcare London: Wiley-Blackwell

McCormack B and McCance TV (2006) Development of a framework for person-centred nursing Journal of Advanced Nursing 56 (5) p472-479

McCormack B, Borg M and Cardiff S et al (2015) Person-centredness – the state of the art International Practice Development Journal 5 p1-15 Special Edition - September

McCormack B, Dewing J and Breslin L et al (2010) The implementation of a model of person-centred practice in older person settings: final report Dublin: Health Services Executive

McLeod HJ, Deane FP and Hogbin B (2002) Changing staff attitudes and empathy for working with people with psychosis Behavioural and Cognitive Psychotherapy 30 p459-470

Mencap (2012) Death by Indifference: 74 Deaths and Counting London: Mencap

Mencap (2008) Advice for Hospitals and Health Professionals https://www.mencap.org.uk/sites/default/files/201606/Mencap_tips_for_healthcare_professionals.pdf (Accessed November 2017)

Mencap (2007) Death by Indifference England: Mencap

Merrifield J (2011) Meeting the needs of people with a learning disability in the emergency department International Emergency Nursing 19 p146-151

Melville CA, Finlayson J and Cooper SA et al (2005) Enhancing primary health care services for adults with intellectual disabilities Journal of Intellectual Disability Research 49 (3) p190-198

Michael J (2008) Healthcare for All: Report of the Independent Inquiry into Access to Healthcare for People with Learning Disabilities HSMO: London

Mokkink lB, Terwee C, and Patrick D et al (2010) The COSMIN checklist for assessing the methodological quality of studies on measurement properties for health related patient reported outcomes Journal of Clinical Epidemiology 63 p737-745

Moher D, Liberati A, Tetzlaff J, et al (2009) The PRISMA Group - Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement PLoS Medicine 339 (4) p332-339

Moore L, Britten N and Lydahl D et al (2017) Barriers and facilitators to the implementation of person-centred care in different healthcare contexts Scandinavian Journal of Caring 31 p662-673

Morse JM and Niehaus L (2009) Mixed Methods Design: Principles and Procedures Walnut Creek: Left Coast Press

Moule P and Goodman M (2014) Nursing research: an introduction 2nd Ed Sage Publications: London

Moulster G, Ames S and Griffiths T (2012) A new learning disability nursing framework Learning Disability Practice 15 (6) p14-18

Murphy F, Rosser M, Bevan R et al (2012) Nursing students' experiences and preferences regarding hospital and community placements Nurse Education in Practice 12 p170-175

Nastasi K, Hitchcock B and Brown JH (2010) An inclusive framework for conceptualizing mixed methods design typologies: moving toward fully integrated synergistic research models In A Tashakkori and C Teddlie (Eds) Handbook of Mixed Methods in Social and Behavioural Research Thousand Oaks: Sage Publications

National Assembly for Wales (2014) Social Services and Well-being (Wales) Act http://www.legislation.gov.uk/anaw/2014/4/contents/enacted (Accessed April 2017)

National Institute for Health and Care Excellence NICE (2017) Mental Health Problems in People with Learning Disabilities Overview https://pathways.nice.org.uk/pathways/mental-health-problems-in-people-with-learning-disabilities (Accessed November 2017)

National Patient Safety Agency (2004) Understanding the Patient Safety Issues for People with Learning Disabilities London: NSPA

Newman I, Lim J and Pineda F (2013) Content validity using a mixed methods approach: its application and development through the use of a table of specifications methodology Journal of Mixed Methods Research 7 (3) p243-260

NHS Education for Scotland (2012) Ten Shared Essential Capabilities Supporting Person Centred-care Approaches: a Learning Resource for all Healthcare Staff

http://www.nes.scot.nhs.uk/education-and-training/by-theme-initiative/mental-health-and-learning-disabilities/publications-and-resources/publications-repository/10-

essential-shared-capabilties-supporting-person-centred-approaches.aspx (Accessed June 2017)

NHS Scotland (2004) Health Needs Assessment Report: People with Learning Disabilities in Scotland Edinburgh: The Stationary Office

Niewiadomy R and Bailey C (2017) Foundations of Nursing Research 7th Ed New York: Pearson

Nilsson A, Rasmussen B and Evardsson D (2013) Falling behind: a substantive theory of care for older people with cognitive impairment in acute settings Journal of Clinical Nursing 22 p1682-1691

Nolan M, Davies S and Brown J et al (2004) Beyond person centred care: a new vision for gerontological nursing International Journal of Older People Nursing 13 p45-53

Northway R (2017) Perspectives: the health of people with intellectual disabilities: realising the future potential of all nurses and nursing to reduce health disparities Journal of Research in Nursing 22 (8) p637-640

Northway R, Rees S and Davies M et al (2017) Hospital passports, patient safety and person-centred care: a review of documents currently used for people with intellectual disabilities in the UK Journal of Clinical Nursing 26 p5150-5168

Nunkossing K (2011) The social construction of learning disability In HL Atherton and DJ Crickmore (Eds) Learning Disabilities - Towards Inclusion Churchill Livingstone: London

Nunnally J (1978) Psychometric Theory 2nd Ed New York: McGraw-Hill

Nunnally JC and Bernstein IH (1994) Psychometric Theory 3rd Ed New York: McGraw-Hill

Nursing and Midwifery Council (2017a) Standards to for Proficiency for Registered Nurses London: NMC

Nursing and Midwifery Council (2017b) Requirements for Pre-registration Nursing Programmes London: NMC

Nursing and Midwifery Council (2015) Standards to Support Learning and Assessment in Practice London: NMC

Nursing and Midwifery Council (2010) Standards for Pre-registration Education London: NMC

Nursing and Midwifery Council (2008) Standards for Competence for Registered Nurses London: NMC

O'Cathain A (2010) Assessing the quality of mixed methods research: towards a comprehensive framework In A Tashakkori and C Teddlie (Eds) Handbook of Mixed Methods in Social and Behavioral research 2nd Ed Thousand Oaks: Sage

O'Cathain A, Murphy E and Nicholl J (2008) The quality of mixed methods studies in health services research Journal of Health Services Research and Policy 13 (2) p92-98

Onwuegbuzie AJ and Combs JP (2010) Emergent data analysis techniques in mixed methods research: a synthesis In A Tashakkori and C Teddlie (Eds) Handbook of Mixed Methods in Social and Behavioral research 2nd Ed Thousand Oaks, CA: Sage

Onwuegbuzie, AJ and Teddlie C (2003) A framework for analysing data in mixed methods research In A Tashakkori and C Teddlie (Eds) Handbook of Mixed Methods in Social and Behavioral Research Thousand Oaks: Sage Publication

Onwuegbuzie AJ and Leech NL (2005) On becoming a pragmatic researcher: the importance of combining quantitative and qualitative research methodologies International Journal of Social Research Methodology 8 (5) p375-389

Oppenheim AN (1992) Questionnaire Design, Interviewing and Attitude Measurement London: Pinter Publishers

Ouellette-Kuntz H, Garcin N and Lewis ME et al (2005) Addressing health disparities through promoting equity for individuals with intellectual disability Canadian Journal of Public Health 96 (2) p8-22

Pallant J (2010) SPSS Survival Manual Maidenhead: Open University Press

Parahoo K (2014) Nursing Research: Principles, Processes and Issues 3rd Ed United Kingdom: Palgrave McMillian

Parahoo K (2006) Nursing Research: Principles, Process and Issues Basingstoke: Palgrave Macmillian

Parliamentary and Health Service Ombudsman and Local Government Ombudsman (2009) Six Lives London: HMSO

Parkes C, Samuels S and Hassiotis A et al (2007) Incorporating the views of service users in the development of an integrated psychiatric service for people with learning disabilities Journal of Learning Disabilities 35 p23-29

Patton MQ (2002) Qualitative and Evaluation Research Methods 3rd Ed Thousand Oaks: Sage Publications

Patton MQ (1999) Enhancing the quality and credibility of qualitative analysis HSR: Health Services Research 34 (5) p1189-1208

Pedhazur EJ and Schmelkin LP (1991) Measurement, Design and Analysis: an Integrated Approach New Jersey: Lawrence Erlbaum Associates

Pelleboer-Gunnink WM, Van Oorsouw J and Van Weeghel J et al (2017) Mainstream health professionals' stigmatising attitudes towards people with intellectual disabilities: a systematic review Journal of Intellectual Disability Research 61 (5) p411-434

Pett MA, Lackey NR and Sullivan JJ (2003) Making Sense of Factor Analysis Thousand Oaks: Sage

Pirhonen L, Olofsson EH and Fors A et al (2017) Effects of person-centred care on health outcomes: a randomised controlled trial in patients with acute coronary syndrome Health Policy 121 (2) p169-179

Plano Clark V and Ivankova N (2016) What is the core of mixed methods research practice: introducing the mixed methods research process Mixed Methods Research: A Guide to the Field Thousand Oaks: Sage Publications

Plano Clark VL and Badiee M (2010) Research questions in mixed methods research In A Tashakkori and C Teddlie (Eds) Handbook of Mixed Methods Research 2nd Ed Thousand Oaks: Sage

Polit DF (2015) Assessing measurement in health: beyond reliability and validity International Journal of Nursing Studies 52 (11) p1746-1753

Polit DF, Beck CT and Owen SV (2007) Is the CVI an acceptable indicator of content validity? Appraisal and recommendations Research in Nursing and Health 30 p459–467

Polit DF and Yang FM (2016) Measurement and the Measurement of Change: A Primer for the Health Professions Wolters Kluwer, Philadelphia

Prater L and McEwen M (2006) Called to nursing perceptions of student nurses Journal of Holistic Nursing 24 (1) p63-69

Press Z and Richards D (2015) The power of patient ownership: the path from engagement to equity Patient Experience Journal 2 (1) p15-17

Price B (2015) Understanding attitudes and their effects on nursing practice Nursing Standard 30 (15) p50-57

Price SL (2009) Becoming a nurse: a meta-study of early professional socialisation and career choice in nursing Journal of Advanced Nursing 65 (1) p11-19

Public Health England (2017) Reasonable Adjustments a Legal Duty https://www.gov.uk/government/publications/reasonable-adjustments-for-people-with-learning-disabilities/reasonable-adjustments-a-legal-duty#contents (Accessed November 2017)

Public Health Wales (2014) Improving General Hospital Care of Patients who have a Learning Disability http://www.1000livesplus.wales.nhs.uk/sitesplus/documents/1011/How%20to%20%2822%29%20Learning%20Disabilites%20Care%20Bundle%20web.pdf (Accessed June 2016)

Quality Improvement Scotland (2004) Quality Indicators for Learning Disabilities Edinburgh: NHS Quality Improvement Scotland

Quality Improvement Scotland (2006) Promoting Access to Healthcare for People with a Learning Disability – a Guide for Frontline Staff Edinburgh: NHS Quality Improvement Scotland

Quality Improvement Scotland (2009) Tackling Indifference – National Overview Report Edinburgh: NHS Quality Improvement Scotland

Quinn F and Hughes S (2013) Quinn's Principles and Practice of Nurse Education 6th Ed Singapore: Cengage Learning

Race P (2001) The Lecturer's Toolkit: Practical Guide to Learning, Teaching and Assessment 2nd Ed Oxon: Routledge Falmer

Ratti V, Hassiotis A and Crabtree J et al (2016) The effectiveness of person-centred planning for people with intellectual disabilities: a systematic review Research in Developmental Disabilities 57 p63-84

Registered Nurses Association of Ontario (2006) Establishing Therapeutic Relationships Nursing - Best Practice Guideline http://rnao.ca/bpg/guidelines/establishing-therapeutic-relationships (Accessed May 2012)

Reichardt CS and Rallis SF (1994) The Qualitative-Quantitative Debate: New Perspectives Jossey-Bass: San Francisco

Reinders H (2010) The importance of tacit knowledge in practice of care Journal of Intellectual Disability Research 54 (1) p28-37

Rice P and Ezzy D (1999) Qualitative Research Methods: a Health Focus Melbourne: Oxford University Press

Roberston J, Emerson E and Hatton C et al (2007) Person-centred planning: factors associated with successful outcomes for people with intellectual disabilities Journal of Intellectual Disability Research 51 (3) p232-243

Robson C (2002) Real World Research Oxford: Blackwell Publishing

Roche M, Duffield C and White E (2011) Factors in the practice environment of nurses working in inpatient mental health: a partial least squares path modelling approach International Journal of Nursing Studies 48 p1475-1486

Rogers, Carl (1961) On Becoming a Person: A Therapist's View of Psychotherapy London: Constable

Rogers CR (1957) The necessary and sufficient conditions of therapeutic personality change Journal of Consulting Psychology 21 p95-103

Rodgers CR (1951) Client-centered Therapy: Its Current Practice, Implications and Theory Boston: Houghton Mifflin Harcourt

Rognstad M, Norverdt P and Aasland O (2004) Helping motives in late modern society: values and attitudes among nursing students Nursing Ethics 11 (3) p227-239

Rolfe G (2006) Validity, trustworthiness and rigour: quality and the idea of qualitative research Journal of Advanced Nursing 53 (3) p304-310

Rose N, Kent S and Rose J (2012) Health professionals' attitudes and emotions towards working with adults with intellectual disability and mental ill health Journal of Intellectual Disability Research 56 (9) p854-864

Royal College of Nursing (RCN) (2010) The Principles of Nursing Practice https://www.rcn.org.uk/professional-development/principles-of-nursing-practice (Accessed June 2016)

Ryan K, Guerin S and McEnvoy J (2016) The nature and importance of quality of therapeutic relationships in the delivery of palliative care to people with intellectual disabilities BMJ Supportive and Palliative Care 6 p430-436

Sanelowski M (2010) Re-embodying qualitative enquiry In P Atkinson and S Delemont (Eds) Sage Qualitative Research Methods Sage: Thousand Oaks

Saldana J (2015) The Coding Manual for Qualitative Researchers Thousand Oaks: Sage Publications

Sarantakos S (2005) Social Research 2nd Ed Hampshire: Palgrave Macmillian

Scheepers KM, O'Hara D and Bainbridge D (2005) Reducing health disparity in people with intellectual disabilities: a report from health issues special interest research group of the International Association for the Scientific Study of Intellectual Disabilities Journal of Policy and Practice in Intellectual Disabilities 2 p249–255

Scholl JC (2007) The use of humor to promote patient-centered Care Journal of Applied Communication Research 35 (2) p156-176

Schoonenboom J and Johnson RB (2017) How to construct a mixed methods research design Cologne Journal of Sociology and Social Psychology 69 (7) p107-131

Schuengel C, Kef S and Damen S (2010) People who need people: attachment and professional care giving Journal of Intellectual Disability Research 54 p38-47

Schwandt T (2001) Dictionary of Qualitative Inquiry Thousand Oaks: Sage Publications

Scior K (2011) Public awareness, attitudes and beliefs regarding intellectual disability: a systematic review Research in Developmental Disabilities 32 p2164-2182

Scior K, Connolly T and Williams J (2013) The effects of symptom recognition and diagnostic labels on public beliefs, emotional reactions, and stigmas associated with intellectual disability American Journal of Intellectual and Developmental Disabilities 118 (3) p211–223

Scottish Consortium for Learning Disabilities (2017) Learning Disability Statistics Scotland https://www.scld.org.uk/wp-content/uploads/2017/12/2017-Learning-Disability-Statistics-Scotland-3.pdf (Accessed December 2017)

Scottish Executive (2000) The same as you? A review of services for people with learning disabilities Edinburgh: The Stationary Office

Scottish Executive (2002) Promoting health, supporting inclusion: the national review of the contribution of all nurses and midwives to the care and support of people with learning disabilities Edinburgh: The Stationary Office

Scottish Government (2017) Nursing Vision 2030: Promoting Confident, Competent and Collaborative Nursing for Scotland's Future Edinburgh: The Stationery Office

Scottish Government (2013) Keys to Life: Improving Quality of Life for People with Learning Disabilities http://www.gov.scot/Resource/0042/00424389.pdf (Accessed on August 2014)

Scottish Government (2012) Strengthening the Commitment: the Report of the UK Modernising Learning Disabilities Nursing Review Edinburgh: The Stationery Office

Scottish Government (2011) The Patient Rights (Scotland) Act 2011

http://www.legislation.gov.uk/asp/2011/5/contents (Accessed June 2017)

Scottish Government (2010a) The Healthcare Quality Strategy for Scotland Edinburgh: The Stationery Office

Scottish Government (2010b) Caring Together: the Carers Strategy for Scotland

http://www.gov.scot/Resource/Doc/319441/0102104.pdf (Accessed June 2017)

Scottish Government (2008) Equally Well: Report of the Ministerial Task Force on Health Inequalities Edinburgh: The Stationery Office

Shaw S, Cartwright A and Spratley T et al (1978) Responding to drinking problems London: Croom-Helm

Sidani S and Fox M (2014) Patient-centered care: clarification of its specific elements to facilitate interprofessional care Journal of Interprofessional Care 28 p134–141

Sinclair S, Morris JM and McConnell et al (2016) Compassion: a scoping review of the healthcare literature BMC Palliative Care 15:6

Skills for Health (2016) Learning Disabilities Core Skills Education and Training Framework http://www.skillsforhealth.org.uk/images/resource-section/projects/learning-disabilities/Learning-Disabilities-CSTF.pdf (Accessed December 2017)

Slater L (2006) Person-centredness: a concept analysis Contemporary Nurse 23 (1) p135-144

Slater S, McCance T and McCormack B (2017) The development and testing of the person-centred practice inventory-staff (PCPI-S) International Journal of Quality in Health Care 29 (4) p541-547

Slevin E (1995) Student nurses attitudes towards people with learning disabilities British Journal of Nursing 4 (13) p761-766

Slevin E and Sines D (1996) Attitudes of nurses in a general hospital towards people with learning disabilities: influences of contact, and graduate, non – graduate status, a comparative study Journal of Advanced Nursing 24 (6) p1116-1126

Smith P, Ooms A and Marks-Maran D (2016) Active involvement of learning disabilities service users in the development and delivery of a teaching session to pre-registration nurses: students' perspectives Nurse Education in Practice 16 p111-118

Sowney M and Barr OG (2007) The challenges for nurses communicating with and gaining valid consent from adults with intellectual disabilities within the accident and emergency care service Journal of Clinical Nursing 16 p1678-1686

Sowney M and Barr OG (2006) Caring for adults with intellectual disabilities: perceived challenges for nurses in accident and emergency units Journal of Advanced Nursing 55 (1) p36-45

Spinks J (2015) Hugh variation in adult nurses' learning disability training Learning Disability Practice 18 (1) p8-11

Stacey G, Stickely T and Diamond B (2011) How do nurses cope when values and practice conflict? Nursing Times 107 (5) p20-23

Stevens J (1996) Applied multivariate statistics for the social sciences 3rd Ed Boston: Houghton Mifflin

Stone S (2008) A retrospective evaluation of the impact of the Planetree patient-centred model of care on inpatient quality outcomes Health Environments Research and Design Journal 1 (4) p55-69

Straetmans JM, van Schrojenstein Lantman-De Valk HM and Schellevis FG et al (2007) Health problems of people with intellectual disabilities: impact for general practice British Journal of General Practice 57 p64-66

Streiner DL, Norman GR and Cairney J (2015) Health Measurement Scales: a Practical Guide to their Development and Use 5th Ed Oxford: Oxford University Press

Streiner DL and Norman GR (2008) Health Measurement Scales: a Practical Guide to their Development and Use 4th Ed Oxford: Oxford University Press

Strauss ME and Smith GT (2009) Construct validity: advances in theory and methodology Annual Review of Clinical Psychology 5 p1–25

Stump GS, Husman J and Brem SK (2012) The nursing student self-efficacy scale: development using item response theory Nursing Research 61 (3) p149–58

Sutton C (2011) Social surveys: design to analysis In T May (Ed) Social Research Maidenhead: Open University Press

Sutton C (2004) Social surveys: design to analysis In D Matthew and C Sutton (Eds) Social Research: the Basics London: Sage

Szablowski JJ (2017) Learning disabilities and mental health: families' experiences of hospitalisation Learning Disability Practice 20 (4) p26-29

Tabachnick BG and Fidell LS (2007) Using Multivariate Statistics 5th Ed New York: HarperCollins

Tabachnick BG and Fidell LS (2001) Using Multivariate Statistics 4th Ed Boston: Allyn & Bacon

Tashakkori A and Teddlie C (2008) Quality of inferences in mixed methods research: calling for an integrative framework In MM Bergman (Ed) Advances in Mixed Methods Research: Theories and Applications London: Sage Publications

Tashakkori A and Teddlie C (2003) Handbook of Mixed Methods in Social and Behavioural Research Thousand Oaks: Sage Publications

Tatano-Beck C (1997) Humor in nursing practice: a phenomenological study International Journal of Nursing Studies 34 (5) p346-352

Tatano-Beck C and Harrison L (2016) Mixed-Methods Research in the Discipline of Nursing Advances in Nursing Science 39 (3) p224–234

Taua C, Neville C and Scott T (2017) Appreciating the work of nurses caring for adults with intellectual disability and mental health International Journal of Mental Health 26 p629-638

Teddlie C and Tashakkori A (2009) Foundations of Mixed Methods Research Thousand Oaks: Sage Publications

Temple B and Mordoch E (2012) Nursing student perceptions of disability and preparation to care for people with intellectual disabilities Journal of Nursing Education 51 (7) p407-410

Terwee CB, Bot SD and de Boer MR (2007) Quality criteria were proposed for measurement properties of health status questionnaires Journal of Clinical Epidemiology 60 (1) p34-42

Toode K, Routasalo P and Suominen T (2011) Work motivation of nurses: a literature review International Journal of Nursing Studies 48 p246-257

Tracy J and Iacono T (2008) People with developmental disabilities teaching medical students: does it make a difference? Journal of Intellectual and Developmental Disabilities 33 p345-348

Trollor JN, Eagleson C and Turner B et al (2016) Intellectual disability health content within nursing curriculum: an audit of what our future nurses are taught Nurse Education Today 45 p72-79

Tuffery-Wijne I, Abraham E and Goulding L et al (2016) Role confusion as a barrier to effective carer involvement for people with intellectual disabilities in acute hospitals: findings from a mixed methods study Journal of Advanced Nursing 72 (11) p2907-2922

Tuffery-Wijne I, Goulding L and Gordon V et al (2014) The challenges in monitoring and preventing patient safety incidents for people with intellectual disabilities in NHS acute hospital: evidence for a mixed methods study BMC Health Services Research 14:432

United Kingdom Parliament (2011) Equality Act: Public Sector Equality Duty London: HMSO

United Kingdom Parliament (1990) National Health Service and Community Care Act London: HMSO

United Kingdom Strengthening the Commitment Steering Group (2015) Strengthening the commitment: living the commitment Edinburgh: Scottish Government

Vaismoradi M, Turunrn H and Bondas T (2013) Content analysis and thematic analysis: implications for conducting a qualitative descriptive study Nursing and Health Sciences 15 p398-405

van de Mortel TF (2008) Faking it: social desirability response bias in self-report research Australian Journal of Advanced Nursing 25 (4) p40-48

van der Meer l, Nieboer AP and Finkenflugel H (2017) The importance of person-centred care and co-creation of care for the well-being and job satisfaction of professional working with people with learning disabilities Scandinavian Journal of Caring Sciences http://onlinelibrary.wiley.com/doi/10.1111/scs.12431/full (Accessed November 2017)

von Elm E, Altman DG and Egger M et al (2007) STROBE Initiative. The Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) statement: guidelines for reporting observational studies. Lancet 370 (9596) p1453-1457

Warne T, Johansson U, Papastavrou E et al (2010) An exploration of the clinical learning experience of nursing students in nine European countries Nurse Education Today 30 p809-815

Watson H, McLaren W and Kerr S (2006) Staff attitudes towards working with drug users: development of the drug problems perceptions questionnaire Addiction 102 (2) p206-215

Watt G and Brittle R (2008) The influence of attachment on relationships in caring for people with learning disability Learning Disability Practice 11 (2) p16-19

Webber R, Bowers B and Bigby C (2010) Hospital experiences of older people with intellectual disability: responses of group home staff and family members Journal of Intellectual and Developmental Disability 35 (3) p155-164

Werner S and Abergel M (2017) What's in a label? The stigmatizing effect of intellectual disability by any other name Stigma and Health http://dx.doi.org/10.1037/sah0000108 (Accessed October 2017)

Werner S and Grayzman A (2011) Factors influencing the intention of students to work with individuals with intellectual disabilities Research in Developmental Disabilities 32 p2502-2510

Welsh Assembly (2001) Fulfilling the Promises: Proposals for a Framework for Services for People with Learning Disabilities Cardiff: Welsh Assembly

While AE and Clark LL (2014) Development of a competency toll for adult trained nurses caring for people with intellectual disabilities Journal of Nursing Management 22 p803-810

White E and Clark L (2014) Development of a competency tool for adult trained nurses caring for people with intellectual disabilities Journal of Nursing Management 22, p803-810

Wilkinson J, Dreyfus D and Bowen D (2013) Patient and provider views on the use of medical services by women with intellectual disabilities Journal of Intellectual Disability Research 57 p1058–1067

Willis Commission (2012) Quality with compassion: the future of nursing education Royal College of Nursing

World Health Organisation (2007) International classification of diseases-10 http://www.who.int/classifications/apps/icd/icd10online/ (Accessed April 2017)

Yardley L (2008) Demonstrating validity in qualitative psychology In JA Smith (Ed) Qualitative psychology: a practical guide to research methods London: Sage Publications

Yong AG and Pearce S (2013) A beginner's guide to factor analysis: focusing on exploratory factor analysis Tutorials in quantitative methods for psychology 9 (2) p79-94

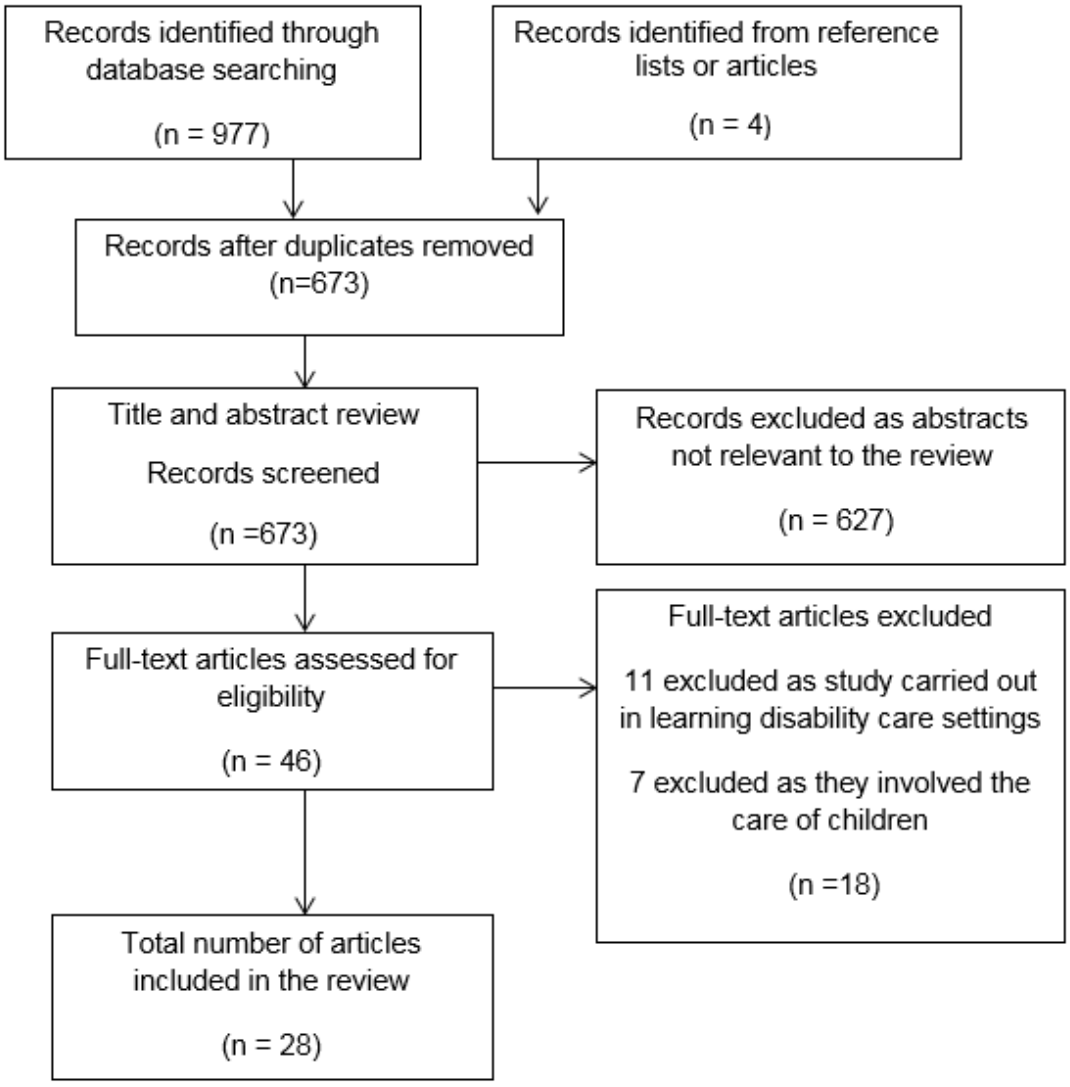
Appendix 1

Example of search strategy used in CINAHL

Search no.	Specific term	No. of results
1	learning disabilities	8954
2	intellectual disabilities	23200
3	mental retardation	12862
4	developmental disabilities	14836
5	mental handicap	4959
6	1 OR 2 OR 3 OR 4 OR 5	46676
7	nurses	826525
8	therapeutic relationship	13017
9	engagement	135900
10	therapeutic commitment	101
11	caring relationship	1412
12	care experience	6300
13	nursing care	17170
14	attitudes	1179212
15	8 OR 9 OR 10 OR 11 OR 12 OR 13 OR 14	3595375
16	6 AND 7 AND 15	470

Appendix 2

Search strategy



Appendix 3

Ethical Approval Process

In April 2012, contact was made with the Head of School within each university to gain their permission to have their university and students involved in the research, enquire about their School's ethics approval processes, as well as establishing a link person to assist with data collection. Each Head of School or nominated person responded in agreement with the requested information. Two universities ethics committees were satisfied to receive confirmation of ethical approval from the University of Stirling ethics committee, however one university requested full submission to their panel.

The full ethical approval process was embarked upon through University of Stirling School of Nursing, Midwifery and Health Research Ethics Committee (SREC) by the submission of School Ethics Research Committee application form, research protocol and supporting documents. At the same time approval was also sought from Robert Gordon University (RGU) School of Nursing and Midwifery School Ethics Review Panel.

The SREC responded first and amendments were advised as they expressed confusion about the proposed recruitment process. The research protocol and information sheet was amended with a more detailed process, replacing the introduction letter with a verbal explanation of the study by the researcher prior to data collection. Additionally, an electronic poster providing information that would be published on each universities student e-noticeboard was included which led to approval being granted. The letter of approval from the SREC along with the amended research protocol and supporting documents were shared with other three universities ethics committees for information and approval.

RGU School Ethics Review Panel then gave their outcome and the proposal was approved subject to several amendments. The first request was for clarity on the data collection process similar to SREC, the amendments to the protocol submitted to SREC responded to this. The second concern was in relation to the role of the personal tutor if students required further support. It was agreed that personal tutors would be briefed on the research prior to the period of data collection. The third area of concern related to my role as a researcher/clinical doctorate student and my employment as a Consultant Nurse for NHS Grampian and Associate Lecturer with RGU, therefore additional information was added to the information sheet to inform the participants of my occupation and to inform participants that their involvement with the

study would not have any effect on the future academic or clinical journey as a student or registered nurse. The final area questioned by RGU was why I was seeking to know which university the student attended. It was explained that I intended to draw comparisons between the levels of therapeutic commitment shown by adult and mental health student nurses from universities that delivered the learning disability nursing programme and those who did not. These amendments and rationales were accepted and ethical approval granted. The amendments required to meet approval at the RGU ethics panel then were shared with the other three Ethics Committees to ensure they were satisfied with the changes. Approval was granted from Glasgow Caledonian University (GCU) without any amendments.

Edinburgh Napier University Faculty of Health and Life Sciences Ethics Committee then responded requesting that I gain consent from each participant as this was a requirement of approval of any study within their university. Throughout the ethics process I had considered the reading of the participant information sheet and completion of the questionnaire as implied consent. I discussed this with my supervisors and agreed since ENU were one of the two universities in Scotland who deliver undergraduate learning disability nursing programme, the risk of not being able to recruit learning disability student nurses was too great. Therefore amendments were made to the study protocol, participant information and a consent form was introduced. Completing a consent form may have altered the dimension of anonymity I had planned to have in the study, as a result of this other measures were put in place to achieve anonymity. For example, the consent form and questionnaire were different documents with the same index number entered on both. These were kept separately and securely with little requirement to access the consent form holding the participant's name. Also, this information was only used for the purpose of consent and did not feature in the data set in any way. Again, these changes had then to be communicated to the other three universities ethics committees, who accepted them. Annual progress reports were provided to the University of Stirling.

JP/SG

21 June 2012

June Brown
62 St. Ternans Road
Newtonhill
Stonehaven
Kincardineshire
AB39 3PF

UNIVERSITY OF STIRLING

SCHOOL OF
NURSING, MIDWIFERY
AND HEALTH

Email: nursingmidwifery@stir.ac.uk
Web: www.nm.stir.ac.uk

John Paley
Chair
School Research Ethics Committee

School of Nursing, Midwifery and Health
University of Stirling
Stirling FK9 4LA

Tel: +44 (0) 1786 466366
Fax: +44 (0) 1786 466333
Email: john.paley@stir.ac.uk

Dear June

Exploring therapeutic commitment towards people with learning disabilities: the perceptions of final year student nurses

Thank you for submitting your application, which was reviewed at the meeting on 13 June 2012 and also for submitting an amended proposal on 19 June 2012

I can now confirm the study has now been approved.

May I take this opportunity of reminding you that a site-file of *all* documents related to the research should be maintained throughout the life of the project, and kept up to date at all times. The site file template can be found on the SREC page of the School's website. Please bear in mind that your study could be audited for adherence to research governance and research ethics protocols.

Best Wishes

John Paley
(Chair)
School of Nursing, Midwifery and Health Research Ethics Committee

Appendix 4

Email Heading - Calling all (adult, mental health and learning disability) final year student nurses!!

Dear Student Nurses,

I am currently doing the Doctor of Nursing programme at University of Stirling and I am looking to recruit final year adult and mental health and learning disability student nurses for my study.

I would like to invite you to take part in a research study to look at student nurse's perceptions of working with patients who have a learning disability.

- The study is aimed at all adult, mental health and learning disability student nurses in their final year of nurse education.
- The questionnaire will take approximately 15 minutes to complete and may support you to reflect on your practice with people who have learning disabilities.
- I will attend one of your classes on the 9th of October to hand out the questionnaires.
- Please read the information sheet attached to this email
- If you want more information, contact June Brown, j.g.brown@stir.ac.uk.

Thank you

June Brown

Appendix 5

UNIVERSITY OF STIRLING

PARTICIPANT INFORMATION SHEET

Study Title: *Final year pre-registration student nurses perceptions of working with patients who have a learning disability*

You are invited to take part in a research study. The researcher will attend one of your classes in the next week to give you an opportunity to take part and hand out the questionnaire. Before you take part, it is important for you to understand why the research is being done and what it will involve.

Please take time to read the following information carefully and discuss it with others if you wish. Ask if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

The aim of this study is to measure the level of therapeutic commitment shown by final year student nurses when working with patients who have a learning disability. Therapeutic commitment is the positive attitude towards working with patients who have a learning disability.

Why have I been chosen?

The study requires having participants who are final year student nurses from the fields of adult, mental health and learning disabilities who are studying in a Scottish University. Also, you will have worked in a clinical environment where a person with a learning disability may have accessed care.

Do I have to take part?

No. Participation is entirely voluntary. If you do wish to participate, you will be given this information sheet to keep and be asked to complete a consent form then a short questionnaire.

If you do not wish to take part it would be helpful if you could return the questionnaire uncompleted.

What will happen if I take part in the study?

If you wish to take part in the study you need to read this information sheet and be satisfied that you have a clear understanding of its contents. Then you complete a consent form and a questionnaire then return them both to the researcher on the day they attend your university within the next week. The questionnaire will ask you demographic questions as well as questions regarding your views about providing care for people with learning disabilities. Your involvement with this study will have no

detrimental effect on your future academic or clinical journey as a student or registered nurse.

What are the benefits of taking part?

The benefits of the study are that areas of good practice may be highlighted and there is an opportunity for you to reflect on your current practice and future learning needs.

Will my taking part in this study be kept confidential?

All information that is collected from you during this survey will be kept strictly confidential and anonymous. Questionnaire data will be securely stored under lock and key and will be destroyed after five years.

What will happen to the results of the research study?

The results of this study will be used as part of a Doctor of Nursing thesis and will also be presented at conferences and published in academic journals. The anonymity of all respondents will be guaranteed.

A summary of the findings will be made available in July 2014, which you will be able to access via the Learning Disability webpage, Keeping Up to Date section on the Learning Disability MKN portal, access at http://www.knowledge.scot.nhs.uk/home/portals-and-topics/learning-disabilities-portal.aspx.

Who has approved this study?

The University of Stirling Research Ethics Committee has approved this study and the University where you are currently studying has given permission for this study to take place. Following this your local university has considered the ethical approval and given permission for the study to take place.

Contact Details

If you need further information or wish to discuss any aspect of the study please contact June Brown who is the researcher for this study and also a Consultant Nurse in Learning Disabilities who supports student nurse education –

June Brown, Unit 12 & 13, The Green, Berrymuir Road, Portlethen, Aberdeen. AB12 4UN. Tel. no. – 01224 785083. Email – j.g.brown@stir.ac.uk

If you require contacting the University of Stirling concerning this study, please contact the Clinical Doctorate Programme Leader –

Dr Kathleen M Stoddart, Clinical Doctorate Programme Director

Department of Nursing and Midwifery (Room 3S6), University of Stirling,

Stirling, FK9 4LA

Tel. No - 01786 466395

Email – k.m.stoddart@stir.ac.uk

Thank you for taking part in this study.

UNIVERSITY OF STIRLING

Centre Number:
Study Number:
Participant Identification Number for this study:

CONSENT FORM

TITLE : *Final year pre-registration student nurses perceptions of working with patients who have a learning disability*

Name of researcher: **June Brown**

Please initial box

1. I confirm I have read and understood the information sheet dated June 2012 (version 3) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my legal rights being affected. ☐
3. I agree to take part in the above study. ☐
4. I understand that all data will remain confidential to the research team. ☐

_____	_____	_____
Name of Participant	Date	Signature of Participant

_____	_____	_____
Name of person taking consent	Date	Signature

Contact details of the researcher: Unit 12 & 13, The Green, Berrymuir Road, Portlethen, Aberdeen. AB12 4UN.

Tel. no. – 01224 785083. Email – **j.g.brown@stir.ac.uk**

Appendix 6

Initial alterations made to questionnaire statements

Statement	MHPPQ	LDPQ	Rationale for alteration
1	I feel I know enough about the factors which put people at risk of mental health problems to carry out my role when working with this client group.	I feel that I know enough about the different causes of learning disabilities to carry out my role when working with this patient group.	Focus on knowledge of antecedents to mental health ill health did not fit; reworded to focus on knowledge on the causes of learning disabilities, contributing to the role competency construct.
3	I feel I can appropriately advise my patients about mental health problems.	I feel that I can appropriately advise patients about health issues related to their learning disability.	Learning disability is a condition not an illness, adjusted to question on health knowledge linking to role competency.
4	I feel that I have a clear idea of my responsibilities in helping patients with mental health problems.	I feel that I have a clear idea of my responsibilities when nursing patients who have a learning disability.	'Helping' was changed with 'nursing' as aimed at nurses and their role within the hospital setting.
5	I feel that I have the right to ask patients about their mental health status when necessary.	I feel that I have the right to ask patients and/or their carer about their learning disability where appropriate.	'And/or carer' added to statements as the people with a learning disability may have limited comprehension and communication skills, so in practice a carer may be the person a nurse would communicate with.
6	I feel that my patients believe I have right to ask them questions about mental problems when necessary.	I feel that my patients and/or their carer believe I have the right to ask the questions about the nature of their learning disability where appropriate.	
7	I feel that I have the right to ask a patient for any information that is relevant to their mental health problem.	I feel that I have the right to ask a patient and/or their carer for any information that is relevant to the patient's learning disability where appropriate.	
11	I am interested in the nature of mental health problems and the treatment of them.	I am interested in the provision of services for people with learning disabilities.	Aligned to the motivation construct, reworded to remain focused on nurses motivation to care for people with learning disabilities.

Appendix 7

LDPQ Expert Panel Review

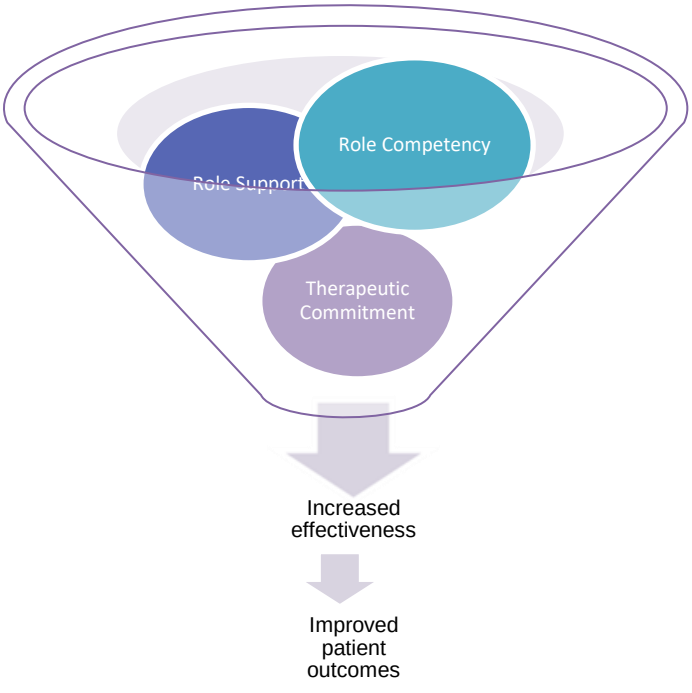
Thank you for agreeing to support the development of the Learning Disability Perception Questionnaire (LDPQ).

The questionnaire is developed on the theory of therapeutic commitment. It is theorised that that therapeutic attitude and commitment are influenced by practitioners' concepts of role adequacy, role legitimacy and role support (Shaw et al. 1978). Furthermore, it proposes that the practitioner (in this study student nurses) requires to exhibit warmth and empathy towards their client to allow the necessary effective interpersonal intervention to take place and by being willing and being able to do this is a function of therapeutic commitment.

Therapeutic commitment is influenced by the non-specialist's self-perception of their role competency and role support whilst working with a certain client group. Role competency is associated with the non-specialist's perception that working with this client group is integral to their role, as well as perceiving they have the appropriate skills and knowledge to carry out the role effectively. In addition, role support is associated with the support the non-specialist perceives they can receive or access from specialist staff to carry out their role.

Therapeutic commitment is primarily a humanist view, similar to the work of Rodgers (1957) where the helper's attitude, cognition and behaviour have an influence on the client's growth. Studies with other patient groups have established a link between high levels of therapeutic commitment, role competency and role support and effective healthcare interventions (Albery et al. 2003; Clark et al. 2005; Lauder et al. 2000, Watson et al. 2005). They propose that by exhibiting high levels of therapeutic commitment this reduces the patient's insecurity, leading to accomplishment of an effective intervention

The diagram below illustrates the theory.



1. **Definitions of each construct being measures**

Therapeutic commitment (TC)

Therapeutic commitment scale aims to measure the willingness of participants to engage therapeutically with patients who have learning disabilities. It is made up from motivation, task specific self-esteem and work satisfaction. They are defined as follows -

Motivation - The motivation subscale aims to measure the level of motivation participants have to care for people with learning disabilities

Task specific self-esteem subscale is examining the participants' levels of self-esteem when working with patients who have a learning disability

Work satisfaction subscale aims to measure the expected level of work satisfaction participants will perceive when caring for patients with learning disabilities

Role competency (RC)

Role competency scale aims to measure the participants' perceived ability to offer effective therapeutic interventions when providing care to patients with learning disabilities and belief it is their role to do this. It is made up from role adequacy and role legitimacy. They are defined as follows -

Role adequacy subscale aims to measure the participant's perception that they have the skills and knowledge to care for patients with learning disabilities

Role legitimacy subscale aims to measure if participant believes caring for someone with a learning disability is part of their job

Role support (RS)

Role support scale purports to measure participants' perceived ease of access to specialist support

1. **Review of Scale Items**

From Section B of the LDPQ you will find 29 statements. Each statement aligns with a subscale and scale as described in the table below.

Scale	Subscale	Statements relating to scale/subscale
Therapeutic commitment	Motivation	11, 13, 17 & 16 which is negatively framed
	Task specific self esteem	12, 18, 29
	Work satisfaction	21, 22, 24, 25 & 23 which is negatively framed
Role competency	Role adequacy	1,2,3, 14, 15, 28, 29
	Role legitimacy	4,5,6,7,20
Role support	Role support	8,9,10,26,27

Please review each statement and consider the following –

a) Does the statement make sense and would a student nurse understand them?
b) Does it reflect the construct they are trying to measure?
c) If, not can you suggest alternatives?

2. Open-ended questions review

Within Section C of the LDPQ, eight open ended questions have been developed to again encapsulate the theory of therapeutic commitment. Again please evaluate the following –

a) Do the questions focus on therapeutic commitment, role competency and role support?
b) Do they make sense and would a student nurse understand them?
c) If, not can you suggest alternations or alternatives?

Questions

1. What skills do you need to care for patients with learning disabilities?
2. How do you feel about patients with learning disabilities?
3. What support can you access to help you care for patients with learning disabilities?
4. What makes you confident to care for this group?
5. What motivates you to care for people with learning disabilities?
6. What attributes do you think you need to care for people with learning disabilities?
7. What do you like about caring for people with learning disabilities?
8. Do you think caring for people with a learning disability should be part of your role?

3. Evaluate the entire questionnaire

Last request when we have reached agreement on parts 1 and 2; I will send you the draft LDPQ.

a) Could you please examine the questionnaire?
b) Does it work?
c) Are there adequate instructions?
d) Does it make sense?
e) Is there anything missing?

Please send all responses to everyone on the distribution list of the email so thoughts and ideas can be shared and discussed.

Thanks all again!! Much appreciated.

Appendix 8

Pilot Evaluation Sheet

The questionnaire you have completed was part of a pilot to ensure the form is suitable to be used in a wider study and yours will not be used in the wider study. To ensure the tool is useable, I would be grateful if you could respond to the following questions –

Please tick √ the box which best suits your response to the question. Then add a comment in the box to support you answers.

Question	Agree	Neither Agree or Disagree	Disagree	Comments
The instructions on how to complete the questionnaire are clear.				
I clearly understand how to complete the questionnaire.				
I understand what the questions are asking.				
The questions are presented in a readable fashion.				
The language used is easy to understand.				
The questionnaire is easy to complete.				
The layout and font of the questionnaire allows it to be easily read.				
The questionnaire took no longer than 15 minutes to complete uninterrupted.				

Thank you for taking the time to complete this form.

Learning Disability Perception Questionnaire

CODE BOOK

This questionnaire has been devised to identify the opinions of final year student nurses regarding certain issues related to their involvement with people who have learning disabilities.

The following questions will identify the level of therapeutic commitment a student nurse has when caring for a patient/client with a learning disability.

Therapeutic commitment is the positive attitude shown towards people with learning disabilities which includes the student nurses' motivation to work with this care group, support they have received to provide this care and how confident and competent they feel providing this care.

The questionnaire has 3 sections – A, B & C. Please complete **all** sections.

Thank you for your kind co-operation

SECTION A

(Please tick the box the appropriate boxes)

1. (a) Male ☐ 1 (b) Female ☐ 2 99- No answer

2. Please enter your age as of the 31st of December 2012?

☐

3. Which field of nursing are you studying?

Adult ☐ 1 Mental Health ☐ 2

Learning Disability ☐ 3

4. Which university are you studying at?

Edinburgh Napier ☐ 1 Glasgow Caledonian ☐ 2 Robert Gordon 3 ☐

Stirling ☐ 4

5. Do you currently or have you previously worked with people who have a learning disability?

Yes ☐ 1 No ☐ 2 Not sure 3 ☐

6. Do you have a family member or a personal friend who has a learning disability?

Yes ☐ 1 No 2 ☐

7. During your pre-registration nursing programme have you had any university teaching on learning disabilities?

Yes ☐ 1 No ☐ 2 Not sure 3 ☐

8. During the clinical placement element of your pre-registration programme, have you had the opportunity to care for someone with a learning disability?

Yes ☐ 1 No ☐ 2 Not sure 3 ☐

9. Are you satisfied with the a) university teaching (including online learning) **and** b) learning obtained in clinical practice on caring for people with a learning disability during your pre-registration programme? Please tick in the appropriate box

	Very satisfied	Satisfied	Neither satisfied/nor dissatisfied	Dissatisfied	Very dissatisfied
a) University teaching (including on line)	5	4	3	2	1
b) Learning in clinical practice	5	4	3	2	1

SECTION B

In this section you will be asked to give your opinions on your involvement in nursing people who have a learning disability.

For many statements there are **no** correct answers and it is important that you try to answer as closely as possible how you **feel**.

You will be asked to comment on 29 statements and asked to rate *how you feel* on a scale from -

1 **Strongly Disagree** to 7 **Strongly Agree**.

Please circle the response, which best indicates *how you feel*.

SECTION B

		1	2	3	4	5	6	7
	STATEMENT	STRONGLY DISAGREE	QUITE STRONGLY DISAGREE	DISAGREE	NEITHER AGREE OR DISAGREE	AGREE	QUITE STRONGLY AGREE	STRONGLY AGREE
1	I feel that I know enough about the different causes of learning disabilities to carry out my role when working with this patient group.	1	2	3	4	5	6	7
2	I feel I know how to treat people with learning disabilities.	1	2	3	4	5	6	7
3	I feel that I can appropriately advise patients about health issues related to their learning disability.	1	2	3	4	5	6	7
4	I feel that I have a clear idea of my responsibilities when nursing patients who have a learning disability.	1	2	3	4	5	6	7
5	I feel that I have the right to ask patients and/or their carer about their learning disability where appropriate.	1	2	3	4	5	6	7
6	I feel that my patients and/or their carer believe I have the right to ask the questions about the nature of their learning disability where appropriate.	1	2	3	4	5	6	7

	STATEMENT	STRONGLY DISAGREE	QUITE STRONGLY DISAGREE	DISAGREE	NEITHER AGREE OR DISAGREE	AGREE	QUITE STRONGLY AGREE	STRONGLY AGREE
7	I feel that I have the right to ask a patient and/or their carer for any information that is relevant to the patient's learning disability where appropriate.	1	2	3	4	5	6	7
8	If I felt the need when working with patients with learning disabilities I could easily find someone with whom I could discuss any personal difficulties I might encounter.	1	2	3	4	5	6	7
9	If I felt the need when working with patients with learning disabilities I could easily find somebody who would help me clarify my professional difficulties.	1	2	3	4	5	6	7
10	If I felt the need I could easily find someone who would be able to help me formulate the best approach to a patient with a learning disability.	1	2	3	4	5	6	7
11	I am interested in the provision of services for people with learning disabilities.	1	2	3	4	5	6	7
12	I feel that I am able to work with patients with learning disabilities as effectively as other patients who do not have learning disabilities.	1	2	3	4	5	6	7

	STATEMENT	STRONGLY DISAGREE	QUITE STRONGLY DISAGREE	DISAGREE	NEITHER AGREE OR DISAGREE	AGREE	QUITE STRONGLY AGREE	STRONGLY AGREE
13	I want to work with patients with learning disabilities.	1	2	3	4	5	6	7
14	I have the skills to work with patients with learning disabilities.	1	2	3	4	5	6	7
15	I feel that I can assess and identify the nursing needs of patients who have a learning disability.	1	2	3	4	5	6	7
16	I feel that there is nothing I can do to help patients with learning disabilities.	1	2	3	4	5	6	7
17	I feel that I have something to offer patients with learning disabilities.	1	2	3	4	5	6	7
18	I feel that I have much to be proud of when working with patients with learning disabilities.	1	2	3	4	5	6	7

	STATEMENT	STRONGLY DISAGREE	QUITE STRONGLY DISAGREE	DISAGREE	NEITHER AGREE OR DISAGREE	AGREE	QUITE STRONGLY AGREE	STRONGLY AGREE
19	I feel that I have a number of good qualities to work with patients with a learning disability.	1	2	3	4	5	6	7
20	Caring for people with learning disabilities is an important part of a general (adult) nurse's role.	1	2	3	4	5	6	7
21	In general, one can get satisfaction from working with patients with learning disabilities.	1	2	3	4	5	6	7
22	In general, it is rewarding to work with patients with learning disabilities	1	2	3	4	5	6	7
23	I often feel uncomfortable when working with patients with learning disabilities.	1	2	3	4	5	6	7

	STATEMENT	STRONGLY DISAGREE	QUITE STRONGLY DISAGREE	DISAGREE	NEITHER AGREE OR DISAGREE	AGREE	QUITE STRONGLY AGREE	STRONGLY AGREE
24	In general, I feel that I can understand patients with learning disabilities.	1	2	3	4	5	6	7
25	On the whole, I am satisfied with the way I work with patients with learning disabilities.	1	2	3	4	5	6	7
26	When working with patients with learning disabilities I receive adequate supervision from a more experienced person.	1	2	3	4	5	6	7
27	When working with patients with learning disabilities I receive adequate on-going support from colleagues.	1	2	3	4	5	6	7
28	I feel on the whole I can communicate effectively with patients who have a learning disability.	1	2	3	4	5	6	7
29	I feel I have sufficient knowledge about the different health problems patients with learning disabilities can have.	1	2	3	4	5	6	7

SECTION C

In this section, the researcher is interested to hear your views as a student nurse on caring for people with a learning disability.

Please answer the questions below as fully as possible

1. What do you like about caring for people with learning disabilities?

2. What skills do you have to support patients who have learning disabilities?

3. Do you think caring for people with a learning disability should be part of your job?

4. How do you feel about people with learning disabilities?

5. What makes you competent to care for this care group?

6. What attributes and/or values do you think a nurse requires to have to care for people with learning disabilities?

Thank you for completing this questionnaire

Appendix 10

The Learning Disability Perception Questionnaire (LDPQ): Instructions for Researchers on the use of the Scale

This instrument was specifically developed to measure the attitude of nurses to working with patients who have a learning disability. The scale is primarily a revision of the Alcohol and Alcohol Problems Perception Questionnaire (Cartwright et al 1979) which was undertaken by Lauder et al (2000) for use with generalist professionals who worked with people with mental health problems resulting in the Mental Health Problem Perception Questionnaire (MHPPQ). From this the LDPQ was developed.

The theoretical framework underpinning the study is described in some detail by Cartwright et al (1978). Therapeutic commitment is conceptualised as a positive attitude towards working with patients with learning disability. Therapeutic commitment is a function of motivation towards working with this clients group, expectation of work satisfaction, and task specific self-esteem.

Low therapeutic commitment is related to the levels of role competency and role support that is made available to nurses. The lower levels of role competency experienced by nurses and the less role support, the less therapeutic commitment is displayed by the nurses. In addition the experience of the nurses is proposed to be correlated with therapeutic commitment.

The questionnaire comprises of three scales and five sub-scales. There are a total of 29 items in the questionnaire. Each of the five sub-scales is measured by the total indicated in Table One below. Also, the scale Role Support is measured by five items (See Table one)

Scoring the basic scores of the LDPQ

The scores for the overall attitude to working with patients with learning disabilities range from 29-203. Lower scores represent a less positive attitude. Scores can also be calculated for each sub-scale (see table one) -

- Motivation (M) ranges from 4-28.
- Expectation of work satisfaction (ExS) ranges from 5-35.
- Task specific self-esteem (SE) ranges from 3-21.
- Role adequacy (RA) ranges from 7-49.
- Role Legitimacy (RL) ranges from 5-35.

1. Therapeutic Commitment (TC)
   a) Motivation to work with patients with learning disabilities - add together the scores for statements 11, 13, 17. Statement 16 is negatively framed and scores should be reversed (1=7, 2=6 etc.) and then added to sum of 11, 13, 17.
   b) Task specific self-esteem - add together the scores for questions 12, 18, 22
   c) Expectation of satisfaction of working with patients with learning disabilities - add together scores for statements 21, 22, 24, 25. Statement 23 is negatively framed and scores should be reversed (1=7, 2=6 etc.) and then added to sum of 21, 22, 24, 25.

Overall therapeutic commitment levels are calculated by the sum of the scores of motivation and task specific self-esteem and expectation of satisfaction.

2. Role Competency (RC)
   a) To measure role adequacy - add together the scores for questions 1, 2, 3, 14, 15, 28, 29 to establish the level.
   b) To identify the level of role legitimacy the sum of the scores for questions 4, 5, 6, 7, 20 must be calculated.
   c) To find to overall level of Role Competency the scores for role adequacy and role legitimacy required to be added together.

3. Role Support (RS)

   The sum of the scores for questions 8, 9, 10, 26, 27 indicates the level of Role Support

Table One

Scale	Sub-scale	Statement Nos.	Sub-scale Item Total	Subscale Score ranges	Scale ranges
Therapeutic Commitment (TC)	Motivation to work with LD patients (M)	11 + 13 +16 (neg) + 17	4	4 - 28	12 - 84
	Expectation of work satisfaction (ExS)	21 + 22 + 23 (neg) +24 + 25	5	5 - 35	
	Task specific self-esteem (SE)	12 + 18 + 19	3	3 - 21	
Role Competency (RC)	Role adequacy (RA)	1 + 2 + 3 + 14 +15 + 28 + 29	7	7 - 49	12 - 84
	Role Legitimacy (RL)	4 +5 + 6 + 7 + 20	5	5 - 35	
Role Support (RS)	Although not part of the scale information is also obtained on the subjects experience in working with patients with learning disability.	8 + 9 + 10 + 26 + 27	5	----------	5- 35

Appendix 11

Responses to Motivation Subscale Items

Statements	Groups	Strongly disagree *n* (%)	Quite strongly disagree *n* (%)	Disagree *n* (%)	Neither agree nor disagree *n* (%)	Agree *n* (%)	Quite strongly agree *n* (%)	Strongly agree *n* (%)
11. I am interested in the provision of services for people with learning disabilities. (*n*=396)	Whole	1 (0.3)	1 (0.3)	11 (2.8)	43 (10.9)	157 (39.7)	79 (20.0)	103 (26.1)
	NLDG	1 (0.3)	1 (0.3)	11 (2.8)	43 (10.9)	156 (39.5)	75 (19.0)	71 (18.0)
	LDG	0	0	0	0	1 (0.3)	4 (1.0)	32 (8.1)
13. I want to work with patients with learning disabilities. (*n*=396)	Whole	8 (2.0)	8 (2.0)	42 (10.6)	132 (33.3)	87 (22.0)	42 (10.6)	77 (19.4)
	NLDG	8 (2.0)	8 (2.0)	42 (10.6)	131 (33.1)	86 (21.7)	41 (10.4)	43 (10.9)
	LDG	0	0	0	1 (0.3)	1 (0.3)	1 (0.3)	34 (8.6)
16. I feel that there is nothing I can do to help patients with learning disabilities. (*n*=397)	Whole	154 (38.9)	67 (16.9)	135 (34.1)	32 (8.1)	5 (1.3)	1 (0.3)	2 (0.5)
	NLDG	123 (31.1)	62 (15.7)	134 (33.8)	32 (8.1)	5 (1.3)	1 (0.3)	2 (0.5)
	LDG	31 (7.8)	5 (1.3)	1 (0.3)	0	0	0	0
17. I feel that I have something to offer patients with learning disabilities. (*n*=395)	Whole	0	5 (1.3)	6 (1.5)	64 (16.2)	196 (49.7)	69 (17.5)	54 (13.7)
	NLDG	0	5 (1.3)	6 (1.5)	64 (16.2)	193 (49.0)	55 (14.0)	34 (8.6)
	LDG	0	0	0	0	3 (0.8)	14 (3.6)	20 (5.1)

Appendix 12

Responses to Expectation of Work Satisfaction Subscale Items

Statements	Groups	Strongly disagree *n* (%)	Quite strongly disagree *n* (%)	Disagree *n* (%)	Neither agree nor disagree *n* (%)	Agree *n* (%)	Quite strongly agree *n* (%)	Strongly agree *n* (%)
21. In general, one can get satisfaction from working with patients with learning disabilities. (*n*=397)	Whole	3 (0.8)	1 (0.3)	2 (0.5)	36 (9.1)	128 (32.3)	85 (21.5)	141 (35.6)
	NLDG	3 (0.8)	1 (0.3)	2 (0.5)	36 (9.1)	127 (32.1)	77 (19.4)	113 (28.5)
	LDG	0	0	0	0	1 (0.3)	8 (2.0)	28 (7.1)
22. In general, it is rewarding to work with patients with learning disabilities (*n*=397)	Whole	4 (1.0)	1 (0.3)	1 (0.3)	40 (10.1)	128 (32.3)	78 (19.7)	144 (36.4)
	NLDG	4 (1.0)	1 (0.3)	1 (0.3)	40 (10.1)	125 (31.6)	74 (18.7)	114 (28.8)
	LDG	0	0	0	0	3 (0.8)	4 (1.0)	30 (7.6)
23. I often feel uncomfortable when working with patients with learning disabilities. (*n*=398)	Whole	107 (27.0)	70 (17.6)	119 (30.0)	57 (14.4)	38 (9.6)	3 (0.8)	3 (0.8)
	NLDG	86 (21.7)	58 (14.6)	116 (29.2)	56 (14.1)	38 (9.6)	3 (0.8)	3 (0.8)
	LDG	21 (5.3)	12 (3.0)	3 (0.8)	1 (0.3)	0	0	0
24. In general, I feel that I can understand patients with learning disabilities. (*n*=397)	Whole	2 (0.5)	7 (1.8)	42 (10.6)	114 (28.8)	163 (41.2)	52 (13.1)	16 (4.0)
	NLDG	2 (0.5)	7 (1.8)	42 (10.6)	112 (28.3)	153 (38.6)	35 (8.8)	8 (2.0)
	LDG	0	0	0	2 (0.5)	10 (2.5)	17 (4.3)	8 (2.0)
25. On the whole, I am satisfied with the way I work with patients with learning disabilities. (*n*=397)	Whole	1 (0.3)	5 (1.3)	28 (7.1)	112 (28.3)	162 (40.9)	68 (17.2)	20 (5.1)
	NLDG	1 (0.3)	5 (1.3)	28 (7.1)	112 (28.3)	155 (39.1)	48 (12.1)	10 (2.5)
	LDG	0	0	0	0	7 (1.8)	20 (5.1)	10 (2.5)

Appendix 13

Responses to Task Specific Self-esteem Subscale Items

Statement		Strongly disagree *n* (%)	Quite strongly disagree *n* (%)	Disagree *n* (%)	Neither agree nor disagree *n* (%)	Agree *n* (%)	Quite strongly agree *n* (%)	Strongly agree *n* (%)
12. I feel that I am able to work with patients with learning disabilities as effectively as other patients who do not have learning disabilities. (n= 398)	Whole	6 (1.5)	7 (1.8)	77 (19.4)	63 (15.9)	117 (29.5)	64 (16.1)	63 (15.9)
	NLDG	6 (1.5)	7 (1.8)	76 (19.1)	61 (15.4)	111 (28.0)	53 (13.4)	46 (11.6)
	LDG	0	0	1 (0.3)	2 (0.5)	6 (1.5)	11 (2.8)	17 (4.3)
18. I feel that I have much to be proud of when working with patients with learning disabilities. (n = 397)	Whole	1 (0.3)	5 (1.3)	10 (2.5)	118 (29.8)	143 (36.1)	63 (15.9)	56 (14.1)
	NLDG	1 (0.3)	5 (1.3)	10 (2.5)	115 (29.0)	137 (34.6)	54 (13.6)	37 (9.3)
	LDG	0	0	0	3 (0.8)	6 (1.5)	9 (2.3)	19 (4.8)
19. I feel that I have a number of good qualities to work with patients with a learning disability. (n = 397)	Whole	0	3 (0.8)	4 (1.0)	36 (9.1)	196 (49.5)	96 (24.2)	61 (15.4)
	NLDG	0	3 (0.8)	4 (1.0)	36 (9.1)	190 (48.0)	83 (21.0)	43 (10.9)
	LDG	0	0	0	0	6 (1.5)	13 (3.3)	18 (4.5)

Appendix 14

Responses to Role Adequacy Subscale Items

Statements	Groups	Strongly disagree *n* (%)	Quite strongly disagree *n* (%)	Disagree *n* (%)	Neither agree nor disagree *n* (%)	Agree *n* (%)	Quite strongly agree *n* (%)	Strongly agree *n* (%)
1. I feel that I know enough about the different causes of learning disabilities to carry out my role when working with this patient group. (*n*=398)	Whole	13 (3.3)	28 (7.1)	150 (37.8)	53 (13.4)	98 (24.7)	43 (10.8)	12 (3.0)
	NLDG	13 (3.3)	28 (7.1)	150 (37.8)	50 (12.6)	87 (21.9)	25 (6.3)	7 (1.8)
	LDG	0	0	0	3 (0.8)	11 (2.8)	18 (4.5)	5 (1.3)
2. I feel I know how to treat people with learning disabilities. (*n*=396)	Whole	3 (0.8)	8 (2.0)	51 (12.9)	66 (16.7)	150 (38.0)	60 (15.2)	57 (14.4)
	NLDG	3 (0.8)	8 (2.0)	51 (12.9)	65 (16.5)	143 (36.2)	49 (12.4)	39 (9.9)
	LDG	0	0	0	1 (0.3)	7 (1.8)	11 (2.8)	18 (4.6)
3. I feel that I can appropriately advise patients about health issues related to their learning disability. (*n*=397)	Whole	20 (5.1)	34 (8.6)	154 (38.9)	71 (17.9)	82 (20.7)	25 (6.3)	10 (2.5)
	NLDG	20 (5.1)	34 (8.6)	154 (38.9)	70 (17.7)	67 (16.9)	9 (2.3)	5 (1.3)
	LDG	0	0	0	1 (0.3)	15 (3.8)	16 (4.0)	5 (1.3)
14. I have the skills to work with patients with learning disabilities. (*n*=397)	Whole	4 (1.0)	7 (1.8)	62 (15.7)	95 (24.0)	144 (36.4)	63 (15.9)	21 (5.3)
	NLDG	4 (1.0)	7 (1.8)	62 (15.7)	95 (24.0)	141 (35.6)	37 (9.3)	13 (3.3)
	LDG	0	0	0	0	3 (0.8)	26 (6.6)	8 (2.0)
15. I feel that I can assess and identify the nursing needs of patients who have a learning disability. (*n*=396)	Whole	5 (1.3)	14 (3.5)	60 (15.2)	96 (24.3)	159 (40.3)	54 (13.7)	7 (1.8)
	NLDG	5 (1.3)	14 (3.5)	60 (15.2)	96 (24.3)	147 (37.2)	31 (7.8)	5 (1.3)
	LDG	0	0	0	0	12 (3.0)	23 (5.8)	2 (0.5)
28. I feel on the whole I can communicate effectively with patients who have a learning disability. (*n*=398)	Whole	3 (0.8)	6 (1.5)	22 (5.5)	77 (19.4)	193 (48.6)	70 (17.6)	26 (6.5)
	NLDG	3 (0.8)	6 (1.5)	22 (5.5)	76 (19.1)	185 (46.6)	52 (13.1)	16 (4.0)
	LDG	0	0	0	1 (0.3)	8 (2.0)	18 (4.5)	10 (2.5)
29. I feel I have sufficient knowledge about the different health problems patients with learning disabilities can have. (*n*=398)	Whole	12 (3.0)	27 (6.8)	117 (29.5)	76 (19.1)	106 (26.7)	45 (11.3)	14 (3.5)
	NLDG	12 (3.0)	27 (6.8)	117 (29.5)	75 (18.9)	97 (24.4)	26 (6.5)	6 (1.5)
	LDG	0	0	0	1 (0.3)	9 (2.3)	19 (4.8)	8 (2.0)

Appendix 15

Responses to Role Legitimacy Subscale Items

Statements	Groups	Strongly disagree *n* (%)	Quite strongly disagree *n* (%)	Disagree *n* (%)	Neither agree nor disagree *n* (%)	Agree *n* (%)	Quite strongly agree *n* (%)	Strongly agree *n* (%)
4. I feel that I have a clear idea of my responsibilities when nursing patients who have a learning disability. (*n*=397)	Whole	5 (1.3)	12 (3.0)	53 (13.4)	54 (13.6)	174 (43.9)	58 (14.6)	40 (10.1)
	NLDG	5 (1.3)	12 (3.0)	53 (13.4)	54 (13.6)	166 (41.9)	43 (10.9)	26 (6.6)
	LDG	0	0	0	0	8 (2.0)	15 (3.8)	14 (3.5)
5. I feel that I have the right to ask patients and/or their carer about their learning disability where appropriate. (*n*=397)	Whole	3 (0.8)	5 (1.3)	20 (5.1)	61 (15.4)	205 (51.8)	62 (15.7)	40 (10.1)
	NLDG	3 (0.8)	5 (1.3)	20 (5.1)	58 (14.6)	195 (49.2)	47 (11.9)	31 (7.8)
	LDG	0	0	0	3 (0.8)	10 (2.5)	15 (3.8)	9 (2.3)
6. I feel that my patients and/or their carer believe I have the right to ask the questions about the nature of their learning disability where appropriate. (*n*=397)	Whole	2 (0.5)	4 (1.0)	22 (5.5)	129 (32.5)	166 (41.8)	52 (13.1)	22 (5.5)
	NLDG	2 (0.5)	4 (1.0)	22 (5.5)	125 (31.5)	150 (37.8)	40 (10.1)	17 (4.3)
	LDG	0	0	0	4 (1.0)	16 (4.0)	12 (3.0)	5 (1.3)
7. I feel that I have the right to ask a patient and/or their carer for any information that is relevant to the patient's learning disability where appropriate. (*n*=397)	Whole	2 (0.5)	3 (0.8)	12 (3.0)	47 (11.8)	226 (56.9)	60 (15.1)	47 (11.8)
	NLDG	2 (0.5)	3 (0.8)	12 (3.0)	47 (11.8)	215 (54.2)	47 (11.8)	34 (8.6)
	LDG	0	0	0	0	11 (2.8)	13 (3.3)	13 (3.3)
20. Caring for people with learning disabilities is an important part of a general (adult) nurse's role. (*n*=397)	Whole	2 (0.5)	2 (0.5)	5 (1.3)	26 (6.6)	143 (36.1)	81 (20.5)	137 (34.6)
	NLDG	2 (0.5)	2 (0.5)	5 (1.3)	24 (6.1)	139 (35.1)	72 (18.2)	116 (29.3)
	LDG	0	0	0	2 (0.5)	4 (1.0)	9 (2.3)	21 (5.3)

Appendix 16

Responses to Role Support Scale Items

Statements	Groups	Strongly disagree *n* (%)	Quite strongly disagree *n* (%)	Disagree *n* (%)	Neither agree nor disagree *n* (%)	Agree *n* (%)	Quite strongly agree *n* (%)	Strongly agree *n* (%)
8. If I felt the need when working with patients with learning disabilities I could easily find someone with whom I could discuss any personal difficulties I might encounter. (*n*=397)	Whole	6 (1.5)	15 (3.8)	66 (16.7)	70 (17.7)	154 (38.9)	59 (14.9)	26 (6.6)
	NLDG	6 (1.5)	15 (3.8)	66 (16.7)	67 (16.9)	143 (36.1)	44 (11.1)	19 (4.8)
	LDG	0	0	0	3 (0.8)	11 (2.8)	15 (3.8)	7 (1.8)
9. If I felt the need when working with patients with learning disabilities I could easily find somebody who would help me clarify my professional difficulties. (*n*=397)	Whole	3 (0.8)	9 (2.3)	61 (15.4)	72 (18.1)	162 (40.8)	68 (17.1)	22 (5.5)
	NLDG	3 (0.8)	9 (2.3)	61 (15.4)	72 (18.1)	152 (38.3)	50 (12.6)	13 (3.3)
	LDG	0	0	0	0	10 (2.5)	18 (4.5)	9 (2.3)
10. If I felt the need I could easily find someone who would be able to help me formulate the best approach to a patient with a learning disability. (*n*=397)	Whole	1 (0.3)	14 (3.5)	61 (15.4)	66 (16.7)	161 (40.7)	64 (16.2)	29 (7.3)
	NLDG	1 (0.3)	14 (3.5)	61 (15.4)	66 (16.7)	152 (38.4)	47 (11.9)	18 (4.5)
	LDG	0	0	0	0	9 (2.3)	17 (4.3)	11 (2.8)
26. When working with patients with learning disabilities I receive adequate supervision from a more experienced person. (*n*=397)	Whole	12 (3.0)	20 (5.0)	73 (18.4)	98 (24.7)	124 (31.2)	42 (10.6)	28 (7.1)
	NLDG	12 (3.0)	20 (5.0)	73 (18.4)	97 (24.4)	118 (29.7)	30 (7.6)	10 (2.5)
	LDG	0	0	0	1 (0.3)	6 (1.5)	12 (3.0)	18 (4.5)
27. When working with patients with learning disabilities I receive adequate on-going support from colleagues. (*n*=397)	Whole	8 (2.0)	16 (4.0)	72 (18.2)	102 (25.8)	131 (33.1)	37 (9.3)	30 (7.6)
	NLDG	8 (2.0)	16 (4.0)	72 (18.2)	101 (25.5)	126 (31.8)	24 (6.1)	12 (3.0)
	LDG	0	0	0	1 (0.3)	5 (1.3)	13 (3.3)	18 (4.5)

Appendix 17

Article for Publication

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TITLE PAGE

EXPLORING FINAL YEAR STUDENT NURSES' THERAPEUTIC COMMITMENT TO PEOPLE WITH LEARNING DISABILITIES: A QUANTITATIVE STUDY

June Brown

Faculty of Health Sciences and Sport, University of Stirling, Stirling, FK9 4LA, United Kingdom

Email – j.g.brown@stir.ac.uk

Tel no - +44 7788991219

Twitter - @junebrown116

Jayne Donaldson

Faculty of Health Sciences and Sport, University of Stirling, Stirling, FK9 4LA, United Kingdom

Email – jayne.donaldson@stir.ac.uk

Tel no - +44 1786466345

Julie Cowie

Faculty of Health Sciences and Sport, University of Stirling, Stirling, FK9 4LA, United Kingdom

Email – julie.cowie@stir.ac.uk

Tel no - +44 1786466105

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ABSTRACT

Introduction: Nurses should feel empowered and competent to provide person centred care to their patients. Establishing a therapeutic relationship is essential to delivering person centred care. A nurse's ability to provide person-centred care, affects the patient's outcome. Therapeutic commitment theoretical framework underpinned this study and is described as the therapeutic attitude and commitment that is influenced by practitioners' concepts of role competency and role support.

Study Aim: This study explored final year student nurses' perceptions of therapeutic commitment towards people with learning disabilities.

Methods: The Learning Disability Perceptions Questionnaire (LDPQ) was used to measure the constructs of therapeutic commitment, role competency and role support. SPSS version 23 was employed to analyse data with descriptive and inferential statistics.

Setting: Four higher education institutions in the United Kingdom.

Participants: Final year adult, mental health and learning disability undergraduate student nurses (*n*=398).

Findings: Overall, students perceived they were therapeutically committed. Learning disability student nurses were more therapeutically committed than their adult and mental health student nurses. They perceived that caring for patients with learning disabilities was a legitimate part of their role; they had the ability to fulfil it and could access support readily whereas many of their peers did not. Factors that significantly influenced therapeutic commitment were having previously worked with a person with a learning disability, having a personal experience or the opportunity to care for a patient with a learning disability whilst on clinical placement and having education of caring for people with learning disabilities.

Conclusions: Nursing students had a positive perception of their willingness and ability to therapeutically engage. Contact with people with learning disability and education would change adult and mental health students' perceptions. It is important to enable access to contact with people with learning disabilities through the undergraduate nursing programmes.

KEY WORDS

Therapeutic commitment; Student nurses; Learning disabilities; Competency; Support

INTRODUCTION

Recognising and responding to the needs of people with learning disabilities is the role of all registered nurses (Nursing and Midwifery Council, 2010). However, recent independent inquiries report healthcare professionals' lack of knowledge and skills to meet their needs contributed to people with learning disabilities receiving inequitable and poor quality care (Michael, 2008; Heslop et al. 2013), resulting in recommendations that education on learning disabilities should be mandated in all undergraduate programmes (Michael, 2008). Pre-registration adult and mental health nursing curricula within UK universities greatly vary in learning disability content and experiential learning opportunities (Spinks, 2015) although the importance of educational attainment for all student nurses has been highlighted (Scottish Government, 2012).

BACKGROUND/LITERATURE

The health inequalities adults with learning disabilities experience accessing universal health services are well evidenced (Emerson et al. 2011). They are also more likely to experience premature death, some of which is preventable (Heslop et al. 2013). Life expectancy for this patient group at birth is 19.7 years less than those without a learning disability (Glover et al. 2017). They have greater physical and mental health needs than the general population (Cooper et al. 2015), therefore frequently use services. This suggests that adult and mental health nurses will provide care at some time in their career and have an integral role to play reducing health inequalities. To prevent any further institutional discrimination, health care professionals must be competent to deliver safe and effective care. Nurses have reported feeling unprepared and have challenges effectively communicating with this patient group (Lewis et al. 2016) which may be due to the levels of learning opportunities in pre-registration programmes. Student nurses have previously reported fewer positive attitudes towards people with learning disabilities than those with physical disabilities (Klooster et al. 2009) which impacts on the quality of person centred care provided (Price, 2015). This paper examines final year adult, learning disability and mental health student nurses' commitment to engage in a therapeutic relationship with people with learning disabilities.

Nurses should have the disposition and ability to engage in therapeutic relations with people who have a learning disability. Therapeutic commitment is described as a therapeutic attitude that is influenced by the nurses' perception of role competency and role support (Lauder et al. 2000). This pre-requisite to care is essential in establishing a therapeutic relationship which leads to nurses' increased effectiveness, and results in improved outcomes for the patient (Lauder et al. 2000) (Figure 1). It is dependent on role competency and role support. Role competency is the nurse's perception that working with people who

have a learning disability is part of their role and they have the skills and knowledge to fulfil it. Role support is the nurse's perception that they can easily access support and advice when caring for someone with a learning disability. Therapeutic commitment is primarily a humanist view, similar to the work of Rodgers (1957) where in this case the nurse's attitude, cognition and behaviour have an influence on the patient's growth. By the nurse displaying warmth, genuineness and empathy towards a patient, supports a trusting relationship between them and the patient, therefore creating a therapeutic relationship. This relationship requires trust, allowing the patient to feel secure and participate with the nurse in the relationship (Angus et al 2001; Lauder et al. 2000). People with learning disabilities have different levels of ability; this may affect their engagement in a therapeutic relationship (Jones and Donati 2009). Often families and carers are part of therapeutic alliance.

METHODS

This study utilised a quantitative approach. Data were collected by the administration of a self-administration questionnaire, the Learning Disability Perceptions Questionnaire (LDPQ). The study population comprised of adult, learning disability and mental health nursing students in year 3 of a diploma or degree programme or year 4 of an honours programme in four Scottish higher education institutions (*n*=1505). Child health student nurses were excluded as they would have limited opportunity to care for adults with learning disabilities. Full ethical approval was sought and obtained from the Faculty Research Ethics Committees of each higher education institute. An invitation e-message with a link to the participant information sheet was sent one week prior. Data were collected by self-administration of the LDPQ which were distributed in universities. Students were provided with a verbal explanation of the purpose of the study. Questionnaires and consent forms were offered to students who were advised participation was their individual choice. Completed and uncompleted questionnaires were returned to a box in the university.

Aim and hypotheses

The aim of this study was to measure student nurses' willingness and ability to engage in a therapeutic relationship with people who have a learning disability.

Hypotheses

1. Final year student nurses are therapeutically committed to people with learning disabilities.

2. Learning disability student nurses will report higher levels of therapeutic commitment than their adult and mental health peers.

Research questions

1. Do final year student nurses perceive they are therapeutically committed to people with a learning disability?
2. Is there a difference between specialist (learning disability student nurses) and non-specialist (adult and mental health student nurses) perceived levels of therapeutic commitment?

Instrumentation

LDPQ was adapted from the Mental Health Problems Perception Questionnaire (MHPPQ) with permissions (Angus et al. 2001) and utilises a Likert scale to measure a non-specialist perception of their disposition, competency and access to support to care for people with learning disabilities. The MHPPQ was developed to investigate adult nurses' therapeutic commitment to people with mental ill health and is an adaption of the Alcohol and Alcohol Problems Perception Questionnaire (AAPPQ) developed by Shaw et al. (1978). In the MHPPQ, central concepts of therapeutic commitment, role competency and role support underpin the explicit theoretical framework are explored by 27 statements (Lauder et al. 2000). Demographic questions were added and an expert panel from education and practice revised the changes. LDPQ was piloted with 2nd year student nurses and further changes made. As a result, the LDPQ used 29 statements adapted to include learning disabilities and responses were scored on a 7-point scale. The instrument contains three scales that measure therapeutic commitment with a possible score of 12-84, role competency of 12-84 and role support of 5-35. Higher scores indicate greater perceived levels of therapeutic commitment, role competency and role support.

Validity and reliability of the MHPPQ has previously been measured for use with non-specialist nurses. Given a different population and changes to the instrument, Cronbach's alpha co-efficient were calculated for each scale and were 0.91, 0.89 and 0.91 respectively evidencing validity. Pearson's product moment correlations were used to calculate the construct validity of the instrument. The correlations between therapeutic commitment and role competency (r=0.76, P<0.01), therapeutic commitment and role support (r=0.43, P<0.01) and role competency and role support (r=0.55, P<0.01). These were all significant and positive, in the direction predicted by the theoretical model (Angus et al. 2001).

Data Analysis

Data were analysed using Social Science (SPSS) Statistics Software (Version 23). A number of descriptive and inferential statistical tests were performed. Normality and distribution tests were applied. Differences between the groups, demographic data and scales were tested with parametric independent t-tests. For all other tests one-way ANOVA was calculated. Post-hoc Tukey HSD test was performed to establish if the differences were statistically significant.

DATA/RESULTS

A total of 457 students were offered the opportunity to take part in the study. Some students (*n*=58) returned them uncompleted, mainly due to time constraints. Responses varied by programme of nursing and by university. A total of 398 completed questionnaires were returned; giving an overall response rate of 26.5%. Difficulties were experienced accessing the sample population via gate keepers. For the purposes of data analysis, the participants from the adult and mental health fields were joined to make a non-learning disability student nurse group (NLDG) (*n*=360) and learning disability nurses became the learning disability student nurse group (*n*=37) (LDG) after an outlier was removed. The mean age of NLDG was 27.4 (*SD*=8.92) and LDG was 30.2 (*SD*=10.12), there was no significant difference between the groups.

Therapeutic Commitment

The LDG had the highest mean therapeutic commitment score of 77.38 (SD 4.91) and NLDG had the lowest score of 61.47 (SD 9.13) with a 95%CI [-18.91, -12.91]. A significant difference between the groups was observed (*t*=-10.43, df=388, *P*=0.001 one tailed). As predicated the LDG showed a greater willingness to engage therapeutically with people with learning disabilities than their NLDG peers. Whilst asking students if they wanted to work with people who have learning disabilities, 14.9 % (*n*=59) disagreed with the statement, all responses were from the NLDG. Around one third of the students (*n*=132, 33.2%) indicated their indecision by neither agreeing nor disagreeing of which 131 were from the NLDG. Additionally, 44 students (11.2%) from the NLDG responded to asking if they often feel uncomfortable when working with this patient group and 56 (14.1%) were undecided on their views by neither agreeing nor disagreeing with the statement. Whilst examining the participants levels of self-esteem when working with people who have a learning disability, 89 (22.4%) NLDG students stated they were not able to work as effectively as they do with other patients, plus 61 (15.3%) were undecided if they agreed or disagreed with this statement.

Role Competency

Highest scores were found in the LDG who showed a mean of 71.11 (SD 4.78) and the NLDG with a lower score of 54.57 (SD 8.69) with 95% CI [-19.39, -13.68]. The differences between the groups was statistically significant and showed that LDG perceived working with people with a learning disability is a legitimate part of their role and they have the necessary skills and knowledge, greater than the NLDG. Participants were asked if they felt they could assess and identify the nursing needs of patients who have a learning disability. Just under half of the NLDG (*n*=183, 46.2%) felt they did, 96 (24.2%) specifying that they were undecided and remaining students (*n*=79, 20.0%) felt they did not, whereas all LDG students felt adequately skilled. When asked whether they had a clear idea of their responsibilities when caring for a person with a learning disability, 235 (59.4%) students from the NLDG agreed and 54 (13.6%) were either unclear or undecided, while all students from the LDG agreed.

Role Support

The role support scale aims to measure participants' perceived ease of access to specialist support. There was a significant difference in the scores of the NLDG (*M*=22.04, *SD*=5.10) and LDG (*M*=30.28, *SD*=3.06) conditions; *t* (-9.51) =392, *p*=0.001, *d*=1.96. These results suggest that the LDG perceive they have access to support more than the NLDG. When asked if students felt they received adequate supervision from a more experienced person, 105 (26.6%) students from the NLDG disagreed, 158 (39.8%) agreed and 97 (24.4%) were neutral whereas no students from the LDG disagreed.

INFLUENCING FACTORS

The factors that influenced the student nurses' levels of therapeutic commitment, role competency and role support are summarised in Table 1.

Work experience

ANOVA showed experience working with people with learning disabilities had a significant effect on therapeutic commitment (*F*(2,387)=14.77, *p*=0.001), role competency (*F*(2,387)=15.01, *p*=0.001) and role support (*F*(2, 391)=4.66, *p*=0.010). A Tukey post-hoc test indicated the group with work experience (*M*=64.47, *SD*=10.04) was significantly different from those with no experience (*M*=58.86, *SD*=8.32) and the unsure (*M*=55.1, *SD*=7.74). Similarly for role competency (*F*(2,387)=15.01, *p*=0.001), those with work experience (*M*=57.60, *SD*=9.72) significantly differed from those with no experience (*M*=52.08, *SD*=8.11). With role support, there was a statistically significant difference

between the groups (F(2, 391)=4.66, p=0.010), those who had experience (M=23.18, SD=5.70) and the group who were unsure (M=18.70, SD = 5.33).

Personal experience

Participants were asked to indicate if they had a family member or a personal friend who has a learning disability of which 31.7% (n=126) did and this was significant in influencing levels of therapeutic commitment (t(387)=5.06, p=0.001, one-tailed, d=0.54), role competency (t(387) =4.96, p = 0.001, one-tailed, d=0.54) and role support (t(391)=3.05, p=0.001, one-tailed, d=0.32). Students who had a personal experience scored higher when measuring levels of therapeutic commitment (M=66.66, SD=10.58), role competency (M=59.66, SD=9.71) and role support (M=24.03, SD=6.00), than those with no personal experience.

Clinical placement

Students were asked if they have had the opportunity to care for someone with a learning disability during a clinical placement. The majority said they had (n=336, 84.6%), leaving 13.4% (n=53) answering no and 2.0% (n=8) not sure. Those who had presented the highest mean score for therapeutic commitment (M=63.87, SD=9.90), role competency (M=56.98, SD=9.48), and role support (M=23.14, SD=5.43). The effect of having a clinical placement was significant on therapeutic commitment (F(2,387)=9.27, p=0.001), role competency (F(2,387)=8.32, p=0.001) and role support F(2,391)=4.91, p=0.008).

Education on learning disabilities

In university 73.3% (n=291) of students received education on learning disabilities, 20.2% (n=80) said they had not and 6.5% (n=26) did not know. Students who received education on learning disabilities within their pre-registration curriculum reported highest mean scores for all three scales. There were no statistically significant differences between the means of these three groups.

DISCUSSION

Ryan et al. (2016) found the achievement of effective patient centred care is dependent on the quality of therapeutic relationship between nurse and patient. Werner and Grayzman (2011) found students wanted to work with people with learning disabilities if they believe it would be beneficial, challenging and enjoyable, whereas previous studies that have shown that nurses had a preference to care for people with physical disabilities rather than learning disabilities (Lewis and Stenfert-Kroese 2010; Mc Conkey and Truesdale 2000).

Providing care for people with learning disabilities is every nurse's business (Scottish Government 2012, NMC 2010). Cognition requires to be given to the fact that student nurses are at pre-novice level (Dreyfus and Dreyfus 1986) and may not perceive a level of competence due to this. Some adult and mental health student nurses did not perceive that caring for people with learning disabilities was a legitimate part of their role. This was not consistent with a previous Canadian study focusing on nursing students' perception of people with learning disabilities, where nearly all of student nurses did perceived it was their responsibility (Temple and Murdoch 2012). In the United Kingdom, as there are four fields of practice, there is often confusion about who is responsible for the care of adult with learning disabilities as they access universal services for physical and mental health needs. Role confusion can exist when registered learning disability nurses' roles are not understood by their peers (Donner et al. 2010). This could account for the variance between the groups; nonetheless many adult and mental health students clearly recognised their professional role.

To fully engage in a therapeutic relationship with a patient, the nurse must possess the necessary skills and knowledge (Crotty and Doody 2015). Many adult and mental health student nurses reported feeling incompetent; similar to some registered adult nurses (Lewis et al. 2016). Temple and Mordoch (2012) found students nurses saw themselves as competent, reporting they believed the participants did not fully comprehend the needs of this patient group due to lack of exposure. People with learning disability have poor care experiences when nurses lack the necessary knowledge and skills which can impact on their wellbeing, safety and health (Bradbury-Jones et al. 2013). Studies have shown adult nurses feel uncomfortable caring for people with learning disabilities (Sowney and Barr 2006; Lewis and Stenfert-Kroese 2010) which could lead to avoidance behaviours and that negatively impact on the nurse patient relationship and delivering certain aspects of care (Lewis and Stenfert-Kroese 2010). Flynn et al. (2015) report oncology nurses often experience stress which affects their ability to provide care due to difficulties in communication and developing a therapeutic relationship. To develop a therapeutic relationship, the nurse must understand the patients' ability to take their part in it (Crotty and Doody 2015). Therefore, having the necessary communication skills is vital to effectively develop them (McCormack and McCance 2017). However, this will be dependent on the patients' abilities (Jones and Donati 2009).

In this study, role support is the support the student perceives they can access to help to effectively care for a patient with learning disabilities. This support could be from someone

they viewed as more experienced; a mentor, parent or carer or from the learning disabilities field. It would be expected that student nurses would report high levels of support given the mandatory supervision they receive whilst in clinical practice (NMC 2008) and support is crucial for a positive learning experience (Warne et al. 2010). LDG reported high levels of support; the reasons for this could be due to the fact that their mentors were more likely to be learning disability nurses and seen as experienced and competent practitioners in this field. However, NLDG reported moderate levels. In order to learn how to care for people with learning disabilities on clinical placement, students require effective support from a competent mentor in a quality learning environment (Willis 2012). As many adult registered nurses report a lack of confidence, knowledge and skills when caring for people with a learning disability (Lewis et al. 2016) the necessary support may not be accessible to students. Student nurses may also access support from specialists from the field of learning disabilities. Learning disability liaison services are seen as an effective model to provide support in acute general hospitals to prevent inadequate care (MacArthur et al. 2015; Castles et al. 2013), although are not established in all general hospitals. Link nurses from community learning disability teams are also viewed as beneficial (Cartlidge and Read 2010; Hastings 2007). Some families and carers perceive the expert knowledge and skills they hold are not recognised by healthcare staff (Mencap 2007), whereas others report they are often overly relied upon to assist in delivering care (Backer 2009). Accessing families and carers for advice is another way of gaining role support. There is a need for student nurses to understand the role carers can have in developing a therapeutic relationship with their patient.

Student nurses who reported having a personal experience reported higher levels of therapeutic commitment and role competency. Conversely, Klooster et al. (2009) reported having a family member with a learning disability did not improve student nurses' attitudes. McConkey and Truesdale (2000) report nurses and therapists' confidence in caring was increased if they had a personal experience out with their work situation. However, at the same time they report that having an experience in the workplace reduced nurses' confidence. This contradicts the findings of this study where student nurses who had employment, educational or social contact perceived higher levels of therapeutic commitment and role competency than those who had no similar experience. Slevin (1995) found that having an experience with a person with a learning disability during a clinical placement improved a student nurse's attitude towards this group. Often adult and mental health student nurses do not get the opportunity to meet and engage with someone with a learning disability as part of their programme (Spinks 2015). It is suggested that student

nurses should have the opportunity to interact and engage with people with learning disabilities when they are well, out with a clinical environment so they can experience developing a relationship with them when the person with a learning disability is not experiencing the stress of a hospital or clinical environment.

Limitations

The response rate in this study was low at 26.5%. This creates bias in the study due to the number of non-responders who may have had differing views; therefore consideration requires to be given to the representativeness of the sample. Student nurses could have reported on the future skills/knowledge they expected to have rather than their present perception, or perceived they were not competent due to their undergraduate status. Also, social desirability bias may have led participants to score themselves higher than they truthfully perceived, portraying a positive image of themselves.

CONCLUSIONS

Our study provides invaluable insights into the willingness and abilities of student nurses to engage in a therapeutic relationship with people with learning disabilities. Some adult and mental health student nurses believe they do not have the skills and knowledge to engage in a therapeutic relationship or that it is part of their role. They also believe they cannot access the necessary support. It can be concluded opportunities of having contact with a person with learning disability within their educational programme will improve student nurses' willingness and ability to therapeutically commit.

REFERENCES

Angus N, Lauder W and Reynolds W (2001) Further testing of the mental health problems perception questionnaire Journal of Advanced Nursing 33 (5) p628-643.

Backer, C., Chapman, M., Mitchell, D. 2009. Access to secondary healthcare for people with intellectual disabilities: a review of the literature. Journal of Applied Research in Intellectual Disabilities. 22, 514-525.

Bradbury-Jones, C., Rattray, J., Jones, M. 2013. Promoting the health, safety and welfare of adults with learning disabilities in acute care settings: a structured literature review. Journal of Clinical Nursing. 22, 1497-1509.

Cartlidge, D., Read, S. 2010. Exploring the needs of hospice staff supporting people with an intellectual disability: a UK perspective. International Journal of Palliative Care. 16 (2), 93-98.

Castles, A., Bailey, C., Gates, B. Sooben, R. 2013. Experiences of the implementation of a learning disability nursing liaison service within an acute hospital setting: a service evaluation. British Journal of Learning Disabilities 42, 272-281.

Cooper, S.A., McLean, G., Guthrie, B., McConnachie, A., Mercer, S., Sullivan, F., Morrison, J. 2015. Multiple physical and mental health comorbidity in adult with learning disabilities: population based cross-sectional analysis. BMC Family Practice. 16:110.

Crotty, G., Doody, O. 2015. Therapeutic relationships in intellectual disability nursing practice. Learning Disability Practice. 18 (7), 25-29

Donner, B., Mutter, R., Scior, K. 2010. Mainstream in-patient mental health care for people with intellectual disabilities: service user, carer and provider experiences. Journal of Applied Research in Intellectual Disabilities. 23, 214-225.

Dreyfus, H.L. Dreyfus, S.E. 1986. Mind over Machine: the power of human intuition and expertise in the age of the computer. Oxford: Basil Blackwell.

Emerson, E., Baines, S., Allerton, L., Welch, V. 2011. Health inequalities and people with learning disabilities in the UK Lancaster: Learning Disability Observatory https://www.ndti.org.uk/uploads/files/IHAL_2011_healthinequalityguidance.pdf (Accessed March 2015)

Flynn, S., Hulbert-Williams, L., Bramwell, R. Stevens-Gill, D, Hulbert-Williams, N. 2015. Caring for patients with intellectual disability: attitudes and care perceptions of UK oncology nurses. European Journal of Oncology Nursing. 19, 568-574.

Glover, G., Williams, R., Heslop, P., Oyinlola, J., Grey, J. 2017. Mortality in people with intellectual disabilities in England. Journal of Intellectual Disability Research. 61 (1), 62-74.

Hastings, R.P. 2007. A survey of the learning disability service user's view of admission to an acute psychiatric ward. The British Journal of Developmental Disability. 104, 71-76.

Heslop, P., Blair, P. and Fleming, P., Hoghton M., Marriot, A., Russ, L., 2013. Confidential inquiry into premature deaths of people with learning disabilities: final report. Norah Fry Research Centre: Bristol.

Jones, R. and Donati, M. 2009. The therapeutic relationship in psychological therapy for individuals with learning disabilities: a review of existing literature. Advances in Mental Health and Learning Disabilities. 3 (1), 47-51.

Klooster, P.M., Dannenberg, J.W., Taal, E., Burger, G., Rasker, J.J. 2009. Attitudes towards people with physical or intellectual disabilities: nursing students and non-nursing peers. Journal of Advanced Nursing. 65 (12), 2562-2573.

Lauder, W., Reynolds, W., Reilly, V., Angus, N. 2000. The development and testing of the mental health problems perception questionnaire. Journal of Psychiatric and Mental Health Nursing. 7, 221-226.

Lewis, P., Gaffney, R., Wilson, N. 2016. A narrative view of acute care nurses' experiences nursing patients with intellectual disability: underprepared, communication barriers and ambiguity about role of caregivers. Journal of Clinical Nursing. 26, 1473-1484.

Lewis, S., Stenfert-Kroese, B. 2010. An investigation of nursing staff attitudes and emotional reactions towards patients with intellectual disability in a general hospital setting. Journal of Applied Research in Intellectual Disabilities. 23, 355-365.

MacArthur, J., Brown, M., McKechanie, A., Mack, S., Hayes, M., Fletcher J. 2015. Making reasonable and achievable adjustments: the contribution of learning disability liaison nurses in 'Getting it right' for people with learning disabilities receiving general hospital care. Journal of Advanced Nursing, 71 (7), 1552-1563.

McConkey, R. Truesdale, M. 2000. Reactions of nurses and therapists in mainstream health services to contact with people who have learning disabilities Journal of Advanced Nursing 32 (1) p158-163

McCormack, B., McCance, T.V. 2017. Person-centred practice in nursing and healthcare. London: Wiley-Blackwell.

Mencap. 2007. Death by indifference. England: Mencap.

Michael, J. 2008. Healthcare for all: report of the independent inquiry into access to healthcare for people with learning disabilities. HSMO: London.

Nursing and Midwifery Council, 2010. Standards for pre-registration education. London: NMC.

Nursing and Midwifery Council (2008) Standards for competence for registered nurses London: NMC.

Price, B. 2015. Understanding attitudes and their effects on nursing practice. Nursing Standard. 30 (15), 50-57

Rodgers, C.R. 1957. The necessary and sufficient conditions of therapeutic personality change. Journal of Consulting Psychology. 21, 95-103.

Ryan, K., Guerin, S. and McEnvoy, J. 2016. The nature and importance of quality of therapeutic relationships in the delivery of palliative care to people with intellectual disabilities. BMJ Supportive and Palliative Care. 6, 430-436.

Scottish Government, 2012. Strengthening the commitment: the report of the UK modernising learning disabilities nursing review. Edinburgh: The Stationery Office.

Shaw S, Cartwright A and Spratley T., Harwin, J.1978. Responding to drinking problems. London: Croom-Helm.

Slevin, E. 1995. Student nurses attitudes towards people with learning disabilities. British Journal of Nursing. 4 (13), 761-766.

Sowney, M., Barr, O.G. 2006. Caring for adults with intellectual disabilities: perceived challenges for nurses in accident and emergency units. Journal of Advanced Nursing. 55 (1), 36-45.

Spinks, J. 2015. Hugh variation in adult nurses' learning disability training. Learning Disability Practice. 18 (1), 8-11.

Temple, B., Mordoch, E. 2012. Nursing student perceptions of disability and preparation to care for people with intellectual disabilities. Journal of Nursing Education. 51 (7), 407-410.

Warne, T., Johansson, U., Papastavrou, E., Tichelaar, E., Tomietto, M., Van den Bossche, K., Moreno, M., Saarikoski, M. 2010. An exploration of the clinical learning experience of nursing students in nine European countries. Nurse Education Today. 30, 809-815.

Werner, S., Grayzman, A. 2011. Factors influencing the intention of students to work with individuals with intellectual disabilities. Research in Developmental Disabilities. 32, 2502-2510

Willis Commission. 2012. Quality with compassion: the future of nursing education. London: Royal College of Nursing.

Figure 1 – Lauder et al. (2000) Model of therapeutic commitment

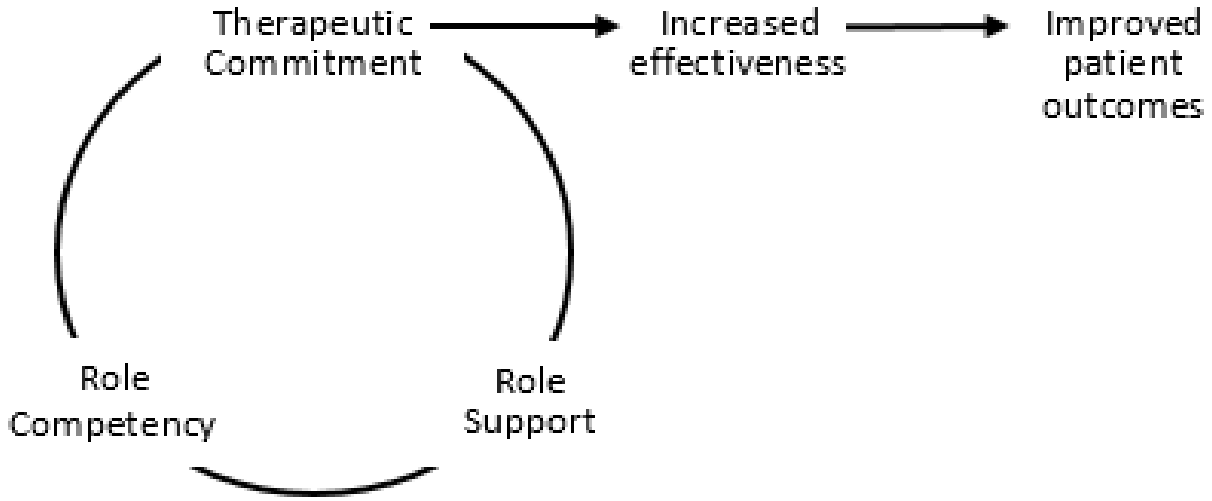

Table 1 – Factors influencing therapeutic commitment, role competency and role support

Variable	Variable response categories	Therapeutic Commitment			Role competency			Role support		
		M	*SD*	95%CI	M	*SD*	95%CI	M	*SD*	95%CI
Work experience	Yes	64.47	10.04	63.31-65.62	57.60	9.72	56.49-58.72	23.18	5.70	22.53-23.84
	No	58.86	8.32	57.09-60.03	52.08	8.11	50.35-53.81	21.94	4.47	20.99-22.89
	Unsure	55.10	7.74	49.56-60.63	48.60	8.93	42.21-54.99	18.70	5.33	14.88-22.52
	ANOVA	*F*(2,387)=14.77, *p*=0.001			*F*(2,387)=15.01, *p*=0.001			*F*(2,391)=4.66, *p*=0.010		
Personal experience	Yes	66.66	10.58	3.27 - 7.43	59.66	9.71	3.09 – 7.14	24.03	6.00	0.64 - 2.97
	No	61.31	9.24		54.55	9.29		22.22	5.16	
	t-test	*t*(387)=5.06, *p*=0.001, one-tailed, *d*=0.54			*t*(387) =4.96, *p* = 0.001, one-tailed, *d*=0.54			*t*(391)=3.05, *p*=0.001, one-tailed, *d*=0.32		
Pre-registration education	Yes	63.65	9.43	62.55-64.74	56.73	9.14	55.66-57.79	23.08	5.16	22.48-23.68
	No	61.45	12.10	57.08-60.63	54.95	11.72	52.32-57.57	22.20	6.66	20.72-23.68
	Unsure	60.04	7.83	56.81-63.27	53.38	8.40	49.99-56.78	21.42	4.88	19.45-23.39
	ANOVA	*F*(2,387)=2.67, *p*=0.070			*F*(2,387)=2.18, *p*=0.115			*F*(2,391)=1.67, *p*=0.189		
Clinical placement	Yes	63.87	9.90	62.80-64.94	56.85	9.75	55.80-57.91	23.14	5.43	22.55-23.72
	No	57.76	9.03	55.22-60.30	51.60	9.87	48.85-54.34	21.13	5.39	19.63-22.63
	Unsure	59.12	8.46	52.05-66.20	51.12	8.56	43.97-58.28	19.12	5.91	14.18-24.07
	ANOVA	*F*(2,387)=9.27, *p*=0.001			*F*(2,387)=8.32, *p*=0.001			*F*(2,391)=4.91, *p*=0.008		

*$p<0.05$