Enrolled Nurses' Experiences of Conversion to First Level

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Abstract

The study focuses on enrolled nurses' experiences of conversion and altered perceptions of self and others as they progress through a conversion course to first level. The experience involves a cultural transition that requires questioning of traditionally held values and adoption of a critical stance to professional practice. The transition mirrors current tensions within nursing as the prevalent direction of professionalisation in recent years has influenced the need for individual accountability that has implications for the self-regulation of practice.

Thirty enrolled nurses participated in the study and were interviewed on three occasions as they progressed through specific parts of a conversion course. A grounded theory approach was utilised and important findings emerged in relation to the nature of learning from practice, the influence of gender and class on perceptions of academic ability and occupational standing and the development of self-agency through critical reflection.

The findings challenge predominant scientific values within professional nurse education and support the validity of a situated learning approach for this group of experienced nurses. It is contended that, if opportunities for professional development and education are to be genuinely accessible, the diverse needs influencing learner participation must be considered. The main recommendations include the provision of accessible, experiential learning conversion courses for enrolled nurses and the development of a facilitative approach to professional development within nurse education.

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Chapter 1: Introduction

The aim of the study is to examine enrolled nurses' experiences of conversion and altered perceptions of self and others as they progress through a conversion course.

Enrolled nurses are qualified second level nurses whose experience is mainly related to the provision of direct patient care. Their initial training was two, as opposed to three years and was regarded as more practical and less academic than first level training. Entry criteria did not rely on academic qualifications and was based on interview alone or, in some instances, an entrance test. The move to one level of professional registration in nursing in 1989 and the introduction of the Project 2000 programme with a more academic focus (UKCC 1986) devalued the enrolled nurse qualification. Clinical grading introduced in the mid-1980's (DHSS 1983) further undermined the status of enrolled nurses. Second level training was discontinued in 1992 (Webb 2001, Iley 2004).

Most enrolled nurses have been qualified for 25 years or more and are between 45 and 55 years old, which means that they could practice for at least another 10 – 20 years before retirement (Seccombe et al 1997). Despite being experienced, enrolled nurses feel that they have been denied opportunities for further personal and professional development and most remain at D grade which is the equivalent to that of a newly qualified staff nurse. Evidence suggests that confusion amongst employers about the second level qualification and enrolled nurse competence has restricted practice development (Seccombe et al 1997). However, enrolled nurses report that whilst they are officially regarded as assistants they are often expected to take charge when staffing levels are low. Furthermore, many have found it difficult to secure the

support of their employers to enable them to undertake conversion to first level (Seccombe et al 1997).

The conversion experience of enrolled nurses is interesting because it involves a cultural transition that requires them to question traditionally held values and to adopt a critical stance to professional practice. The transition mirrors current tensions within nursing as professionalisation has influenced the need for individual accountability that has implications for the self-regulation of practice.

The open learning conversion programme that participants are undertaking aims to promote individual professional development and acknowledges the value of experience in practice. Prior to commencing the programme all applicants undertake a process, Accreditation of Experience Derived Learning (AEDL) (Stillie and McQueeney 1990), that values experience and enables competence, evident within current practice, to be accredited. Consequently the requirement for supernumerary status is reduced enabling enrolled nurses to remain in employment whilst on the programme. The conversion programme promotes self-reflection and the assessment strategy provides opportunities for personal and professional development and is flexible in order to meet the individual needs of students.

As the programme progresses students appear more confident and willing to take responsibility for their own development. The rate and extent to which this transformation occurs varies between individuals, however, all students report changes in the way that they think and act. An in-depth exploration of the nature of

the experience of change and possible internal and external influences would be of benefit to professional educators.

1.1. Assumptions

There are a number of assumptions underlying the study that influence the nature of the enquiry and reflect my own and others' perceptions of enrolled nurses that are relevant to the study. The assumptions derive from my experience as programme leader to the conversion course and relate to differing perceptions of enrolled nurses and conversion including those held by myself, other registered nurses and nurse educators and enrolled nurses themselves. The perceptions are also influenced by statutory regulations and higher education policy. Perceptions of enrolled nurses and conversion influence, and are influenced by, the sociocultural context of nursing and nurse education. Assumptions provide a framework for exploration of the context within which the study is situated and a post-positivist approach demonstrates the historical and cultural 'locatedness' (Usher 1996, p. 13) of the research and the assumptions on which it rests within a social context.

Scientific generalisability and the prediction and control of individual pre-understandings and actions are not possible within social research (Usher 1996). An interpretive epistemology that focuses on meaning of human action and interactions 'within the context of social practices' (Usher 1996, p. 18) underpins the study. In hermeneutics, it is not assumed that knowledge pre-exists scientific 'discovery' (Crotty 1998, p. 27), nor is knowledge 'separated from the pre-understood historical and cultural context that defines one's interpretive framework' (Usher 1996, p. 19).

Meaning is neither singular nor absolute but presents an infinite number of possibilities (Kvale 1996, Crotty 1998) which means that it is not easily quantified or measured but emerges from a researcher's interaction with the object and requires a receptiveness to re-interpretive potential (Crotty 1998). However, to some extent one's imagination is constrained by pre-understanding and cultural domination (Usher 1996). Rather than discovery of existing truths or laws, interpretive inquiry involves a process of 'modification' of one's own prejudices or biases through encounters with what one is trying to understand. Clarifying assumptions can expose researcher prejudice and bias, enable one to reflect on one's own 'situatedness' and act as a 'starting point for acquiring knowledge' (Usher 1996, p. 21). Objective measurement of the validity of the assumptions is not intended. Instead they form a framework for contextual exploration and exposure of possible tensions. Assumptions enable the cultural and historical elements of the object of a research study to be explored (Crotty 1998). The following assumptions provide a framework for inquiry and underpin the literature review, influence the research questions and methodology and contribute to theory development from findings.

1.2. Underpinning assumptions

The overarching assumption is that, enrolled nurses' perceptions of themselves and others alter as they progress through the conversion course. This assumption derives from my observations of changes in students' self-perceptions during the course. The purpose of the research study is to explore altered perceptions and perceived influences on them.

There are a further six related assumptions:

- Enrolled nurses are experienced registered nurses whose experience is not always acknowledged by others.

Enrolled nurses' frustrations concerning lack of acknowledgement of their experience as qualified nurses has been documented in other studies (Seccombe et al 1997, McKenzie 1997, Allan and McLafferty 2001, Kenny and Duckett 2005). Lack of available opportunity for professional development and career progression means that the majority of enrolled nurses have remained at the same grade as newly qualified staff nurses for twenty years.

- Enrolled nurses are non-traditional students and perceive themselves to be 'non-academic' and more practically orientated.

From my knowledge of the conversion course, applicants are less likely to hold academic entrance qualifications and the majority express concern about being able to meet the academic requirements of the course.

- Enrolled nurses perceive that their role is being eroded, their scope of practice is becoming increasingly restricted and opportunities for professional development and career progression are limited.

Enrolled nurses' perceptions of becoming de-skilled have been documented in other studies (Seccombe et al 1997, McKenzie 1997, Dowsell, Hewson and Millar 1998, Allan and McLafferty 2001, Kenny and Duckett 2005). For example, enrolled nurses state that they are no longer able to administer medications even although this was part of their initial training.

- Enrolled nurses require further training to become first level registered nurses.

Regardless of the professional experience and further development needs of individuals, it is assumed by higher education institutions that enrolled nurses require further pre-registration education and training in order to meet the standards of proficiency for professional registration.

- Enrolled nurses perceive as challenging the changes imposed by conversion and the changes in role and responsibility involved in the transition to first level registration.

From my experience of the conversion course many students initially find the course and associated role change daunting. Webb (2001) has also identified negative feelings towards conversion by enrolled nurses because of its impact on domestic life and the increased demands and responsibilities of practising as a first level nurse.

- Enrolled nurses perceive that they lack control over decisions influencing their practice.

Enrolled nurses' feelings of exclusion from decision-making and powerlessness with regard to influencing changes in their own role or professional development has been documented in other studies (McKenzie 1997, Seccombe et al 1997, Dowsell, Hewson and Millar 1998, Allan and McLafferty 2001, Kenny and Duckett 2005).

The above assumptions lend themselves to the exploration of specific areas of theory that are summarised in Table 1. An indication of the focus of the discussion is also given.

Table 1: Assumptions and Theoretical Discussion

Theoretical Area	Assumption	Theoretical Discussion
Experiential Learning	Enrolled nurses are experienced registered nurses whose experience is not always acknowledged by others.	The perceived validity of the knowledge derived from learning from experience.
Adult Learning	Enrolled nurses are non-traditional students and perceive themselves to be 'non-academic' and more practically orientated.	The influence of lifespan development, attribution and self-efficacy on adult learning and the implications for curriculum design.
Professionalisation and Academisation	Enrolled nurses perceive that their role is being eroded; their scope of practice is becoming increasingly restricted and opportunities for professional development and career progression are limited.	The potential influence of current knowledge values associated with professionalisation and academisation within communities of practice and the impact on enrolled nurses' experiences of conversion.
Professional Competence	Enrolled nurses require further training to become first level registered nurses.	Contested views of professional competence and its assessment relevant to nurse education, enrolled nurses and the nature of conversion programmes.
Autonomy, Agency and Accountability	Enrolled nurses perceive that they lack control over decisions influencing their practice.	The perceived role of education in the development of professional autonomy, agency and accountability.
Role Transition and Transformative Education	Enrolled nurses perceive as challenging the changes imposed by conversion and the changes in role and responsibility involved in the transition to first level registration. .	The nature of role transition and transformative education and the theoretical insight it provides into the conversion experience.

There are nine chapters including this one and the remaining chapters are:

Chapter 2: Enrolled nurses – background and context

The historical background of the role of the enrolled nurse from its creation in 1943 is examined including significant political influences on professionalisation and its impact. An overview of the findings of studies on conversion experiences is provided and issues related to the assumptions with which the study is concerned are highlighted.

Chapter 3: Literature review

Six main theoretical areas and associated issues are examined in relation to the assumptions:

- Experiential learning

- Adult learning

- Professionalisation and academisation

- Professional competence

- Professional autonomy, agency and accountability

- Role transition, transformative education and conversion

Chapter 4: Methodology

Social constructionist assumptions and the phenomenological perspective underpinning the study are discussed and the grounded theory approach to data collection and analysis is described. Semi-structured interviews were used to collect data involving a sample of thirty enrolled nurses interviewed on three occasions before during and after a period of the course perceived as challenging. The thirty were drawn from three separate cohorts each at a different stage in the course enabling experiences across the whole course to

be examined. Four main themes emerged from analysis of the data and the findings related to each theme will be presented in separate chapters (5 – 8).

Chapter 5: Being experienced

Chapter 6: Academic credibility

Chapter 7: Motivation

Chapter 8: Conscientization

Chapter 9: Discussion, conclusions and recommendations

The findings of the study are specific to the enrolled nurses who participated in it and are not generalisable. Nevertheless they are important because they question assumptions about the nature of learning and competence in nursing.

Chapter 2: Enrolled nurses and conversion – background

2.1. Profile of Enrolled Nurses

Enrolled nurse training was two, as opposed to three years. The shorter training was developed in 1943, due to a shortage of qualified nurses in specific areas of nursing. The course was regarded as being more practical and less academic than the three-year registered nurse training. Entry was not based on academic qualification but on interview alone or, in some instances, an entrance test (Bendall and Raybould 1969).

2.2. The Briggs Report

The demise of enrolled nurse training resulted from the decision by the newly constituted UKCC to have only one level of nurse training. This was one of the key changes in the regulation of nurse education recommended by the Briggs Committee (DHSS 1972). The Report identified that, although the qualification and career progression of enrolled and registered nurses was quite distinct, enrolled nurses often undertook the same level of work as staff nurses. In order to eradicate this difference the Committee recommended only one portal of entry but with different exit options. Namely, a basic education of 18 months for all entrants leading to a Certificate in Nursing Practice followed by an 18-month period of branch specialisation leading to registration and a Higher Certificate in Nursing Practice for those who demonstrated specific interest and aptitude. Fundamental to this proposal was that entrance to and progression within nursing should be based on ability and motivation rather than academic qualification.

'We believe that nursing often appeals to late developers and to people with average intelligence or more who, though they have few formal qualifications have a high degree of motivation. … At point of entry to the nursing and midwifery profession applicants should be drawn from a wide range of intelligence from average to highest. Suitability should not be determined by 'O' levels alone.' (DHSS 1972, pp. 82-83).

The characteristics of enrolled nurses identified within the Briggs Report closely resemble those of the participants in this study. Briggs reported that pupil nurses were more likely to have had work experience related to nursing prior to commencing training. The report also identified the lack of awareness of some applicants of the difference between the two levels of nursing and the implications for future career opportunities. Some well-qualified applicants had difficulty distinguishing between the two types of training and chose enrolment because it was shorter. This was one of the reasons influencing the Committee's recommendation of one point of entry.

Briggs highlighted that perceived status was one feature that distinguished enrolled nurses from registered nurses. When asked whether they would like to be treated like other students in further or higher education, 46% of the enrolled nurse sample did not think that it would be a good idea for them. Pupil nurses thought that it would be a good idea for student nurses but not themselves. Briggs concluded that this indicated existence of a 'marked feeling of status difference' reflected in the similarity in social background of pupil nurses and nursing assistants and auxiliaries compared to that of the student group (DHSS 1972, p. 62).

In evidence to the Committee, the RCN (1971) endorsed a model of nurse education with a single portal of entry and two distinct exit points. General Duty Nurse was the title recommended for those who did not wish to undertake further specialist training leading to registration. It was envisaged that enrolled nurses would be regarded as general duty nurses but that they would also have access to opportunities for further specialist training and management courses and would be eligible to apply for ward sister or charge nurse posts. Briggs also recommended that assimilation for enrolled nurses should include the opportunity to undertake a shortened course leading to registration with credit for experience and certain post enrolment courses undertaken (DHSS 1972).

2.3. The Griffith Report and Grading

In 1983 the Griffith Report recommended the implementation of general management principles into the NHS in order to plan and implement change and to control resources effectively (West 1992). The focus on savings within the nursing budget resulted in the introduction of a pay grading system that had a profound effect particularly on the position of enrolled nurses and their influence on the scope of practice and potential for individual professional development and progression. The introduction of the grading system caused tensions amongst all levels of nursing staff and reinforced status differences.

At a professional level the impact of Griffith was perceived to greatly disempower nursing by eradicating representation in resource management and policy development. Robinson (1992) suggests that this reflects a nursing legacy of powerlessness that

derives from two related sources. One concerns the perception of caring as women's work for which there are plentiful skills compared to those of medical specialists. The second concerns nursing as a women's issue where socialisation and tradition influence behaviour, in particular the degree to which women lack a critical stance and 'acquiesce to others' formulations (Robinson 1992, p. 7). She believes that nursing is relatively unimportant to government and the medical profession and that Griffith represents an attempt by the former to curb the power of the latter with nursing 'getting caught in the crossfire.' (Robinson 1992, p. 5). The impact on nurses' perception of the profession's powerlessness had a profound impact on esteem.

2.4. Enrolled Nurses: A Study for the UKCC

In the early 1990's stand alone conversion programmes were developed that were offered by Colleges of Nursing but enrolled nurses generally did not find that they were easily accessible. Results of a survey commissioned by the UKCC highlighted difficulties experienced by enrolled nurses trying to access conversion programmes. The study explored problems that enrolled nurses had identified in relation to professional practice and identified issues related to employment, role and conversion (Seccombe at al. 1997).

Statistical information showed that enrolled nurses formed 25% (110,529) of registered nurses at that time. More recent figures show the number of enrolled nurses on the professional register to be 54,665 (NMC 2002). Furthermore, 50% of enrolled nurses trained in the 1970's and potentially could have more than thirty years experience post qualifying. 40% have 10 years before expected retirement and could practice during that

time. The 1997 study found that the majority of enrolled nurses were employed at D grade or equivalent. Newly qualified staff nurses are also grade D (Seccombe et al 1997).

Table 2: Enrolled Nurse Grades

GRADE	%
C	18
D	63
E	16
F	<1

Source: Seccombe et al (1997).

The main reasons given by employers for not considering applications from enrolled nurses for D grade were conversion costs and restrictions on practice, perceived to have been imposed by the UKCC or local policy. The survey found that the commonest restrictions on practice experienced by enrolled nurses included:

- Mentoring

- Administration of controlled drugs

- Setting clinical standards

- Being in charge of nursing homes

- Undertaking first assessment visits in the community.

Five issues were identified that affected the professional practice of enrolled nurses:

- Narrow interpretation of Rule 18(2)

- Clinical grading

- Scope of professional practice

- Standard for the Administration of Medicines

- Difficulties in gaining access to conversion programmes

(Seccombe et al 1997).

Following publication of the Institute of Employment report Norman (1997) stated that Rule 18(2) referred to the level of competence expected at point of registration and that it should not limit individual professional development. The UKCC set up a working party to consider issues of professional accountability and as a result, made clear the position by stating that enrolled nurses are accountable for their practice, the scope of which will be limited only by individual competence (UKCC 2000).

However, discrimination against enrolled nurses continues which restricts professional development and denies access to post-registration education. Those employed part-time and on permanent night duty are more likely to have limited access (Barribal and While 1996).

2.5. Summary of policies

The Briggs Report portrayed a vision of wider access that would have enabled individuals from a wide variety of backgrounds to enter nursing, including mature applicants and others that might have applied for enrolled nurse training in the past. However, it would be necessary to consider the extent to which the pedagogy was relevant to the learning needs of all of the applicants. The appeal to graduates and other

professionals wishing to enter the profession mid career would require the development of a robust but flexible accreditation process.

Enrolled nursing had a relatively short lifespan and was probably doomed before it commenced. The concept of nursing assistants being granted a professional qualification was not welcomed by all within the profession. Bedford-Fenwick, the key protagonist of nursing registration in the late 19th and early 20th century, campaigned against training for the Roll (Bendall and Raybould 1969). Her concerns could be interpreted as elitist protectionism or may have been an attempt to challenge perceived domination of the health service by the medical profession. Briggs identified a status differential between enrolled nurses and registered nurses that he sought to eradicate through the introduction of single portal of entry (DHSS 1972).

The Griffith Report proved to be a political force that changed the control that nursing had over decisions concerning practice at an individual and professional level for reasons of economy and power. Robinson (1992) believes that the perceived lack of importance of nursing is a matter of serious concern, and that it is linked to the general and occupational socialisation of women. She suggests that professional education has the potential to promote the development of self-confident and assertive nurses who are capable of challenging others' assumptions about nursing and enabling them to be reflexive and to take a critical stance in matters in which they are experienced.

Briggs and the RCN recommended assimilation of enrolled nurses that would accredit experience and prior learning. At present, 15 years after training for the Roll ended and

35 years after Briggs, there is still a large number of enrolled nurses who wish to convert to first level but who are finding it increasingly difficult to do so.

2.6. Diminished scope of practice and restricted opportunities

Enrolled nurses perceive that their role has diminished and the scope of their practice has been restricted since the announcement by the UKCC in 1986 that there would be one level of entry to the profession (UKCC 1986). The experience of enrolled nurses reflects a process of professionalisation within nursing during an intense period of change. The main catalyst was academisation marked by a shift from apprenticeship training to supernummerary status and academic qualification. The change originated from the Briggs recommendations and marked a shift from the old order to a new position for nursing. The process of professionalisation can be examined from the perspective of enrolled nurses whose perceptions of the change in their role include three main elements:

- Diminished scope of practice.

- Restricted opportunities for professional development.

- Lack of opportunities for career progression.

2.6.1. Diminished scope of practice

A survey by the Institute of Employment (Seccombe et al. 1997) identified specific aspects of practice that enrolled nurses perceived that they no longer engaged in including mentoring students and administering medicines. According to the survey the main influence was misinterpretation by managers and employers of Rule 18(2). The

Rule formed part of the regulation that identified the competences required for entry to the professional register developed by the UKCC. Rule 18(1) applied to first level nurses and Rule 18(2) to second level nurses.

Table 3: Rule 18(2) Competences

(a)	Assist in carrying out comprehensive observation of the patient and help in assessing her care requirements.
(b)	Develop skills to enable her to assist in the implementation of nursing care under the direction of a person registered in parts 1, 3, 5, or 8 of the register.
(c)	Accept delegated nursing tasks.
(d)	Assist in reviewing the effectiveness of the care provided.
(e)	Work in a team with other nurses, and with medical and paramedical staff and social workers.

(Source: UKCC 1983.)

According to the results of the survey managers were confused about what enrolled nurses should be allowed to do resulting in locally imposed limitations that varied from one area to another (Seccombe et al. 1997). Clinical grading provided a mechanism for legitimising limitations on practice.

The majority of enrolled nurses have remained at the same grade for twenty years. Despite their experience professional development opportunities have been restricted. For example, until recently mentorship preparation was restricted to first level nurses in most areas. Access to specialist modules was restricted because most enrolled nurses have insufficient academic credit and entry is often limited to first level nurses. Enrolled nurses have expressed a sense of frustration and, in some instances have become de-skilled, especially those at grade C. The assimilation recommended by Briggs has not transpired and they appear to have received little credit for their experience and few real opportunities for professional development or promotion. Some areas no longer employ enrolled nurses.

2.7. Change Process

Enrolled nurses' transition to first level registration is influenced by experiences of the conversion process. An outline of the structure and aims of the processes involved and related theory partly informs the nature of the experience. However, whilst curricular influences are important the learning experience is dependent on individual and collective perspectives of learners and teachers participating in the process and the sociocultural context in which learning is situated.

> 'Learning cannot be designed. Ultimately it belongs to the realm of experience and practice. It follows the recognition of meaning; it moves on its own terms. It slips through the cracks; it creates its own cracks. Learning happens design or no design.' (Wenger 1998, p. 225).

Learning is an integral part of everyday experience and is not confined to planned experiences and, although curricular design has the potential to positively enhance or adversely influence the learning experience, it cannot control what emerges. Consideration of the conversion programme as an instrument of change provides only a partial view of the process of transition, however, it enables observation of the power-identity dynamic, central to which is the belief that learning has the potential to empower and transform.

> 'Learning, whatever form it takes, changes who we are by changing our ability to participate, to belong, to negotiate meaning. And this ability is configured socially with respect to practices, communities and economies of meaning where it shapes our identities.' (Wenger 1998, p. 226).

2.8. Conversion Programme

On entry to the programme enrolled nurses' perceptions of the nature of the experience of transition and its purpose vary. However, some shared feelings can be identified arising from perceptions of occupational position and academic credibility. All of the students on the conversion programme are experienced registered nurses who are motivated to convert to first level but are apprehensive about the process involved. As demonstrated in chapter 6, section 6.5.3. apprehensions arise from self-doubt about ability to meet the demands expected of a first level nurse and fear of failure due to perceived lack of academic ability. Most do not question the need for a conversion programme however, whilst a few welcome the challenge most express concerns about being able to meet the demands of the course. Individual perceptions vary according to disposition, past experiences of education and perceived occupational role and position.

This section will examine possible influences on perceptions of self and others and how these alter as students progress through the programme.

The conversion programme to first level is designed to gradually increase student responsibility for learning and to promote the development of self-direction. Prior to commencing the programme all learners participate in a profiling process that acknowledges and accredits learning derived from experience. The programme is presented in an open learning format that provides a degree of flexibility that can address most of the learners' needs. The assessment strategy drives learning and development and promotes critical self-reflection. As learners progress through the programme they appear to become more confident and self-directed as demonstrated in chapter 7, section 7.10. The rate and degree of change varies between individuals but all learners report that they experience change in the way that they think and act (chapter 7, section 7.11.3.). Initially learners tend to seek the security of a structured programme with clearly defined goals and predetermined outcomes and can become anxious when asked to consider their own learning needs. However, later in the programme they appear more able to identify learning goals, set attainment criteria and appraise their own performance and achievement with little guidance.

The conversion course involved in the study is a 104-week open learning programme leading to a Diploma of Higher Education in Nursing with first level registration in either adult, mental health or learning disability nursing. The professional qualifications equivalent to that of newly qualified staff nurses. Conversion students remain in employment throughout the programme and must have a contract for a minimum of twenty hours a week to meet the statutorily required hours of practice. Learners

normally have experience of the particular branch of nursing that they are converting to and the area in which they are employed must meet the audit requirements that demonstrate that the learning experience provided is relevant to branch of nursing that learners are preparing for. Theoretical hours are provided by activities within the open learning materials and practice-focused assignments.

The programme is designed to promote professional development through profiling and goal and action planning and opportunities for learning and development occur through practice experiences both in the learners' own clinical areas and other clinical placements and through assignments and the activities within the materials. Processes involve promoting increased self-awareness and critical reflection. learners form small tutorial groups of about 6 to 10 learner members and each group is facilitated by a tutor counsellor. Groups normally meet fortnightly for about 2 to 3 hours and in addition each learner receives individual support from the tutor counsellor usually in the form of constructive feedback which can be face to face, written, by telephone or online. Flexible delivery is possible and learners at a distance can participate in group tutorials online. There are two residential workshops during the course involving one or more cohorts enabling learners develop a broad network and to experience learning through participation within a larger learner forum.

The study was designed to examine students' experiences of transition through challenging periods of the programme. A brief outline of aspects forming the main framework of the programme includes the following:

2.8.1. Accreditation of Experience Derived Learning (AEDL)

AEDL is a process specifically designed to acknowledge and accredit enrolled nurses' experience evident within current practice (Stillie and McQueeney 1990). The process involves written descriptions and analyses of critical incidents occurring over a three-month period. Specific elements of competence evident within the context of the situation are discussed by the student and the tutor counsellor and consideration given to other possible decisions and courses of action. Comparisons of actions possible within other contexts are explored using knowledge derived from experience. Learning through reflection on experience is credited against the requirement for supervised practice within a learner's normal area of employment. The key elements of competence involved in the process can be linked to the NMC standards of proficiency (NMC 2004) that require to be met for entry to the professional register.

Learners report that they find the process invaluable to their development (as illustrated by one of the participants in chapter 7, section 7.9.1) and a formal evaluation of the AEDL process in 2005 identified benefits which were perceived by learners to include:

- Increased confidence and assertiveness

- Improved self-esteem

- Heightened awareness of professional accountability

- Awareness of skills and knowledge derived from experience

- Appreciation of the need for continuous professional development

- Awareness of reflection on practice

Documenting and discussing critical incidents and elements of practice with others, for example practice supervisors, colleagues, peers, is valued by learners and is perceived

to enhance and personalise the process. External validation is an important symbolisation of legitimate practice as a registered nurse. Critical incidents provide opportunities for discussion and exploration of professional dilemmas within the context of actual situations of practice. These are unpredictable and often uncomfortable and provide a focus for learning from experience. Discussion with others including colleagues and peers provides opportunities for shared learning and has the potential to enhance practice by stimulating change at an individual level and within the workplace. Academically AEDL encourages critical reflection and is perceived as a legitimate process of learning within the educational institution.

2.8.2. Specialist Modules

The programme commences with a series of four 6-week modules in community health, mental health, child health and mother and newborn. Open learning materials and activities act as a learning guide and each module includes a 2-week specialist placement. This structure forms a series of relatively small and easily achievable steps. Constructive feedback on learners' work is provided quickly and this is important to the learners who perceive this as their first real academic work and are apprehensive because they do not know what is expected of them. Receiving tutor's comments for the first time can be a daunting experience. As learners succeed and proceed through the modules they experience a growth in self-esteem and a developing sense of efficacy in relation to academic ability. In addition the modules are interesting and stimulating and involve learning about areas of practice of which they may have had little or no past experience. Learners are encouraged to arrange some visits on their own and to develop a profile of learning from their experiences and goal and action planning is an inherent

aspect of the learning process. A study day is held at the beginning and end of each module to provide guidance with the learning process. At the first day the module is introduced and learners work together to identify what they would like to learn and how that could be achieved. The second day provides an opportunity to reflect on what was actually learned. Participation in group discussion stimulates diversity and enables students to share common feelings related to apprehension and growth.

2.8.3. In Depth Study of Nursing

The In Depth Study assignment focuses on management of the process of change. Learners select an aspect of practice within their own area of employment that they feel could be improved upon and following assessment and planning are expected to implement and evaluate the change process. Assignment guidelines are divided into five discrete stages that are well structured. Learners receive formative feedback on each stage, before submission of the completed assignment for summative assessment. The development of formal writing skills is promoted during this assignment and literature searching, critical reading and referencing are introduced. The whole process lasts for about 8 months during which learners' perceptions of themselves perceptibly alter, as demonstrated in chapter 7, section 7.4.3. Reasons for this derive from participation in a process of managing actual change include promotion of deep learning about the chosen subject area, development of skills in negotiation with members of staff and other professionals including senior nursing medical staff, gaining a sense of achievement through observed improvement and completing an academic assignment that is perceived to be a substantial piece of work. On completion of the process learners appear to be more self-controlled and self-confident.

2.8.4. Clinical Placements

Placements in areas outwith learners' own area of employment provide opportunities to experience areas of practice that are new to them or that they haven't been involved in for a long period. learners are encouraged to be proactive by visiting placement areas in advance to introduce themselves and to discuss relevant and realistic goals that could be achieved during the placement. Initial resistance or reluctance to this suggestion possibly derives from learners' perceptions of their experiences of pupil nurse training as passive recipients rather than active participants in the learning process.

2.8.5. Reflective Practice Assignment

The process involves deeper reflection that questions assumptions and examines values, attitudes and beliefs influencing practice. Alternative perspectives are considered and other possible decisions and courses of action explored. Although perceived to be a challenging piece of work, learners find it stimulating and satisfying. Guidelines are much less structured than in previous assignments and learners assume much greater responsibility for interpreting what is required and for seeking clarification and assistance from their tutor counsellor when necessary.

2.8.6. Conversion Programme Assumptions

The process of conversion is driven by the assignments, each of which provides a series of steps that build on one another and gradually enable the learner to become more self-

directed. Motivation is captivated by the challenge provided by each step and its successful achievement. There are five main assumptions embedded within the process:

1. Agentic perspective - an agentic perspective assumes that an individual is capable of self-direction. However, the role of the enrolled nurse is subject to internal and external constraints on perceptions of agency.

2. Promotion of self-efficacy - self-efficacy requires a balanced self-appraisal of the degree of control that one has within a situation.

3. Enable self-awareness of constraints - awareness of internal and external constraints associated with being an enrolled nurse assists in the transition to a perception of self as agentic and as a first-level registered nurse. The transition also includes altering perception of self as a pupil nurse constrained by educational values of learner passivity to become self-directed and responsible for one's own learning and development.

4. Acknowledges and accredits experience - acknowledgement of experience validates strengths and highlights potential capability for self-regulation through negotiation of a definition of competence according to the context of the situation and also determining one's own learning and development needs.

5. Promote critical self-reflection - consciousness of internal and external constraints imposed by one's perception of self as a pupil or an enrolled nurse is replaced by a critical awareness of the need to challenge unquestioned assumptions through critical self-reflection. Role transition involves challenging taken for granted assumptions and behaviours that influence self-perception of abilities and determine interaction, for example between tutor and learner.

2.9. Previous studies on enrolled nurse conversion

Enrolled nurse conversion has been the subject of a number of studies, each of which has focused on different aspects of the experience. Although there is considerable variation between studies in the theoretical perspectives and research methods employed the similarities in the findings are striking. Common findings can be categorised into five main areas:

- Reasons for enrolled nurse training

- What it means to be an enrolled nurse

- Reasons for conversion

- Perceptions of conversion experiences

- Outcomes of conversion

2.9.1. Reasons for enrolled nurse training

The main reasons identified include having insufficient academic qualifications for the three-year training and a desire to give physical care. Not understanding the difference between the two qualifications (first and second level) and choosing enrolled nurse training because it was shorter and not having to wait to commence nursing were also identified as important reasons as were family commitments and also enrolled nurse training being the only one offered locally (McKenzie 1997, Allan and McLafferty 2001).

2.9.2. What it means to be an enrolled nurse

Feelings of low morale and self-esteem and lack of confidence associated with a less meaningful role and a recent loss of identity as an enrolled were identified and related to job insecurity, lack of role protection and reduced status. Feelings of being discriminated against and of not being valued by others were also reported (Webb 2001). McKenzie (1997) identified that the enrolled nurses she studied felt inferior to first level nurses and had little control over decision-making. They were also passive and unlikely to speak out about practice even when it was perceived to be of a poor standard. She found that they put themselves down and felt embarrassed about being regarded as a second rate nurse. Job role satisfaction was greater where no difference in status was perceived and least where hierarchy and status were dominant workplace features (McKenzie 1997). Iley (2004) found that enrolled nurses who had a high level of job satisfaction were less likely to convert. Dowsell, Hewison and Millar (1998) suggested that a collective view of the role of the enrolled nurse and a group identity was evident in the way that individuals refer to their feelings as being the same as that of the group. McKenzie (1997) also reported this.

2.9.3. Reasons for conversion

Reasons for conversion often related to feelings about being an enrolled nurse and five main categories can be identified:

- Lack of career progression and few or no professional development opportunities (McKenzie 1997, Allan and McLafferty 2001).

- Role erosion particularly in relation to medication issues contributed to feelings of discontentment and disillusionment with the enrolled nurse role. Being excluded from decision-making and deskilling influenced perceptions of feelings of being undervalued and of having a second rate qualification which has been compounded by rigid interpretation of Rule 18(2) competences (McKenzie 1997, Dowsell, Hewson and Millar 1998, Allan and McLafferty 2001, Kenny and Duckett 2005).

- Role ambiguity due to being used as a first level nurse when staffing levels or untoward experiences require experience. On the other hand feeling threatened by the role of health care assistants who are perceived to be undermining the enrolled nurse qualification. Frustrations have strained relations between enrolled nurses and first level nurses and in particular with managers (McKenzie 1997, Allan and McLafferty 2001, Kenny and Duckett 2005).

- Job security was important. Enrolled nurses felt 'trapped' because the qualification was no longer recognised influencing feelings of lack of control and anger. In some cases this was compounded by a perceived threat of demotion (Dowsell, Hewison and Millar 1998, Kenny and Duckett 2005).

- Lack of acknowledgement of experience by others and learning from experience not being regarded as legitimate by enrolled nurses themselves led them to convert to first level (McKenzie 1997, Allan and McLafferty 2001, Kenny and Duckett 2005).

Findings by Dowsell, Hewison and Millar (1998) suggested that enrolled nurses felt under pressure to convert. Their study also revealed that participants believed that they were already experienced and that conversion was unlikely to develop their practical skills. Most enrolled nurses undertook conversion because they felt that it would lead to greater job security and opportunities (McKenzie 1987, Dowsell, Hewison and Millar

1998, Webb 2001, Iley 2004, Kenny and Duckett 2005). Webb (2001) focussed on reasons given by enrolled nurses for not wanting to convert and found that fear of academic expectations and a high level of commitment to family needs were the most influential barriers.

2.9.4. Perceptions of experiences of conversion

Dowsell, Hewison and Millar's (1998) study of continuing education and training within the NHS highlighted the personal and professional impact of conversion on enrolled nurses. They identified difficulties experienced by enrolled nurses on an open learning course in relation to release for placements and lack of study time, which had a negative impact on home life and family relationships. In particular pressure and guilt associated with perceived parental role inadequacy and lack of time for housework, family or self. They noted that there was little impact on work roles because these were perceived by the participants to be non-negotiable. Lack of support and additional workplace pressure was also highlighted as a concern within Kenny and Duckett's (2005) study. Prompted by Dowsell to consider possible benefits of conversion, the enrolled nurses identified that they were aware of critically questioning and reflecting on their clinical practice and that these developments were perceived to have been facilitated by placements outside the normal workplace. Library, writing and computing skills were also perceived to have developed as a result of the conversion course (Dowsell Hewison and Millar 1998).

2.9.6. Outcomes of conversion

Research articles that identified outcomes of conversion focus mainly on the perceived benefits and value of courses with limited discussion of underlying influences. For example, Allan and McLafferty (2001) reported that more than 50% of those who completed conversion courses went on to further academic study and that positive changes in the knowledge, skills and attitudes of converters were perceived. Similarly Hill and McGregor (1998) claimed that enrolled nurses had perceived positive changes in their self-confidence, knowledge, increased career prospects and critical thinking as a result of conversion. Iley (2004) on the other hand reported that converters were less likely to be satisfied with their work role post conversion citing reduced clinical time and increased administration as factors. However she suggested that individual expectations may be a significant influence as converters were more likely to be young, male, experienced and have a high career orientation. They were also more likely to have higher educational qualifications and work full-time and never to have taken a career break. She warns that emphasis on conversion is more likely to promote the value of technical skills and devalue caring.

Webb (2001) concluded that enrolled nurses should not be pressurised into conversion to first level registration and recommended that more should be done to invest in the role and to improve the profile of enrolled nurses by highlighting their experience. Dowsell, Hewison and Millar (1998) recommended that the personal costs of conversion be taken seriously by employers who have a responsibility to provide adequate study leave, to recognise the requirements of open learning study and to accommodate these within the existing work organisation. Educational providers should

also acknowledge the findings and seriously consider how course expectations impact on personal experience.

Two research studies are particularly relevant to this study and merit further consideration:

Dearnley and Matthew's (2000) study aimed to explore the impact of an open learning conversion course on participants' attitudes towards learning using a grounded theory approach. Motivation emerged as a key theme. Similarities in findings between Dearnley and Matthew's study and this one include the importance of the process of the In Depth Study and peer group support. The main difference between the studies is that Dearnley and Mattew claim that an open learning approach has a significant influence on attitude change in the case of enrolled nurses converting to first level registration. I would suggest that there is a need to examine the processes involved in more depth. However, the small sample involved (six participants) is limiting and Dearnley and Matthew state that the purpose of the study is to 'identify key concepts for further investigation' which it does (Dearnley and Matthew 2000). Contrasting findings raise awareness of possible further dimensions for consideration within this study in relation to the experiences of change in perceptions of self and others during conversion.

McKenzie's (1997) study investigates 'subjective work experiences' of enrolled nurses using a feminist methodology that highlights themes of identity and exploitation related to perceptions of rank, status and expertise within nursing. The relationship between power and dependence within a nursing hierarchy and its potential impact on patient care is most significant.

The controversy of enrolled nurse conversion has not dissipated. From the 31st August 2007 enrolled nurses who wish to convert require to become full-time students should have supernumerary status (NMC 2004). This means undertaking a shortened pre-registration nursing programme. Whilst the efficacy of protecting the student experience can be understood for many enrolled nurses this will be financially, geographically and socially impossible. Stand alone conversion programmes must demonstrate robust mechanisms of accrediting knowledge and skills equivalent to those provided by the three-year pre-registration programme in order to meet the criteria for professional validation.

Chapter 3: Literature Review

The chapter aims to consider the context of the study and, with reference to relevant theory, explore and explain:

- The nature of the perceived experience of cultural transition.

- Individual perceptions of self and others and how perception alters as a person progresses through the conversion programme.

- The nature and impact of internal and external influences on the experience of transition.

- The degree of control that an individual perceives that they have over their practice and how that alters as they progress through the process.

- The implications for professional education of the experience and perceived changes.

3.1. Occupational Self-Concept

This section will explore what is known about the concept of being experienced, constraints on becoming experienced and how they operate.

The main issues concerning occupational self-concept that will be considered are:

- Being experienced – including what it means to be experienced and the process of becoming experienced. Theories of skill acquisition and experiential learning will be examined and the concept of professional competence will be considered.

- Diminishing scope of practice and lack of opportunity.

- Position within a hierarchical structure of the organisation.

3.1.1. Theory of Skill Acquisition

Dreyfus and Dreyfus's (1986) theory of skill acquisition is based on the assumption that experience is acquired from repeated exposure to situations that enable the development of familiarity and outcome prediction. Where practice is consistent, predication is relatively easy. However, professional practice can be unstructured and unpredictable (Schon 1983) and, where this is the case, exposure to a large number of situations is required for skill acquisition. It is usual for an individual to be more experienced in some situations and less so in others.

Five discrete stages of development are identified through which an individual progresses. Each stage is marked by an alteration in the way that situations are perceived as an individual becomes more familiar with them and is able to predict likely outcomes. The five stages are novice; advanced beginner; competent; proficient and expert.

- Novice - elements of a situation are perceived as separate, objectively definable entities that are unrelated to the context in which they occur. Actions are governed by procedural rules, regulations and policies.

- Advanced Beginner - becoming familiar with situations regularly experienced, individuals perceive similarities in elements between situations and attend to them. Perception of the situation as a whole is beginning to develop and reliance on and use of procedural rules is more complex.

- Competent - a competent individual is able to identify a large number of elements within a situation but initially finds it difficult to prioritise between them. Over time

the presence and absence of elements is observed and prioritising abilities developed through planning, organising and setting goals.

One of the main differences between novice, advanced beginner and competent practitioner is the shift from having to follow rules and guidelines to being able to prioritise elements, plan actions and set goals within a given situation. This implies that competent practitioners make decisions about and take more responsibility for their practice. However, deliberation on rules and guidelines before deciding is still usual.

- Proficient - beyond competence skilled practitioners are more likely to perceive situations holistically without focusing on each feature as a separate entity. Also attention rapidly focuses on unusual features that stand out within a situation. The ability to focus on the unusual develops from exposure to a large number of similar situations in the past whose features have been committed to memory and contributes to performance that appears to be intuitive. Detached and rational decision-making follows intuition. Dreyfus and Dreyfus perceive intuition to be 'an ability that our tradition has acknowledged only in women, usually in impersonal situations, and has been adjudged inferior to masculine rationality.' (Dreyfus and Dreyfus1986, p. 29).

- Expert - an expert performer need not engage in detached deliberation when deciding on action. Situations are holistically perceived and actions are based on experience of past situations and associated actions. An expert tends to be deeply involved in the situation and actions may appear to be automatic.

Reasoning is more implicit and actions and related decisions can be difficult to explain. Dreyfus and Dreyfus suggest that cultural expectations for rational justification may lead expert performers to use complicated jargon or invent reasons for their actions where none are perceived. Progression through the stages of acquisition is based on 'an accumulation of concrete experiences and the unconscious recognition of new situations similar to whole remembered ones.' (Dreyfus and Dreyfus 1986, p. 35). Expert judgement is believed to be intuitive rather than based on rational analysis of competence although detached, deliberative rationality is employed when needed.

In a study of skill acquisition in nursing, Benner (1984) claimed that differences between novice and expert perceptions of a situation demonstrate the speed and precision with which skilled judgement influences decision-making.

3.1.2. Professional Competence

Professional competence implies an ability to use knowledge derived from experience to inform judgement of actions in the best interests of clients within a given situation (Eraut 1994). It also involves understanding situational culture and context, being open and receptive to other perspectives and critically evaluating possible alternatives in order to maximise client choice (Eraut 1994, Hodkinson 1995, Barnett 1997). Reflective practice enables uncertainty to be confronted within a variety of familiar and unfamiliar situations (Schon 1983). Professional competence also requires an ability to monitor and appraise one's own performance, challenge unquestioned assumptions, raise awareness of perceived constraints and to speak out on professional matters that could affect the well being of clients (Barnett 1997). Professional competence is more

than ability to prioritise and perform tasks or duties effectively. It derives from experience of practice and associated development of an integrated conceptual framework that contributes to the holistic perspective claimed of proficient and expert practitioners.

3.1.3. Tacit Knowing

Tacit knowing represents the unique perspective of an individual and is personal and subjective. It influences attention, interpretation and assimilation of information and forms an integrative, holistic perspective where personal values, attitudes and beliefs create an understanding of experience that contributes to personal knowledge (Polanyi 1966, Kolb 1984). Individual gestalt cannot be known by others. However, paying attention to a particular element of a situation can positively influence an individual's understanding of the whole and can permanently transform one's perspective (Polanyi 1966).

As demonstrated in chapter 5, section 5.4. enrolled nurses perceive themselves to be experienced. They monitor and evaluate their own performance and can control the development of their personal and professional knowledge. However, knowledge from experience informing professional practice is tacit rather than explicit. Self-doubt about the validity of professional knowledge and competence can adversely influence practice. For example, it may lead to hesitation in putting forward one's viewpoint based on experience, or uncertainty in using one's initiative. Lack of confidence can also influence the responses of others. Promoting awareness of tacit knowing through reflection has the potential to improve self-esteem and perceived self-control.

3.1.4. Experiential Learning Theory

Being experienced is dependent on a process of learning that Kolb (1984) describes as a 'continuous process of adaptation' and derives from a reciprocal determination between internal and external forces. Learning results from a tension between accommodation and assimilation. Accommodation involves the influence of internal concepts and schemas on the interpretation of experiences encountered and assimilation occurs where existing concepts and schemas are altered by the experiences. Interpretation and what is learned depends on individual learning style that derives from a combination of influences including heredity and socialisation within family, school and occupation.

Kolb makes three claims about learning from experience that are particularly relevant to the nature of being experienced, the processes involved in becoming experienced and potential for the development of professional competence.

- Learning is a process of reciprocal determination between individual and environment that is not simply about fitting in but concerns contributing towards it. This implies that an individual has the potential to exert control over the environment and that this can be achieved by being proactive rather than reactive.
- Recognition that ability to contribute to the environment is worthwhile can enhance self-confidence and self-esteem and awareness of control.
- Learning occurs where a dialectic tension exists between concrete experience and abstract analytical detachment and reflection and action.

Kolb developed the dialectic into a 4-stage cycle in which learning from experience is presented as a continuous process of confrontation resulting in the achievement of new knowledge, skills and attitudes.

> Immediate concrete experience is the basis for observation and reflection. These observations are assimilated into a theory from which new implications for action can be deduced. These implications or hypotheses then serve as guides in acting to create new experiences. (Kolb 1984, p. 21).

Enrolled nurses perceive themselves to be experienced nurses but find that the knowledge that they have gained is often not acknowledged within clinical practice nor is it academically accredited as illustrated in chapter 6, section 6.7.6.

Horwitz (1989) defines experiential learning as

> The process of acquiring knowledge and skills outside the formal or traditional methods commonly encountered in the academic classroom. It implies an active participation of the learner in a real or simulated context where what is to be learned is embedded in a larger setting one which is encountered in real life or simulates real life. (Horwitz 1989, p. 81).

Warner Weil and McGill (1989) identify four diverse areas that are influenced by experiential learning including accrediting prior experiential learning (APEL), post-school education, in education for social change and for personal growth and development. However, they claim that all experiential learning promotes learner empowerment through processes that influence learners' perspectives and create possibilities for new identities.

Fenwick (2001) is critical of the dominant constructivist perspective on experiential learning based on critical reflection on concrete experience which she claims is reductionist. From this perspective adult learning is managed and controlled by educators acting as facilitators, coaches or mentors who shape experiential knowledge to fit the requirements of the institutional standard. Regulation of experience in this way ignores the multiplicity of identity. A focus on mental processes decontextualises an individual from the learning situation and separates them from the experience which becomes a depersonalised commodity with which to trade. She outlines four alternative perspectives on experiential that address more complex dimensions of experiential learning and which are relevant to the processes of accreditation of experience derived learning experienced by enrolled nurses during the conversion programme.

Psychoanalytic perspective – concerns the dilemma between the conscious and the unconscious and the desire to know. Conscious anxiety about what is not known can lead to learning resistance through negation of what is desired. The role of education within this perspective is to make desires known. Fenwick suggests that educators need to confront their own unconscious desires for 'certainty and the students' love of authority' in order to assist learners to continuously draw out their fears and anxieties. The psychoanalytical perspective is limited to the view that learning occurs in the mind and it gives insufficient consideration to the influence of social interaction on learning.

Situated perspective – in situated cognition knowing concerns being able to participate meaningfully and holistically. Knowledge and practice are constantly changing and competence continually negotiated. This requires of participants a receptiveness to alternative and new ways of practice. The difficulty with a situated perspective is that

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poor or unacceptable practices could be condoned. It could also promote acceptance of changes in competence without question which means that practice is open to domination without challenge.

Critical cultural perspective – issues of power are central to experience in a critical cultural perspective in which learning aims to emancipate oppressed social groups through conscientization and social action. Within discourses semiotics label people into dualistic categories creating inequality through legitimisation of knowledge, inclusion and exclusion of groups and restriction of possible identities. Educators aim to make clear different perspectives and to promote social action through a 'coming to awareness of one's own implications of one's oppression.' (Fenwick 2001, p. 40).

Enactivist perspective – enactivism, or co-emergent cognition derives from evolutionary biology and assumes that humans exist with the environment. Knowledge exists through participation in the dynamic relational changes and knowledge alters with changes in the symbols of participation. It differs from a situated perspective where and individual has to learn about participating. In an enactivist perspective participant and context are one.

Fenwick suggests that, because of disputable issues of relevance, APEL practices are becoming more restrictive. She cites early examples of APEL that balanced limited reductionism with a philosophy in empowering learners. Fenwick's real concern is that experiential learning is being treated as a 'learning project' without critical examination of assumptions. She raises some serious concerns about the potential power that

educators have over learners' experience and there is a need to challenge their intentions and make them transparent.

3.1.5. Action Learning

Action learning (Revans 1980) principles are relevant to learning processes within the programme. It promotes discussion of perceived problems in practice from different perspectives. It can involve professional groups concerned about aspects of practice and through discussion assess and analyse problems and associated influences and consider alternative courses of action. Action learning is a process that involves learning from experience. According to Revans (1980) learning to think about how one does something enables individuals to use professional judgement and to consider potential actions from all perspectives. Learning by doing involves validation of learning and knowledge claims through demonstration in practice. It encourages one to get on with the task rather than discussing behaviour and treatment and emphasises action preventing prolonged deliberation or introspection. The process focuses on doing something about the problem instead of dwelling on it. It provides an opportunity to learn through reflection on conflict. It is a democratising process and gives individuals control over decision-making and promotes a sense of agency.

The role of the educator in action learning is to facilitate the learning experience and not to judge learners' actions or act as an expert. It is an educational contract between equals. Facilitation is promoted through questioning, seeking a response and ensuring progress and to promote learning how to learn by doing, and with and from others who are also learning how to learn by doing. Throughout the conversion programme tutorial

group discussions enable reflection on learners' events, and promotes learning from each other. Comparing self with others promotes an open-mindedness to seek from others what one needs to know (Revans 1980).

3.1.6. Professionalisation

Professionalisation is a 'process by which occupations seek to gain status and privilege in accord with that ideology (professionalism).' (Eraut 1994, p. 1). The ideology of professionalism is based on that of the powerful professions of medicine and law to which other occupations aspire. It has influenced the identification of defining characteristics that clarify the boundary between an occupation and a profession. Justification for the existence and worth of a profession is normally expressed as protection of the client, lay person or public from unqualified persons whose knowledge and conduct is not under the scrutiny of an approved regulatory body and therefore whose standards may not meet those of registered professionals.

A profession must demonstrate that its members serve in the best interests of clients and that the required standards of competence and conduct are met. Individual members must maintain their knowledge base, have moral integrity, act in the best interests of their clients and demonstrate the required standards of conduct and conditions of service. Regulation of membership is achieved by ensuring that clearly defined standards for entry are met through approved programmes of preparation in theory and practice. Continued fitness for practice of qualified members is monitored through formal mechanisms for assessing continued professional development and a code of conduct that acts as a measure of professional accountability. From a critical perspective

professional protectionism could be considered to be self-seeking and the existence of regulatory measures perceived to protect the status of an elite by restricting entry.

The power differential that exists between professions can be related to the degree of autonomy over decisions concerning service and client which is influenced by two forces:

1. The most powerful professions control those less powerful but related professions, for example, professions allied to medicine. Concept of service is influenced by the uniqueness of the service provided by the profession.

2. Government regulation of professional autonomy through national guidelines for practice and frameworks ascribing vocational and academic qualifications to levels of behavioural outcomes.

Etzioni (1969) suggested that nursing lacked sufficient autonomy to be regarded as a profession because of an emphasis on accountability to superiors that exists within the hierarchical structure of the occupational organisation.

Professional status is enhanced by academic validation of the qualification and competition for recruitment has influenced the move towards degree status for many professions. However, academization has influenced a bias toward technical-rationality and a scientific knowledge base as opposed to intuitive practice and professional artistry which has an experiential base. The Briggs's recommendations for the reform of nurse education attempted to assure recruitment and retention in view of increased competition for more highly qualified school leavers. Part of the strategy recommended widening entry to nursing enabling access to the profession of mature and motivated applicants who lacked sufficient academic qualifications. The recommendation for

regulatory reform through the creation of a central council led to the legitimisation of the nursing qualification by higher education, development of a code of professional conduct and the introduction of evidence of continued professional development for renewal of professional registration.

Robinson (1992) describes two perspectives on nursing that could affect how needs for professional education are defined. The first view involves a holistic approach in which decisions about care are determined by ethical considerations. Clinical nurses control their own decision-making based on the assessment of the needs of individual patients. The personal autonomy involved in the decision-making could enhance a nurse's sense of meaning and improve job satisfaction. This requires a broad education that enables the practitioner to develop an ability to use discretionary judgement based on ethical considerations. The second view is set within a rational scientific framework in which nursing is regarded as a supply of labour. The purpose of education would be to ensure the acquisition of the necessary level of competence to carry out tasks in the most effective way. Robinson suggests that professional practitioners would select the first approach, while the cost effectiveness implied in the second approach would appeal to employers. On the other hand, from a manager's perspective, Robinson (1992) warns against the proletarianism of the nursing workforce through 'the creation of a highly skilled nursing elite necessary to primary nursing being achieved at the expense of the majority of the workforce.' (Robinson, 1992, p. 36).

It would appear that a dichotomy exists between education and training that has implications for the degree of autonomy nurses have over decisions about patients' care and treatment.

3.1.7. Hierarchical Structure

Five assumptions from social dominance theory concerning hierarchically determined power relationships are relevant to this study:

1. All societies are organised hierarchically creating relations of dominance and subordination between different social groups.

2. Positions of dominance and subordination enable groups to assert their status and power in relation to each other within a hierarchical structure.

3. Status and power differential is associated with gender with females occupying a subordinate position. Historically women have always been treated as inferior to men and excluded from political and military power.

4. Groups in subordinate positions contribute to their subordination and perpetuate status and power differentials within a hierarchy.

5. Within a hierarchy inequality is maintained through social discourse and is enhanced by ideologies, beliefs and myths

(Sidanius and Pratto 1999).

Within the health service medicine is the dominant profession and is accorded a higher status than, and has a controlling influence over, other professional groups. Medical dominance is assured by other occupational groups being viewed collectively as professions allied or supplementary to medicine (Eraut 1994). The Government has attempted to curb the perceived autonomy of the medical profession by controlling clinical decision-making for reasons of economy. However, doctors assume legitimate authority and take responsibility for actions that they claim cannot be delegated to other professional groups. Doctors have a higher degree of autonomy than other professionals

do, however, they are accountable to a regulatory body and performance is monitored; although it may be difficult for others to challenge medical authority and clinical judgement.

Traditionally nurses' relationship with doctors was one of subservience based on obedience and loyalty and derived from a perception of nursing as subordinate women's work (Garmarnikow 1991). Davies (1995) suggests that gender inequalities between nurses and medical staff persist because nurses behave in ways that perpetuate subordination of their role. The professionalisation of nursing is regarded by Salvage (1992) as an 'attempt to escape the shaming association of nursing with female domestic labour.' It is no longer acceptable for nurses to follow orders if they feel that it will not be in the best interests of the patient although the Briggs Report stated that nurses could defer to doctor's responsibility in particular instances (DHSS 1972). This change reflects a move towards individual accountability for nurses and a move away from dependence of nursing on medicine.

A power difference also exists within nursing between different grades of staff that is related to perceived authority. Continued professionalisation, Salvage (1992) suggests, is being led by nurses who are academics seeking enhanced status for nursing through the development of theory and the role of the nurse as the primary carer of patients. This involves the development of a therapeutic partnership between nurse and patient who engage in meaningful interaction. She welcomes the power structure within nursing development units where nurses consult medical staff, however, she warns of the need for a critical examination of the assumption that 'empowering nurses is the route to empowering patients.' (Salvage 1992, p. 22). More recent developments have promoted

team integration through interprofessional education, however, professional divisions run deeper than role function.

As demonstrated in chapter 8, section 8.2., enrolled nurses commonly refer to themselves as 'only an enrolled nurse' which implies a perception of self as having low or inferior status. Individuals regarded as members of a subordinate group can actively participate in the processes that contribute to their own subordination. Furthermore, subordinates may support existing domination through co-operation, although some resistance and resentment towards dominants is discernible within subordinate groups.

> We suggest that it is the subordinates' high level of both passive and active co-operation within their own oppression that provides systems of group-based social hierarchy with their remarkable degrees of resiliency, robustness and stability. Therefore seen from this perspective, social hierarchy is not maintained primarily by the oppressive behaviour of the dominants but by the deferential and obsequious behaviour of the subordinates. (Sidanius and Pratto 1999, p. 44).

Melia's (1987) account of occupational socialisation of student nurses pre-Project 2000 provides another view of enrolled nurses whom she observed were core members of the ward staff alongside the ward sister and nursing auxiliaries. The core group normally remained in one ward whereas staff nurses constantly came and went moving on to other posts after a relatively short period of time. Melia (1987) reported that student nurses perceived themselves to be powerless being at the lowest level within the hierarchy.

Student nurses arriving in the wards were immediately presented with an image of themselves as subordinate members of a subordinate division of the healthcare team. Internalisation of this could then create a downward spiral of reduced self-esteem and acceptance of the handmaiden role. (Salvage 1992, p. 19).

3.2. Work-role Transition

Two perceptions that enrolled nurses have of themselves are that they are 'hands on' nurses and that they are 'non-academic'. Both perceptions derive from internal tensions concerning and influencing individual experiences of role transition to first level registration as demonstrated in chapter 6, section 6.3.

3.2.1. Practical Nurse Identity

This perception is associated with a traditional perspective of nursing as the giving of physical care. It suggests that enrolled nurses value this image and that they perceive first level nursing to be less practically orientated. A significant number of the participants stated that they did not want to lose this part of their role. The desire to remain as a practical nurse reflects the traditional values held regarding the nature of nursing and beliefs about what it should be. Being hands on concerns physical care and what might be considered as women's work. It also implies that enrolled nurses feel that first level nurses are less practical, perhaps more involved in technical or administrative duties, less involved with the direct care of the patient. From a broader perspective it could represent resistance to the cultural transition and the professionalisation of nursing and associated insecurity about employment and status.

The practical nurse identity also reflects loyalties to the established social structure and those with whom enrolled nurses identify. This could be related to the perceived position within the hierarchy between qualified and unqualified staff. A change in role could affect social standing with the nursing auxiliaries with whom some enrolled nurses share work-related values about getting the work done and perhaps social friendship.

First level registration will enhance professional development, extended scope of practice and career opportunities. However, it will also involve greater professional responsibility and role expectations that are new and uncertain. As demonstrated in chapter 6, section 6.5.4., enrolled nurses may fear that they will not be able to meet the expectations of the role of a first level nurse because of lack of the necessary knowledge, skill or ability.

Enrolled nurses are core staff members and are more likely to have worked in the same area for a number of years. They are comfortable in an area where they are familiar with the routine and know what the procedures are in most situations. Change and uncertainty is likely to be resisted. Having had little or no experience of transition in the past, enrolled nurses do not know what to expect or what is expected of them. Defending the value of practical nursing could be a legitimising myth. It also provides a legitimate reason for not proceeding or opting out of the process at some future point because of a desire to remain hands on.

Nicholson (1984) claims that two processes occur when an individual engages in a new role. One relates to the development of the person and the other to development of the

role. The degree to which a person or role changes is dependent on perceived demands of the role in relation to the use of personal discretion and the disposition of the individual in relation to desire for control or the need for feedback (West, Nicholson and Rees 1987). Individual disposition is influenced by prior occupational socialisation and a person who has not been used to using their discretion in the past is more likely to 'adopt a passive, externally-controlled orientation and adjust by personal rather than role change.' (Ashforth and Saks 1995, p. 160).

Work-role transition also involves disengagement from past role. Enrolled nurses are less likely to have much previous experience of role change which means that the process and future prospects are unknown and therefore less predictable and more uncertain. Disengagement can also mean loss of identity and the need to relinquish long-held values. Transition may be marked by a period of discontinuity that can have an impact on perceived competence and ability (Ashforth and Saks 1995).

Occupational socialisation within old and new environments is believed to influence individual perception of the degree of control held and can lead to frustration where a desire for control is high and expectation of the use of discretion within the role is low. West and Rushton (1989) studied work-role transition in newly qualified nurses and reported that 'The socialisation process in nursing can be equalled with the tactics… used by organisations to prompt the individual to accept the status quo of the workplace.' (West and Rushton, 1989, p. 272).

Individuals with a positive sense of self-efficacy are more able to perceive that events can be influenced and changed. Perceived self-control is associated with less stressful

adaptation. Glen and Waddington (1998) highlight the role of occupational socialisation in 'reconciling the conflict between personal and professional needs and expectations; the demands of the job and the organisational structure and culture.' (Glen and Waddington 1998, p. 290).

There is a need for professional education to enable individuals to become aware of their personal abilities to cope with new roles and to develop strategies that promote clarification of role expectation, appraise current values, attitudes and beliefs and provide opportunities to develop skills through participation in processes of change that are perceived as non-threatening. Identification of individual need for control and feedback and a facilitative approach to promoting transformation of perceived locus of control would also assist the transition. At a professional level cultural transition could be helped by clearly defined predictions, enabling controllers to innovate and supporting those who are unused to adapting to or controlling change. The same strategies would also enable enrolled nurses converting to first level to develop the personal potential for self-control. However, the difficulties inherent in a culture of bureaucratic hieracrchy with a top-down approach to implementing change remain. Managing and controlling change for others rather than enabling the development of self-control can have a negative impact on individual agency and perpetuate self-subordination and the primacy of organisational aims.

3.2.2. Academic Status

Concerns associated with being non-academic originate from a low sense of personal efficacy and a fear of failure and stress that derives from feeling that one is not able to

meet others' expectations. In chapter 6, section 6.5.3. it is demonstrated that lack of skill and ability, in particular lack of IT skills and a perceived inability to write academically are most likely to be reported as concerns by enrolled nurses. Perceived inability to write is associated with self-doubt about being sufficiently knowledgeable, being able to express oneself in the required language and style and ability to understand the rules of referencing. Fears associated with lack of academic skill and ability could relate to having left school with few or no qualifications and may be related to coming from a cultural background that does not value academic qualifications. As demonstrated in chapter 6, section 6.3. many enrolled nurses left school at fifteen to work with few or no qualifications due to economic pressures within the family. For some further or higher education was not regarded as worthwhile because of expectations of females that they would marry within a couple of years of leaving school. Education was not encouraged and may even have been discouraged. Few families had experience of higher education. It was not the norm. Many enrolled nurses chose pupil nurse training because academic qualifications weren't required for entry and the course of training was regarded as practical rather than academic.

Part of the experience of the conversion programme involves transformation of self-perception about one's ability to learn. Fear of failure is heightened by the public nature of the experience. During the programme enrolled nurses must continue to work in their normal area of employment and managers and colleagues are aware that they are undertaking the programme. This can exert even greater pressure on performance. Position within a bureaucratic hierarchy and occupational socialisation processes influence perceptions of personal efficacy. On entry to the programme enrolled nurses often focus on personal weaknesses, what they don't know, and skills that they don't

have. Self-doubt and low self-esteem can adversely influence performance. There are individual differences however, the majority of students harbour doubts about their academic ability and this is demonstrated in chapter 6, section 6.4.

3.2.2.1.Academic credibility

Enrolled nurses' self-doubts about their academic ability could be reinforced by perceptions of the credibility of different forms of knowledge within the dominant academic discourse and the control exerted by HEI's over the processes of accreditation. It is necessary to examine the difference between the knowledge that is valued within higher education and knowledge that enrolled nurses derive from experience that informs their professional judgement.

3.2.2.2.Knowledge derived from experience

Experienced professionals develop an implicit understanding of practice from years of exposure to familiar situations, specific cases and individual clients. The wisdom of tacit knowing influences skilled judgement and rapid decision-making but remains largely automatic. Tacit knowing represents an individual's unique perspective involving integration of experience from which knowledge is discovered and held to be true. Discovery alters perspective through internalisation and personal interpretation. Perspective determines attention to, and interpretation and utilisation of information that contributes to one's perception of the environment. Gestalt perception involves integration and it is difficult to focus on specific elements as single entities, although the potential to enhance awareness of one's perception and to alter one's perspective exists.

3.2.2.3. Academic Knowledge

Within higher education propositional knowledge is valued and includes discipline-led, objective facts derived from a scientific perspective that is claimed by professions to underpin and legitimise practice. Barnett (1994) suggests that the academization of professional qualifications has increased the focus on positivist methodology to validate the knowledge base of professions. At the same time the perceived value of tacit knowing and learning derived from experience has diminished. Propositional knowledge is relatively easy to assess in comparison to the subjective nature of tacit understanding which is difficult to articulate and not easily isolated from the context in which it is situated and of which it is an integral part. Accreditation of experiential learning within higher education normally involves commodification of extracted elements that match propositional knowledge and fit the existing assessment and credit framework (Fenwick 2003). Atomisation of tacit knowing reduces it to an instrumental level and alters its meaning through separation from the social and cultural context of which it is part. Separation of theory from practice assumes a technical rational approach that perceives theory to be external to and objectively applied to practice. Foucault (as cited in Barnett 1994) suggests that separation of mind and body can lead to external control of actions through prescribed ways of behaving and decision-making which has implications for professional judgement, discretion and agency.

Within professional education the reduction of practice to a framework of pre-determined outcomes has been criticised for focusing on technical, procedural know how to the detriment of critical thinking and reasoning required for professional judgement within the uncertain and unpredictable context of practice (Schon 1983,

Barnett 1997, Eraut 1994, Hodkinson and Issitt 1995). Such a narrow interpretation of professional competence fails to acknowledge the complexity of practice and the realisation that competence is situation dependent.

Eraut (1994) believes that professional knowledge derives from the experience of the uncertainty of professional work. It is neither propositional knowledge nor practical knowledge but is individually constructed and depends on personal experience. It is 'the cumulative acquisition, selection and interpretation of that experience.' Professional competence could be defined as the ability to use professional knowledge to inform professional judgement within particular situations in the best interests of the client. The development and maintenance of professional competence is dependent on being motivated and receptive to learning from practice.

> Professional processes which are not extremely rapid usually involve an integrated mix of types of knowledge and modes of cognition that is difficult to unravel. This reflects the complexity of cases, problems and situations which many professionals have to handle. The development of professional knowledge depends on a continuing capacity and disposition to learn from the experience of such cases as well as the ever-growing corpus of public codified knowledge. (Eraut 1994, p. 159).

Promoting learning through critical reflection situated within the complex reality of practice would acknowledge the value of experience to professional knowledge and competence within nursing. Furthermore it would facilitate the articulation of tacit knowing and its contribution to discretionary judgement and decision-making within the context of professional practice. Evidence from lifespan development and adult cognition has informed adult learning theory and supports the above suppositions.

3.2.2.4. Adult learning theory

There are four main assumptions from adult cognition and learning theory that are most relevant to this study.

1. Cognitive development occurs throughout the lifespan. It is not confined to childhood and adolescence but it is a constant process that implies a potential for change or modification in ways of thinking. The traditional view of intellectual ability is that it is general, fixed and learned within school. An alternative view is that practical intelligence and tacit knowing contribute to the development and use of analytical, creative and practical skills that are predominant in adulthood. Adults constantly learn from everyday situations in which they participate and practical intelligence derives from experience over the years of exposure to the poorly defined problems that are part of everyday practice.

2. Cognitive development and learning ability in adulthood differs from stages of development in childhood and adolescence. Adults have less fluid and greater crystallised intellectual ability. Fluid ability is believed to be genetically determined and enables an individual to grasp situations rapidly. It is linked to academic intelligence which decreases as an individual matures. Crystallised intelligence on the other hand is believed to be culturally determined and relates to problem-solving ability and improves in adulthood peaking at about 40 – 50 years of age (Grigorenko 1999, Torff and Sternberg 1998).

3. Adults have a greater potential to develop metacognitive abilities due to their experience and expertise. This means that they are more able to control their

learning having developed personal learning strategies and have the potential to develop this capacity to actively influence learning (Nelson 1999, Sternberg 1999) Metacognition is a 'multidimensional array of self-constructed regulatory skills that span a variety of diverse cognitive domains.' (Schraw 1998, p. 89).

Schraw (1998) suggests that there are three types of representation hierarchically arranged according to their degree of explicitness. Higher levels of knowledge are constructed over time through experience. Encouraging the development of critical reflection can promote the development of more explicit conceptions of thinking and beliefs.

> Knowledge that can be used to construct higher level knowledge must be tempered with active problem-solving…(enabling) students to generate and test their own theories of a phenomenon and then reflect on what they have learned. (Schraw 1998, p. 102).

This means that learners, encouraged to learn from their own experiences through critical reflection, could make explicit their implicit theories of practice. Promoting problem solving and critical self-reflection through use of actual problems that occur in everyday work experience will enhance the development of metacognitive ability (Torff and Sternberg 1998).

4. Cognition is situated and depends on responses to environmental demands. Learning to think cannot be dissociated from practice and is based on a collection of problem-solving methods that are defined at the representational level and not the application

of problem-solving rules (Sternberg 1999). 'Learning situations give the learner involvement, control, empowerment and a sense of agency.' (Granott 1998, p. 29).

Part of the conversion experience involves a transformation in the way that enrolled nurses perceive themselves in relation to the control of learning. Their perception on entering the programme will be influenced by past experiences of learning which are likely to have been based on memorising facts out of context. They may find daunting expectations that they will actively engage in a more collaborative and reflective approach to learning within their own practice. However, it is through the development of critical self-reflection that individuals will come to appraise their ability to monitor and evaluate their own performance and decision-making abilities.

3.3. Motivation to Change

Enrolled nurses undertaking the conversion programme normally do so voluntarily, motivated by a strength of belief in the value of the outcome which is first level registration. The reasons given by study participants for choosing to do the programme is demonstrated in section 6.6. Motivation is a key element in individual success and the processes that influence and are influenced by it merit examination if perceptions of experience are to be understood. Focus on the outcome of the conversion programme means that some enrolled nurses enter without fully appreciating the nature of the process of change involved. Some submit themselves to it without question. Others perceive it as a welcome challenge although most are apprehensive about the process or specific aspects of it. Some perceive it as a necessary endurance in order to achieve first level registration. A small minority may perceive the need for further training or

preparation as unnecessary, and feel that their experience should be recognised and acknowledged. The level of consciousness and strength of feeling about the conversion programme varies among entrants. First level registration acknowledges and validates an enrolled nurse's competence to practice as a registered nurse and provides opportunities for further professional development and career progression not normally available to second level nurses. Success brings a sense of achievement and personal satisfaction and the potential for greater control over one's practice. However, individuals perceive that there are two risks associated with the programme about which they are apprehensive; one is a fear of failure and the other fear of change as illustrated in chapter 6, sections 6.5.3 and 6.5.4. Enrolled nurses are unlikely to have encountered similar experiences of change or academic study in the past and, although a variety of sources of information are available before commencing the programme (for example, tutors and colleagues who have completed the programme or are currently undertaking it), lack of personal experience and unpredictable expectations induce self-doubt. Also, individual perspective determines attention to, interpretation and utilisation of information so the meaning of any information received will depend on individual perception.

3.3.1. An Agentic Perspective

An agentic perspective concerns perceived control of thought and action which is influenced by self-efficacy belief, locus of control and attributional and situational influences. Perceived lack of control can lead to stress, demotivation and despondency. Perceived agency and efficacy depend on past experience, the nature of the task and the situation. Individual perception and response is dependent on efficacy belief related to a

specific situation and influences the degree to which control is assumed and exerted. The strength of desire to achieve first level registration motivates individual enrolled nurses to undertake the conversion programme and this motivation appears to counter the lack of certainty about personal ability and perceived expectations as demonstrated in chapter 6, section 6.6. However, individual responses are complex and varied.

Agency is 'the capacity to exercise control over the nature and quality of one's life…(it) is the essence of humanness.' (Bandura 2001, p. 1).

An agentic perspective, the belief that one can influence and control one's own life, is positive and implies that a potential exists for change and adaptation in order to develop the capacity to exercise control. Human agency involves control over the reciprocal transactions between individual and sociostructural influences.

3.3.2. Cognitive processes

Disposition, or the tendency to perceive oneself and one's environment and to behave in a particular way, derives from a complex system of cognitive processes that are influenced by affect and motivation and are believed to determine the selection, acquisition, transformation and retention of information from the environment (Pervin 2002).

> Cognitive factors partly determine which environmental events are observed, what meaning is conferred on them, what emotional impact and motivating power they have and how the information they convey is organised and preserved for future use. (Bandura 1999a, p. 170).

Consciousness is subjective, deliberative and reflective and includes control of both the sensory experience of the phenomenon and the functional regulation of motivation and activities. People are thus 'agents of experiences' the nature of which depends on the social and physical environment. Consciousness or individual perspective determines what information is attended to, its interpretation and the way in which it alters or contributes to one's view of the world. Consciousness informs forethought about events and expectations and influences reflection on thoughts and actions. A person develops a unique schema of concepts through which information is interpreted and categorised and self and others are perceived and judged. Personal schemata influence individual beliefs about possibilities of self and what one might become (Pervin 2002).

3.3.3. Role and Identity

> In modern society people define themselves in terms of multiple positions and associated roles (Simon 2004, p. 22).

According to Simon (2004) multiple identities are arranged hierarchically according to perceived importance or degree of commitment to the role. Role identity is socially constructed and results from interaction between a person and the social environment. Perceived identity influences behaviour and experience, it is not fixed and is continuously being renegotiated through social interaction. Future-oriented perceptions of possible selves are influenced by what one wants to become and what one is afraid of becoming. Language is an important element of identity and is necessary for social interaction and influences belonging and group membership. For example, understanding and using medical jargon can influence interaction in particular situations.

3.3.4. Personality and personal construct

Personality includes a personal construct of self, others and situations influenced by beliefs and expectations. It determines individual strategies for organising and regulating behaviour (Pervin 2002). However, the degree of awareness that one has about the extent to which one's behaviour is influenced by one's perceptions cannot be assumed. Nor can it be known the extent to which an individual engages in self-reflection and the conscious regulation and adaptation of behaviour. Although the influence of personal construct on the interpretation of environmental data on behaviour can be long lasting and may not be easily changed, it is not a fixed entity.

The relationship between influencing factors is bi-directional and a reciprocal relationship exists between behaviour and situation. Whilst social intelligence influences adaptation of behaviour according to perceptions of what is expected within a given situation, a compulsion to act stereotypically is influenced by perceived social norms. For instance a subordinate position may be assumed if it is perceived as normal behaviour within a given situation. Whatever the outcome situation influences perception and behaviour.

> Social cognitive theory is founded on a causal model of triadic reciprocal causation in which personal factors in the form of cognitive, affective and biological events, behaviour patterns and environmental events all operate as interacting determinants that influence one another bidirectionally. Within this theory human agency is embedded in a self-theory encompassing self-organising, proactive, self-reflective and self-regulative mechanisms… personal agency operates within a broad network of

sociostructural influences. In these agentic transactions people are producers as well as products of social systems. (Bandura 1999b, p. 21).

3.3.5. Interdependence of personal agency and social structure

People adapt and change their thinking and actions according to interaction with the social systems with which they interact. Social structures are human creations that organise and regulate behaviour, they impose constraints on, and provide opportunities for personal development. Human agency is not simply reactive to, but operates on a social system through pro-active and generative thought and action. To understand the interdependent nature of personal agency and social structure it is necessary to consider sociocultural influences on behaviour.

> Economic conditions, socioeconomic status and family structure affect behaviour through their impact on people's aspirations, sense of efficacy and other self-regulatory factors rather than directly. (Bandura 1999b, p. 24).

An agentic perspective assumes that individuals are not automatons but are proactive, reflective, regulative, determinative, generative and purposive beings. Human behaviour is situated and 'sociocultural influences operate through psychological mechanisms to produce behavioural effects.' (Bandura 2001, p. 15).

Bandura (2001) identifies four core features of human agency:

1. Intentionality - involves proactive planning to make real future intended actions.
2. Forethought - considers possible consequences of future actions and acts in ways that will bring about deliberate outcomes.

'When projected over a long time course on matters of value, a forethoughtful perspective provides direction, coherence and meaning to one's life.' (Bandura 2001 p. 7).

3. Self-reactiveness - an agent motivates and regulates actions through goal setting and includes the influence of moral reasoning on behaviour.

4. Self-reflectiveness - metacognitive self-reflection enables evaluation of thoughts and action.

Forethought and planning is difficult where expectations are only imaginable rather than based on experience. Uncertainty makes the development of clearly defined and achievable goals is difficult. However, a potential exists for facilitation of the development of an agentic perspective at both an individual level and professional level.

3.3.6. Self-efficacy

According to Bandura (1986) efficacy beliefs influence behaviour and one's sense of agency and ability to exert control over perceptions of self, environment or situation. It relates to perceptions of ability to cope within specific situations and is dependent on the perceived demands of a situation (Pervin 2002). Efficacy beliefs can influence an individual's lifecourse.

It is partly on the basis of efficacy beliefs that people choose what challenges to undertake, how much effort to expend in the endeavour, how long to persevere in the face of obstacles and failures and whether failures are motivating or demoralising. (Bandura 2001, p. 10).

Personal, social and situational factors affect the interpretation of experiences in relation to self-efficacy beliefs. Within a given situation perceived efficacy will depend on perceptions of:

- Ability

- Task difficulty

- Effort expended

- Physical and emotional state

- Assistance received

- Situational circumstances

(Bandura 1995).

Sources of information contributing to efficacy judgement fall into four main categories:

- Personal experience - efficacy belief develops from one's own performance. Success is likely to increase and failure lower efficacy depending on perceived effort and circumstances.

- Vicarious experience - others' successes and failures influence efficacy beliefs where others are perceived to be have a similar ability.

- Verbal Persuasion - where a person is believed to have credible authority and expertise they can positively or negatively influence efficacy by persuasion or dissuasion. Failure to meet perceived expectations of a persuader could adversely affect efficacy.

- Affect - a positive mood can enhance efficacy whereas despondency and depression can lower it and adversely affect performance.

  (Bandura 1986).

Table 4: Influences on belief in ability to succeed academically.

Source of Information	Negative Influence	Neutral Influence	Positive Influence
Own Experience	Past experience of academic failure perceived as negative	No past experience of academic success or failure	Past experience of academic success
Vicarious Experience	Observes others failing course	Does not see others failing or succeeding the course	Observes others successfully complete the course
Verbal Persuasion	Dissuaded from trying	Is neither persuaded nor dissuaded	Persuaded to try
Affect	Fear of failure, despondency about performance or depression and low self-esteem	No strong desire to succeed or fear of failure	Strong desire to succeed, feels confident in ability to succeed and has a positive self-esteem

This table shows examples of possible influences on efficacy.

An ability to make a balanced and realistic appraisal of one's capabilities is important for effective performance and functioning. Cognitive development is accompanied by a development in one's ability to use self-efficacy as a guide to performance and this overtakes the need for external guidance. During infancy personal agency develops as the child learns that they are capable of controlling environmental events. In adulthood self-efficacy assumes an important role in developing and maintaining personal agency.

In adulthood a firm sense of self-efficacy is an important motivational contribution to the attainment of further competences and success. However, rapid technological and social change constantly requires adaptations calling for re-appraisals of capabilities… If self efficacy is lacking, people tend to behave ineffectually even though they know what to do. A strong sense of personal efficacy and a responsive environment that rewards performance achievements fosters assured responsiveness. (Bandura 1986, p. 147).

A low sense of personal efficacy leads to ineffectual behaviour and can lead to despondency, depression and learned helplessness. In a social context the effect of having a subordinate role or inferior label can lead to underperformance (Bandura 1986).

3.3.7. Attribution

Attribution involves the assignment of cause to explain an event. Causal explanations can influence self esteem and affect motivation. For example, success attributed to oneself increases self esteem whilst failure that is attributed to oneself is likely to have a negative effect on esteem. The extent to which an outcome is perceived to be controllable determines its influence and is dependent on perceived locus of control. Attribution of failure to personal deficiency can have a detrimental effect on self-worth. Again a balanced and realistic appraisal of all factors influencing the event is necessary to prevent despondency.

Self-efficacy affects human agency. A positive sense of efficacy can motivate a desire to set and meet challenges and to continuously develop. People who have a strong sense

of efficacy are more likely to expend a greater effort, persist with a task and acknowledge strengths rather than dwell on deficiencies. The potential exists for efficacy beliefs to be promoted or changed. It is possible that personal efficacy could be enhanced by assisting an individual to reflect on their attributions and perceptions and to consider alternative explanations and realisations of what is required for success.

3.3.8. Summary

An agentic perspective asserts that an individual is capable of thinking and acting independently and that behaviour is controlled through personal planning, self-reflection and self-regulation. Self-construct involves perceptions of self, others and situations and influences beliefs and expectations and strategies for organising and regulating behaviour. Self-construct is enduring but not fixed.

Consciousness comprises conceptual schemata influencing cognitive processes that determine attention to, interpretation of, storage and utilisation of information in perception and judgement of self and others. A personal schema influences self-belief including the extent to which one believes that one's perspective can alter.

A reciprocal determination of influence exists between environment, behaviour and person. Situation influences and is influenced by individual perception and behaviour. Social structure imposes constraints and produces opportunities. Human agency is not just reactive but is proactive and generative. Behaviour is influenced by economic conditions, socioeconomic status and family structure, which influence a person's aspirations, efficacy and other self-regulatory factors.

Self-efficacy is an important determinant of human agency. Perceived ability to cope depends on self-evaluation and the perceived demands of a situation. Personal, social and situational factors influence the interpretation of an experience and efficacy. Judgement of self-efficacy is informed by personal and vicarious experience, verbal persuasion and affect. Cognitive development in adulthood can influence efficacy belief and maintenance. Causal explanations influence self-esteem and motivation and depend on perceived locus of control.

The degree to which one perceives that they are agentic varies according to the situation and perceived efficacy and behaviour. The potential to alter one's perspective in relation to efficacy belief exists and can be influenced through positive experience and enhanced self-esteem. Enrolled nurses' fears concerning academic failure and perceived ability to cope with role expectations can be positively influenced by the design of a programme that supports an agentic perspective, acknowledges experience, promotes positive self-esteem and the development of self-directedness.

3.4. Adult Learning Theory and Development

It is assumed that adult learners:

- Are self-directed and autonomous

- Use past knowledge gained from experience to influence their learning

- Demonstrate a readiness to learn and are stimulated to learn what is relevant to the social roles that they undertake

- Are motivated to apply what they learn to personal and professional problems that affect them at the time of learning

(Knowles 1983, Granott 1998).

An individual's self-concept as a learner is influenced by past experiences and can be disabling if it leads to inflexible patterns of thinking and behaviour. As demonstrated in chapter 6, section 6.4. enrolled nurses' perceptions of themselves as learners is influenced by a lack of self-belief in their academic ability and the assumption that they need to depend on others for direction in learning. Lack of confidence and an underestimation of one's ability can interfere with the learning process and leads adult learners to seek external validation for knowledge derived from experience (Brookfield 1986). Lack of exposure to formal education can enhance a negative self-perception. Assumptions that adult learners are self-directed

> … show little concern for what goes on in the mind or individual differences. (Smith and Pourchot 1998, p. 5).

Learning and development are lifelong processes that occur through formally planned education such as school and informally through participation in everyday situations and social interaction. Factors influencing learning and development are varied and complex (Smith and Pourchot 1998).

Cognitive development in adulthood can be linked to learning experiences that have a profound effect on one's perspective that is deep and lasting compared to those experiences whose effect is superficial and reversible (Granott 1998). According to Granott (1998) deep learning or 'developing learning' is a 'fundamental learning process that undergoes microdevelopment (ie shows rapid growth of knowledge during

that learning period) and generates internalisation of knowledge that can trigger further knowledge construction.' (Granott 1998, p. 17).

3.4.1. Constraints and control of developing learning

Instrumental learning that is tightly controlled and where there is little learner involvement or control constrains empowerment and the development of a sense of agency. Granott (1998) suggests that constraints on learner control can adversely affect development and may influence superficial learning. Furthermore, Garrison (1991) claims that self-direction and critical thinking are two separate frameworks linked by the concept of control and responsibility for constructing meaning. Self-direction occurs where there is personal control over the planning and management of learning. Choice and control over learning activities is empowering and provides a sense of personal involvement and stimulates continual self-development through achievement of learning goals. Learning that promotes development is more likely to occur where an individual has a sense of control over the learning method, a specific interest in the subject and perceives it to be challenging. Sufficient time for construction of understanding and a feeling that one is being supported is also important (Granott 1998). Educators can provide challenging opportunities that stimulate learning and enable a learner to construct meaning and knowledge.

> Methodological considerations that constrain the investigated process and force it into the confines of controlled conditions impair the diversity, richness and open-endedness that stimulate developing learning. Practical considerations that create relatively homogenous processes fitting all students eliminate the sense of agency and personal involvement that enables developing learning. To challenge learners to create

developing learning educators and researchers must address a challenge too: scaffolding and analysing diverse, ever-changing processes. (Granott 1998, p. 31)

3.4.2. Sociocultural theory of learning

Vygotsky's sociocultural theory of learning regards learning as a social process in which cognitive development is stimulated by participation and social interaction. Learning occurs at two levels:

- An interpsychological or social level where learning derives from interaction with others.

- An intrapsychological or individual level where learning is integrated within a person's perspective.

To stimulate cognitive development learning opportunities need to present a challenge to the learner's current thinking. The zone of proximal development (ZPD) assumes the existence of a potential to learn that can be prompted through problem-solving that is guided by another. A scaffolding approach to guidance involves the gradual transfer of responsibility from teacher to learner. Initially the teacher is responsible for explaining what is required and modelling it if necessary. This is followed by the learner practising the task or activity and receiving constructive feedback from the teacher. Gradually the learner assumes responsibility for carrying out the task or activity without the need for guidance (Bonk and Kim 1998).

The design of the conversion programme provides a scaffolded approach that enables the learner to become accustomed to an academic learning culture where it is expected that they will take control of their own learning and development. As the learner

progresses through the assignment process they gradually assume greater responsibility for the interpretation and construction of the task and the presentation of their work. Participation in activities and interaction with tutors and peers provides exposure to the language of the learning culture that enables participation in discussion of professional issues and knowledge associated with everyday practice. Learners gain experience and confidence in use of the language through participation in discussion and also through the written work for assignments. In addition participants within small groups or ensembles are believed to learn by directing each others attention to different aspects of a subject (Granott 1998).

Each stage of the programme represents a different challenge to the learner and builds on the successful achievement of the previous stage. The approach motivates and promotes development of self-efficacy through the experience of one's own success and that of others perceived to be of a similar level of ability. Verbal persuasion in the form of constructive feedback from tutors and colleagues and the process of validation and legitimisation enhances self-confidence and self-development. Participation in the programme promotes self-appraisal and profiling, reflection on practice with an increasing emphasis on critical self-reflection, goal setting and pro-active self-management of learning experiences. Learners report that their thinking changes as they progress through the programme. Alteration in perception of self and others is evident in participants' accounts of the nature of their participation and social interaction and this is demonstrated in chapter 7, section 7.11.3.

In scaffolding, learning is mediated where situations are manipulated by a tutor. Exposure to the process induces internalisation of the 'cultural instruments and skills'

that enable learners to become self-mediating; they monitor and evaluate their own performance and assess and plan future actions (Pascal-Leone and Irwin 1998, Bonk and Kim 1998).

3.4.3. Reflective Practice

Project 2000 proposals clearly indicated that preparatory programmes should aim to produce practitioners who, through a broad-based education would be autonomous and accountable (UKCC 1986). By the end of the decade the expectation that nurses would critically question and would be accountable for practice was incorporated within the Strategy for Nursing.

> Accountable practitioners must be more than passive recipients of information. They will need to acquire analytical skills to ask the right questions, to know where to seek answers to them and to reach informed decisions on the basis of the fullest knowledge available. (Department of Health 1989, p. 24).

The change in professional attitude regarding individual autonomy and accountability affected perceptions of competence and emphasised the need for registered nurses to demonstrate continuous professional development and to engage in reflective processes. However, no clear definition of reflective practice existed at that time (James and Clark 1994).

According to Schon (1983) professional practice is indeterminate and unpredictable. A technical-rational approach to problem solving does not promote the desired development of professional artistry where experience and tacit knowing guide actions

and professional knowledge derives from experience of uncertain situations of professional practice. Professional knowledge is neither propositional nor practical knowledge but is individually constructed depending on one's experience and perspective (Eraut 1994). Eraut (1994) defines professional competence as the ability to utilise professional knowledge within particular situations in the best interests of the client.

> The development of professional knowledge depends on a continuing capacity and disposition to learn from the experience of such cases as well as the ever-growing corpus of public codified knowledge.' (Eraut 1994 p 159).

Schon (1983) claims that professional competence requires reflection in and on practice in order to develop new perspectives from practice situations. However, the level of reflection is important. Professional autonomy and accountability require self-monitoring and self-regulation which implies that development of critical consciousness is necessary. Reflection can be instrumental and behaviourist particularly when associated with outcome-led competences that are atomistic and pre-determined and do not necessarily reflect the uncertain reality of professional practice. Barnett (1997) argues that there is a need for critical self-reflection in modern society which requires individuals to engage in critical questioning that is radically reflexive in order to promote new understandings and better alternative constructions. Skills-based reflection, he believes, is reduced to a level of surveillance. Instrumentation can mean acceptance of constraints and concern with making the best of a situation. Critical analysis and self-reflection are different.

The term 'critical' indicates that the self-reflection is accompanied by a range of alternatives. The student interrogates her own thinking or her actions, recognising that her thoughts and actions might be even more worthwhile. In the process, new thinking and new acts may emerge. The self-reflection is accompanied by self-criticism. (Barnett 1997, p. 94).

A narrowly defined and objectivist view of professional competence is also criticised by Hodkinson and Issitt (1995) who believe that competence is not fixed but is dependent on professional and social values and therefore practice requires to be under constant critical review. Also there is a need to challenge practices that support social inequality (Hodkinson and Issitt 1995).

Barnett (2000) suggests that a tension exists between contemplative and performative values that currently predominate in higher education and he believes that higher education has a responsibility to provide professionals with the requisite skills for the adequate performance of professional tasks. Barnett suggests that traditional values of higher education which emphasise the nurturing of criticality, are in danger of being undervalued. In the best interests of clients professional education should seek a balance between the promotion of individual development and the development of competence to provide care in the most efficient way (Barnett 2000).

3.4.4. Transformative Education

If the purpose of adult learning is to alter beliefs, values and attitudes then it is necessary to encourage individuals to critically reflect upon the assumptions underlying their personal, professional and political behaviour in order to transform their thinking.

Control of this process depends on individual ability to be self-directed and critically reflective (Brookfield 1986). As Carr and Kemmis (1986) point out

> The very purpose of critical self-reflection is to expose and identify self-interests and ideological distortions. The practitioner sets out deliberately to examine where his or her own practice is distorted by taken-for-granted assumptions, habits, customs, precedent, coercion or ideology. (Carr and Kemmis 1986, p. 192).

The conversion programme promotes critical reflection and encourages unquestioned assumptions concerning practice to be challenged. Self-reflection involves questioning the impact of values and beliefs on practice and the development of a receptive attitude towards different perspectives. However, the extent to which personal transformation is successful depends on individual disposition and ability to appraise a balanced perception of self-control within situations. There is a further aspect of critical self-reflection related to the development of critical consciousness and enlightenment that may emerge. The purpose of transformative education is to promote a critical consciousness that, at an individual level, will lead to emancipation through raised consciousness of constraints adversely distorting one's perspective. At a societal level critical consciousness aims to eradicate inequality and unjust practices and to promote social justice.

Habermasian emancipation claims that knowledge of oneself and one's role or position in society is necessary if one is to be empowered to transform one's perspective. Enlightenment occurs through the realisation of false consciousness or ideological beliefs that influence perception in order to overcome oppressive constraints (Taylor 2000). According to Freire (1972) conscientization, or new awareness of selfhood is

required before action can be taken to transform society. Barnett (2000) urges that the university should promote enlightenment and that it has a responsibility to do so in an age of uncertainty.

> Supercomplexity requires of its universities, if they are to have a societal role to play, that they become sites for the continual production of revolutionary ideas, that graduates are able to live effectively amid radical uncertainty and that the wider society is enabled to understand its condition and make even more insightful evaluations of the large issues in front of it. (Barnett 2000, p. 172).

To what extent does professional education have a responsibility to promote critical consciousness if practitioners are to be able to serve in the best interests of clients? Seith (2007) reported on a patient who died whilst undergoing an operation because, it was believed, the medical team failed to take appropriate action in an emergency situation. Despite a theatre nurse's 'subtle hints' about the actions required, doctors persevered with another course of action that was unsuccessful. The report suggested that 'status and hierarchy can make people afraid to speak up if they think someone senior is making a mistake.' (Seith 2007). If, as Mezirow (1981) claims, critical consciousness is necessary for awareness and transformation of one's perspective in order that one constantly questions habitual thoughts and actions then it should be promoted through professional education. Enlightenment would enable consideration of other perspectives and has the potential to empower in order that correct or just actions are taken. It does not concern the pursuit of status for individual or professional gain related to having control over others. The urge to become a dominant profession would create a false consciousness, further exacerbate intraprofessional inequality and would not be in the best interests of the client.

Carr and Kemmis (1986) emphasise the necessity for enlightenment to enable change in society:

> To transform the ideology of our present society characterised by forms of work which do not provide access for all to an interesting and satisfying life, forms of communication which do not aim at the achievement of mutual understanding and rational consensus among people and forms of decision-making which do not aim for social justice in which people participate democratically in making decisions affecting their lives, we must transform our current practices of work, communication and decision-making. (Carr and Kemmis 1986, p. 193).

Wenger (1998) suggests that learning occurs within communities of practice which provide contexts for the creation of knowledge through participation. New insights originate from the existence of a tension between competence and experience. Belonging to a community is an integral part of one's identity and how one views oneself. Wenger claims that communities can facilitate or inhibit learning and development and that education has the potential to promote transformation and enable continual development.

> Education in its deepest sense and at whatever age it takes place concerns the opening of identities – exploring new ways of being that lie beyond our current state. Whereas training aims to create an inbound trajectory targeted at competence in a specific practice, education must strive to open new dimensions for the negotiation of self. It places students on an outbound trajectory toward a broader field of possible identities. Education is not merely formative – it is transformative. (Wenger 1998, p. 263).

Wenger's perspective suggests that a learning community that is facilitative will in itself promote perspective transformation. However the theory fails to take sufficient cognisance of internal constraints and the need for individual empowerment. The development of critical consciousness must come from within and developing awareness of constraints and consideration of possible alternative identities within a hierarchical structure that reinforces subordination may prove difficult. Critical reflection is necessary for professional accountability and to ensure that practitioners serve in the best interests of clients. A facilitative approach must be adopted if a critical perspective is to be promoted. Williams (2001) suggests that facilitation is a key element in the development of skills of critical reflection but points out that there is no clear strategy for its promotion within professional nurse education. There is a need for an approach that acknowledges experience and involves learners within a democratic learning partnership that enables them to engage in their own professional development that involves taking initiatives that are stimulated by their own thinking and deliberation and over which they can exert effective control (Keregro 1989).

The conversion programme provides opportunities for individual professional development and influences individual experiences of the transition to first level. However, the extent to which the process promotes the development of critical consciousness is questionable.

Chapter 4: Research Methodology

4.1. Introduction

> At every point in our research – in our observing, our interpreting and everything else we do as researchers – we inject a host of assumptions. These are assumptions about human knowledge and assumptions about realities encountered in our human world. Such assumptions shape for us the meaning of research questions, the purposiveness of research methodologies, and the interpretability of research findings. Without unpacking these assumptions and clarifying them, no one (including ourselves!) can really divine what our research has been or what it is now saying. (Crotty 1998, p. 17).

A reflexive account illustrates the impact of personal influences of a researcher on the research process. It explains what is going on in the research and how decisions have been reached, it clarifies methodological reasoning and makes explicit potential bias (Walford 1998, O'Connor 2007). The transparency attained through reflexive analysis is believed to authenticate and lend weight to the rigour of qualitative research. It enables researchers to fully explore, interpret and understand the data that they gather in light of their own perspective and to examine their influence on roles and responses and perceived meaning. (O'Connor 2007).

> Meaning is socially constructed and arises from our subjectively mediated views of reality. (O'Connor 2007, p. 260).

From a social constructionist stance a researcher gains self-awareness through reflection on one's own history and interaction with others that enables one to understand

constraints on one's ways of seeing, knowing and being (Finlay 2002). From a phenomenological perspective a researcher's pre-understanding influences their perception and interpretation of meaning. New understanding can arise from

> A dialectic between the researcher's pre-understandings and the research process, between the self-interpreted constructions of the researcher and those of the participants. (Finlay 2002, p. 534).

Unconscious processes influence relations between the researcher, participants and the data collected. Reflexive analysis makes explicit researcher integrity through critical examination of the impact of positioning and responses within the interaction between researcher and participant. Awareness of how perceived identity and positions adopted influence interaction between researcher and participant is necessary if the impact of the relationship on the research process is to be understood (Finlay 2002). In particular, issues related to power assymetry within the relationship should be made explicit (Hamberg and Johansson 1999).

Issues of bias related to my position as programme leader to the enrolled nurse conversion course must be made explicit. Perceived power difference between myself and the participants will be examined. However, it is important to acknowledge that I hold the view that, within the hierarchical structure of nursing, enrolled nurses historically have had little control over their professional development or career progression. This view has influenced not only my desire to undertake this study but also the design of the research from the development of the research questions to the presentation of the findings. This chapter aims to clarify the influence of my

assumptions about enrolled nurses on the study. Clarification of the research questions and the chosen methodology will be followed by a retrospective, reflexive analysis.

4.2. Research questions

There are two research questions:

How do individuals understand the way in which their perceptions of themselves and others alter as they progress through the course?

What do they understand as the factors that influence changes in their perceptions?

4.3. Social Constructionism

The study aims to examine enrolled nurses' experiences of conversion and altered perceptions of self and others as they progress through a conversion course. A constructionist epistemology is relevant where 'different people may construct meaning in different ways even in relation to the same phenomena.' (Crotty 1998, p. 9, Denzin and Lincoln 2003). The aim of the methodology is to make explicit the process of the inquiry and, in keeping with a constructionist stance, no claims will be made of 'objective, absolute or truly generalisable' understandings (Crotty 1998, p.13, Denzin and Lincoln 2003).

4.4. Phenomenology

Existential phenomenology links closely to social constructionism as 'phenomena only have meanings when beings make sense of it.' (Crotty 1998, p. 10). A subject's

consciousness of an object is necessary for the existence and individual shaping of a meaning. Phenomenology is a way of seeing things without the restricting influence of unacknowledged cultural values and beliefs. Furthermore, Crotty (1998) believes that phenomenology enables a researcher to be radically critical of existing meaning constrictions that can 'support particular power structures, resist moves towards greater equity and other modes of injustice and unfreedom.' (Crotty 1998, p. 60). Imposed meanings exclude others.

Interpretivism involves looking for different interpretations of a social reality and pertains to individual understanding rather than causation. This opens out possible meanings beyond those derived from a specific culture at a particular period and consideration of diverse perspectives is an inherent part of the research inquiry (Creswell 1998). Individual meaning derives from multiple cultures and subcultures through processes of socialisation and enculturation. It is possible that nurses who trained in the same hospital during a particular period would share similar values and beliefs about nursing due to shared processes of socialisation that could differ from nurses who trained in other organisations at a different period.

In phenomenology bracketing is employed enabling researchers to acknowledge and put aside their own understandings in order to gain clearer insight into the meanings of others. However, the extent to which bracketing can facilitate uninfluenced acceptance of other realities is questionable (Usher 1996). Crotty (1998) assumes that reinterpretation involves challenging taken for granted assumptions and Usher (1996, p. 31) urges researchers to adopt a 'more critical stance towards the practice of sense-making' and to make explicit pre-understandings and intentions. Miller and Glassner

(1997) suggest that a degree of objectivity is necessary to enable researchers to focus on the reality of the other in order to consider and fairly represent their sense of meaning. It is assumed that the enrolled nurses' perceptions of themselves and others alter as they progress through the conversion course. It is also assumed that the meaning of the nature of the changes experienced by the study participants can be discerned by considering the meanings and divergent views within the narratives of their responses.

A phenomenological perspective is relevant in this study because it concerned the essence of changed perceptions. Some degree of objectivity was necessary in order to focus on the emergent phenomena and associated dimensions.

4.5. The issue of validity in qualitative research method

Validity of research findings is judged on measurements of truth and generalisability. A positivistic concept of objective truth dominates judgements of credibility and perceived validity and generalisability requires the specific nature of the object to be determined to enable prediction and regulation. Silverman (1993) and Miles and Huberman (2002) believe that there is a need to demonstrate scientific objectivity in social research to prevent lowering of standards and that it can be obtained through use of 'appropriate methods and rigorous critical and objective' handling of the data. (Silverman 1993, p. 144). The commonest standard of validity in qualitative research is achieved through multiple measurement of the data in triangulation that could include use of a combination of quantitative and qualitative methods such as respondent validation and peer group concurrence (Silverman 1993, Brink 1994, Denscombe 1998).

The difference between positivistic and social constructionist assumptions is problematic. From an interpretive perspective knowledge is situated and local, and claims of universal truth and generalisability are not valid (Crotty 1998, Denzin and Lincoln 2003). However, research claims should be explicit, underlying assumptions clarified and the relevance of methods justified if findings are to be taken seriously (Denscombe 1998). Validity within this study can be measured in the use of a grounded theory approach to data collection and analysis, use of semi-structured interviews and the number of participants (thirty divided into three groups of ten), the number of interviews per participant (three). The phasing of the interviews enabled intergroup comparability at specific points in the conversion course and the data collected during the second and third interviews reinforced the findings from the first interview. During the period of the researcher's experience of the conversion course, observations of changes in enrolled nurses' self-perceptions and self-confidence were made and individual differences noted. The research questions derived from these observations.

4.6. Grounded Theory

Grounded theory is 'a process of inductive theory building based squarely on observations of the data themselves.' (Crotty 1998, p. 78). Glaser and Strauss's (1967) guidelines provide procedural rigour in the form of a series of steps facilitating early detection of categories that are refined and developed until no further relevant information is detected in new cases (Charmaz 2003). The main steps in the process include:

- Interviews or observation

- Note taking or memoing

- Coding data

- Constant comparison

- Category identification

- Theoretical sampling

- Saturation

(Creswell 1998, Denscombe 1998, Charmaz 2003).

Coding fragments data and memos record the theorising behind the creation of codes. Following identification of codes during the first few interviews subsequent interviews are coded using those already identified. Development of a category involves searching for relevant data until no further new information is available and saturation is reached (Charmaz 2003). Constant comparison involves development of the dimensions of a category, connections between categories and the conditions of existence of a category. According to Glaser and Strauss (1967) the size and composition of a sample is dependent on theoretical development rather than being pre-determined. Charmaz (2003) is critical of the restriction imposed by early detection and closure of a category and proposes that, from a constructivist perspective, saturation and development of theory is a more open-ended process. The value of grounded theory is perceived to be the rigour with which it deals with the data. However, as Charmaz (2003) suggests, it can limit theoretical development through restriction of category identification and the development of the dimensions and conditions of existence. Charmaz's (2003, 2006) constructivist grounded theory acknowledges and focuses on the meaning between the researcher and participant whilst retaining the analytical rigour of the theoretical framework. She suggests that this results in a more flexible and less confined analytical process.

4.7. Data Collection

The aim of the research was to examine enrolled nurses' experiences of conversion and altered perceptions of self and others as they progressed through a conversion course. One to one semi-structured interviews were used to gather data from a sample of thirty enrolled nurses who were undertaking conversion. Having some structure helped the interview to remain focused on specific aspects of the experience whilst exploring an individual's meaning (Denscombe 1998). The sample of enrolled nurses was divided across three cohorts and ten were drawn from each one. Each participant was interviewed on three occasions over a period of about 15 months. The interviews were designed to coincide with a part of the course that could be considered challenging and represented a strategic period of progression. Each cohort was undergoing a different stage in the course and interviews were held before, during and after the stage concerned. This enabled consideration of experiences from before the course commenced until after its completion. Table 4 shows when interviews were held.

Table 5: Interview Timetable

COHORT A (September 2002)	**Interview 1** Before AEDL (1) Spring 2002	**Interview 2** On commencing Course (2) Autumn 2002	**Interview 3** After 6 months on Course (3) Summer 2003
COHORT B (April 2002)	**Interview 1** Before In Depth Study (4) Autumn 2002	**Interview 2** Midway during In Depth Study (5) Sprin 2003	**Interview 3** On completion of In Depth Study (6) Winter 2003 / 4
COHORT C (April 2001)	**Interview 1** Before Reflective Practice (7) Autumn 2002	**Interview 2** On completion of Course (8) Summer 2003	**Interview 3** Six months after Completing course (9). Winter 2003/4

Figure 1 demonstrates the periods represented by each of the three cohorts and where interviews between cohorts overlapped (points 3 / 4 and 6 / 7).

Figure 1: Relationship of cohorts to course programme

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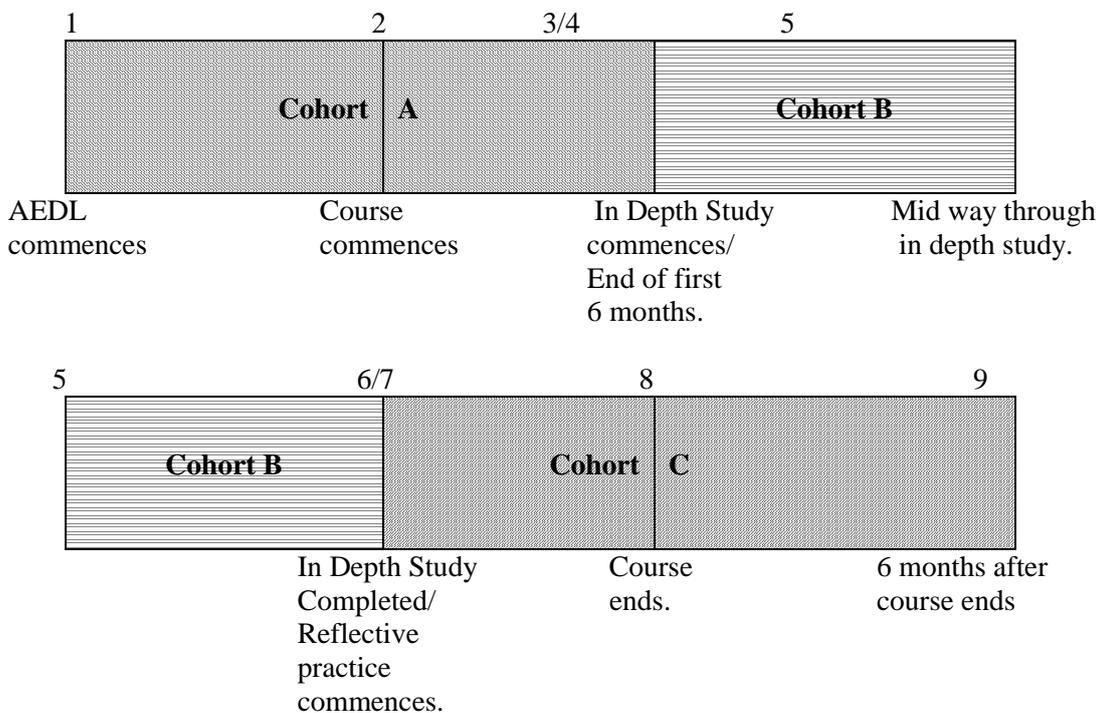
4.7.1. Sampling

The sample of enrolled nurses includes a diverse range of different specialities, areas of practice, ages and geographical location (rural/urban). Tables 6, 7 and 8 shows the age range of the participants and the percentage per area of practice and nursing speciality. There were two male participants and four participants were located in rural or semi-rural areas.

Table 6: Age of Participants	
Age	**Number**
35 – 39	8
40 – 44	7
45 – 49	9
50 – 55	6

Table 7: Area of Practice	
Area	**Number**
Acute	15
Continuing Care	11
Community	4

Table 8: Nursing Speciality	
Speciality	**Number**
Adult	21
Mental Health	8
Learning Disability	1

4.7.2. Interview schedule

To facilitate discussion and comparability of data an interview schedule was devised (Appendix 1) comprising open-ended questions that related to four broad areas:

- Past experience of nursing

- Current workplace experience

- Experience of the course

- Reflective practice

Questions were carefully sequenced to avoid earlier questions influencing later ones (Drever 1995) and commenced with a question that participants would find easy to respond to. The detailed structure of the interview schedule proved invaluable in enabling the discussion to remain focussed particularly as the average length of each interview was between one to two hours. Only the main questions were planned in advance to act as an invitation to the participant to tell me about themselves and their perceptions. The open structure enabled exploration and expansion of particular points or issues using prompts to encourage further discussion and probes for depth (Drever

1995). Including some prompts and probes on the schedule for guidance was particularly helpful in the earlier interviews.

The main focus of the interviews was to establish participants' perceptions of the experience of change and it was important to facilitate their perspectives. Discussing personal background and past experience provided insight into factors that might have influenced development of particular attitudes and beliefs about nursing and perceptions of self as a nurse. Consideration of current workplace experience helped to identify how individuals perceived their position and the degree of agency that they had within their normal work environment. It also highlighted specific tensions. Experience of the course stimulated consideration of perceived challenges, possible influences on motivation and specific coping strategies. Reflection on practice explored changes in self-awareness and perceptions of change in thinking and practice.

4.7.3. Process of data collection

I initially approached potential participants in person either face to face or by telephone. I explained the nature and purpose of the study and expected involvement and asked if they would be willing to become involved. I encouraged them to decline if they did not want to participate. All those approached consented willingly. Arrangements for interviews were made by telephone, followed by a letter of confirmation. It was important to assure participants of confidentiality, which I did at the initial approach and re-affirmed within the letters of confirmation and at each of the interviews. At the same time I also assured participants that they could withdraw at any time. In total three

people withdrew before the second interview, two because they withdrew from the course and the third for personal reasons.

Interviews were normally held either in the participant's place of work or at the university. Occasionally they were held in the participant's home. It was important to provide options and to accommodate specific times and venues that suited participants. It was also important to be punctual and not to appear flustered or harassed. Time spent in general conversation at the beginning helped ease tensions and facilitated a relaxed atmosphere. I prepared and checked the tape recorder and tapes prior to meetings to minimise disruption and ensured that the furniture arrangement and heating and lighting was satisfactory when interviews were held at the university.

As programme leader I was known to all the participants, which was helpful but it did concern me that this could influence responses in several ways. For instance, those approached might have felt obliged to participate or concerned about the consequences of withdrawing. Responses might have been inhibited where participants felt that my perspective differed from theirs or felt that they did not want to disclose their true feelings about the course.

A facilitative approach to interviewing was important. For example, trying not to sound challenging or confrontational when asking questions whilst at the same time ensuring that the main aspects were included and significant points and issues raised by participants were identified and explored. I was conscious of both my own and the participant's non-verbal communication. I also tried to ensure that the environment was private and quiet. I initially lacked skill in probing and in keeping the responses focused

so they tended to be lengthy and not always relevant. My interviewing skills improved with practice. After each interview I made notes on how I felt the interview had gone and any salient features that might have influenced the responses. It mainly acted as a reflective diary and was helpful in monitoring my own performance. I also devised a brief evaluation form based on guidance by Denscombe (1998). After the first interviews with cohort A participants I reviewed the forms and evaluated my approach, which was helpful in identifying what was working well.

4.8. Analysis of the data

Overall the data collection was successful. The participants willingly discussed their experiences and feelings and as a result a considerable amount of valuable data was collected. The main problem was the length of time that it took to transcribe the tape recordings. I felt overwhelmed by the vast amount of data, however, it proved invaluable in the analysis especially once the main themes were identified.

The first six transcripts were read line by line and draft codes developed that were then applied to the remaining transcripts. This process helped me to become immersed in and familiar with the data and to develop a feel for it. Fragmentation through coding did enable some objectivity and allowed observation of patterns and category development. A lot of data was discarded during the refinement of categories and the need to focus on the main elements that stood out.

Similarities and differences were identified through comparison of categories and main themes emerged from the process of explaining the patterns observed. As categories

were explored and refined a description of each one as a thing in itself and an explanation of its relationship with other categories and emerging themes helped to develop the theory of the themes.

Once the main themes were identified existing categories were related to them or discarded. Some new categories were also developed. I did not return to the field to collect further data to support or refute hypotheses but worked on the large amount of data collected that enabled me to develop the themes satisfactorily. However, the potential exists for further research into different dimensions of the themes.

The categories helped to further dimensionalise the theory. Within categories differing responses and variations in the situations and conditions in which they occurred could be detected. The relationship of sub-categories to particular conditions was also deciphered.

4.8.1. Overview of data analysis

Initially breaking down the data by coding was unrefined and there was a lot of overlap between codes. As the categories became more refined and clearer a lot of data was discarded so that the focus was on the main elements that stood out. Explaining the meaning of the categories and the relationship between categories was the most important part of the process in terms of refining and developing robust themes. I did not collect further data to support hypotheses because of the large volume of data that was already available and the number of participants involved. Glaser and Strauss (1967) regard closure through saturation as an essential element of grounded theory

however, Charmaz (2003) disputes the need for saturation from a constructivist perspective. The theory that has emerged from the data in this study are specific to the participants and generalisable only to some extent to other enrolled nurses. The social and political context of conversion, and of nursing, is constantly changing so relevance of findings is also historically situated.

One of the most important effects was the extent to which the findings challenged my personal assumptions. For example, I realised that I had never really considered what being experienced meant to enrolled nurses. I believed that I had acknowledged the experience and that I valued it. However, I now realise that the accreditation process that I was involved in could, potentially, fragment experience into elements and separate it from an individual's perspective in order to fit a prescribed knowledge and skills framework.

4.9. A reflexive critique of the research process

Reflexive analysis involves critical scrutiny of decision-making throughout a research inquiry from its inception to the presentation of findings. It clarifies researcher influence on all aspects of the process of inquiry from development of the questions to analysis of the data. It is claimed that reflexivity strengthens the trustworthiness of the results and hence the integrity of a study (Finlay 2002). It also enables the realisation of intersubjective influences on data collection and analysis within an interpretive methodology (O'Connor 2007). Furthermore, used as a research tool, systematic analysis can enhance researcher self-awareness of positioning within the dynamic interaction between researcher and participant (Finlay 2002), which has the potential to

alter participant and researcher responses and transform perspectives. An altered dynamic can impact on a researcher's decisions concerning the collection, selection, interpretation and presentation of data and influences findings and knowledge construction. Being reflexive is an important component of qualitative research and demonstrates the influence of methodology on the nature of the relationship between researcher and participant, the data generated and subsequent findings. For example, it can clarify intentional and unintentional influences of researcher neutrality and objectivity within a positivist perspective or the conscious positioning and subjectivity of feminist research. A researcher has a social responsibility to critically account for decisions and actions taken and to indicate possible individual and collective benefits of the research process and findings for participants.

4.9.1. Researcher and participant relations

Methodology influences researcher stance and the nature of participation and power relations between researcher and participants. Power relations depend on the perceived importance of agency and subjectivity that can be illustrated by differences between positivist and postmodernist perspectives. Power relations depend on the positions adopted by researcher and participant and are reflected in perceptions of expected or normal behaviour within the relationship. Potentially a researcher is in a position to influence the extent to which a participant can play an active role within the data collection and analysis. However, researcher awareness and realisation of this potential is influenced by ontological and epistemological assumptions associated with the chosen methodology.

A traditional view of the relationship assumes that a researcher will remain objective and distanced from a participant ensuring non-contamination of the data, believed essential for the demonstration of scientific validity and universal truth. From this stance participants adopt a passive role within a hierarchical relationship in which the researcher controls the collection, interpretation and analysis of the data (Oakley 1993). A postmodernist view, on the other hand, influences researcher-participant equality, values subjectivity and acknowledges that ways of knowing are 'culture-bound and perspectival.' (Webb 1993, p.418). These two perspectives reflect differences in the way the other is viewed as demonstrated in the contrasts between 'I-it' and 'I-thou' relations (Mouzelis 1999). 'I-it' relations derive from a controlling and rationalistic perspective in which dominance is legitimised by external objectification. On the other hand, 'I-thou' relations are interpersonal and involve mutual respect for individual autonomy and require full participation and emotional honesty. Mouzelis equates the latter with a 'pure relationship' which 'entails a non-traditionally regulated, non-compulsively established, interactive, self-other relation' (Mouzelis 1999, p.90). A postmodernist perspective assumes that an individual is not an object of scientific study but a knowing and responsible subject (Smart 1999). However, socially constructed self-identity is influenced by differential access and exclusion related to inequalities of class, gender and ethnicity (Giddens 1991). Feminist research aims to improve lives of women and others who are exploited and promotes researcher-participant relations that are inclusive, non-hierarchical and empowering (Webb 1993, Lather 1991). Further exploration of the differences between positivist and feminist perspectives highlight important issues related to potential power differences within researcher-participant relations and clarifies how these can impact on data collection and analysis and subsequent study findings.

I was conscious that my position as programme leader could adversely influence my relations with the participants who were all students on the course at the time and therefore were vulnerable to perceived hierarchical differences. I was concerned that they would assume a passive and subordinate role and that their freedom to choose whether or not to participate or to withdraw from the study would be restricted by feelings of compulsion or obligation towards me. I also wondered how the relationship would influence responses and the extent to which participants would feel that they were being judged by the programme leader. In order to minimise a power differential and to prevent participants from being coerced the moment that I made contact with the participants I clearly stated that they were under no obligation to participate and that, even if they did agree to take part, they could withdraw at any time. The initial approach was followed by a letter, which re-affirmed this. Prior to the first interview each participant signed a consent form that outlined the nature of the study, the purpose of the interviews and measures that would be taken to ensure confidentiality. It also contained a statement that emphasised again that the person was under no obligation to participate and that they could withdraw at any time. When I made contact with each person prior to the follow up interviews I again emphasised that they could withdraw at any time. The degree to which participants felt able to exercise choice can only be presumed. However, all of those approached willingly participated and all but three took part in all three interviews, which suggests that participants had a vested interest in contributing and that they felt that the study was worthwhile.

4.9.2. Contrasting assumptions of subjectivity

Positivism derives from an assumption of scientific rationality in which knowledge is based on universal laws. Scientific objectivity governs discovery of factual knowledge through controlled observation and measurement of objects (Lather 1991). Positivism is criticised for its objective approach to the study of human behaviour which is perceived as 'mechanistic and reductionist' (Cohen et al 2000, p. 17). Furthermore the superiority of empiricism and objectivity invalidates subjectivity and the influence of individually constructed knowledge on behaviour.

> The difficulty in which positivism finds itself is that it regards human behaviour as passive, essentially determined and controlled, thereby ignoring intention, individualism and freedom. (Cohen et al 2000, p. 19).

Whilst positivism claims that researcher objectivism and rationality protect the notion of pure and uncontaminated data, feminist research, on the other hand, aims to purposively influence researcher and participant responses. A feminist perspective is essentially emancipatory and postmodern (Webb 1993), acknowledging interpretive multiplicity and challenging the dominance of masculine rationality (McNay 1992). Feminist methodology focuses on the intersubjective nature of the interaction between researcher and participant. It requires researcher consciousness of perceived positioning and active determination to minimise hierarchical influences on a relationship in which the researcher is an active participant and the participant a collaborative co-researcher (Finlay 2002). Within this relationship a researcher requires to be reflexive rather than neutral as feminist research assumes

a more collaborative, praxis-oriented and advocacy model… (in which) people gain self-understanding and self-determination… in order to transform women's subordinate positions in our dominant institutions. (Lather 1991, p. x).

It involves doing research for people instead of with people. The role of researcher as an active participant within an intersubjective, interactive relationship is grounded in the intent to minimise power assymetry, give greater visibility to women and to realise emancipatory potential (Lather 1991, Webb 1993, Hamberg and Johansson 1999, Oakley 1993).

4.9.2.1. Minimising power assymetry

Power asymmetry exists within a hierarchical relationship where a researcher assumes a dominant position deciding what is best for a participant and also controlling the interpretation of meaning and where a participant assumes a subordinate position and passive role (Hamberg and Johansson 1999). Researcher awareness of a perceived power differential and participant powerlessness is important in feminist research if a non-hierarchical and inclusive relationship is to be achieved.

While we may seek strategies to minimise power, groups without power more generally are not in a position to assert power over the research process either, which is the very essence of vulnerability. (Hamberg and Johansson 1999, p. 463).

Minimising power asymmetry requires researcher awareness of participant positioning and conscious regard for others as equals. If power is asserted through dialogue (Lather

1991, Hamberg and Johansson 1999) then particular attention must be paid to ensuring that it is explicit and reciprocal (Oakley 1993).

4.9.2.2. Giving greater visibility to women

The principal aim of feminism is to overcome the subordinate position of women (McNay 1992). From this perspective research methods are purposive instruments for collecting data that gives 'the subjective situation of women greater visibility' within society (Oakley 1993, p. 235). Furthermore, the researcher is responsible for ensuring that it is what the participant says or wants represented that dominates (Oakley 1993) and that the language conveys subjectivity and does not obscure cultural influences on individually constructed positions (McNay 1992).

4.9.2.3. Realising emancipatory potential

Feminist research aims to uphold emancipatory values (Oakley 1993) through the promotion of justice, participation and equality. Justice is achieved through not exploiting participants or what they have to say. Participation occurs where researcher and participant are active contributors to the research study through intersubjective interaction. Ensuring equality involves conscious and deliberate action to minimise differentials between researcher and participant (Oakley 1993). The aim is to raise awareness of the potential influence on perceptions of dominance and how this is asserted. Open-endedness is necessary for individual realisation of autonomy and agency and emancipation from the 'universal, necessary and obligatory' (Lather 1991, p. 38).

Strategies intentionally employed by feminist researchers to promote intersubjectivity include encouraging participants to read their own transcripts in order to verify authenticity and to enable them to comment on the veracity of researcher interpretation and representation of their views. (Oakley 1993, Webb 1993, Hamberg and Johansson 1999, O'Connor 2007). Openly discussing perceived power differentials with participants (Hamberg and Johansson 1999) and discussing interpretations of the data and inviting participants to give their views (Oakley 1993, Webb 1993, Hamberg and Johansson 1999, O'Connor 2007) are other measures that have been reported as being more inclusive. Giving information and advice to participants is part of a strategy by researchers to relate to participants openly and honestly (Oakley 1993, Hamberg and Johansson 1999). In addition, Oakley (1993) proposes that feminist interviewers should promote a collaborative relationship that is a non-hierarchical, joint undertaking. The relationship should be interactive where the interviewer is responsive to participants' reactions. Interviewers should make clear their intentions not to exploit either the participant or the information that they provide. Answering questions openly and honestly as opposed to acting deferentially and trying to distance oneself from the participant can help the interviewer to develop a rapport with the participant and can encourage participants to reflect on issues raised. Forming a personal relationship with participants by relating person to person, woman to woman, professional to professional according to the situation can facilitate a more equal relationship (Oakley 1993).

4.9.3. Power relations in research

Two contrasting views of the individual, derived from Foucault's theories of mind-body dualism and technology of self (McNay 1992), illustrate possible researcher-participant

power relations. From the first viewpoint, a mind-body dualism based on socially constructed hierarchies of dominance and subordination, participants are perceived as research objects, passive, docile bodies who comply with a researcher's wishes without question (Oakley 1993). The researcher, as subject, assumes legitimate authority over the object of the study and also assumes control of interactive behaviour governed by norms of scientific convention (Oakley 1993, Andersen 2003). Participants can feel compelled to follow instruction and are vulnerable to exploitation by a researcher that can be intentional or unintentional. From the second viewpoint, a technology of self, it is acknowledged that an individual has the capacity to act autonomously and to choose for themselves whether or not to participate in a research study and the extent to which they will comply with a researcher's wishes. From this viewpoint a potential exists for the acknowledgement of intersubjective influences on data generated by interaction between researcher and participant. Feminist research, for instance, aims to ensure respect for, and recognition of the

> intellectual and political capacities… of all people involved in an unequal power relation, not only women. In relation to this value feminist research must ensure that participants are enabled, as far as possible, to participate as equals within the research process. (Lather 1991, p. x).

Researchers have a moral responsibility to protect the rights and dignity of participants and to prevent exploiting their vulnerability, consciously and unconsciously. Furthermore, they are ethically accountable for ensuring transparency of decision-making and the recognition of the potential effects of decisions on participants.

On reflection the approach that I adopted during the interviews appears to be positivistic. I consciously tried to be objective and avoided engaging in conversation with participants other than asking the questions, probing and seeking clarification as I believed necessary. My reasoning was to avoid distraction in order to remain focussed on participants' perceptions of their experiences. However, I also believed that, in the interests of objectivity, I should not influence participants' responses. At the time I was aware that responses would be influenced by me, and other uncontrollable factors and this caused me concern. In future I would be more confident in taking a more open-ended and interactive approach to data collection and analysis where appropriate. The sample selection also assumes a perception of participants as research objects although there was no conscious intent to exploit participants by using them as a mine of information to be extracted for the sake of the research or to support pre-conceived notions about particular issues. The focus of the study is to explore individuals' perceptions of their subjective experiences and the findings should benefit the participants, enrolled nurses, by highlighting injustice or powerlessness. Generalisability of the findings beyond the participants cannot be claimed. The interpretation of reality derives from my perception of participants' self-representations.

4.9.4. Researcher and participant interaction and positioning

Researcher-participant interaction is influenced by a multiplicity of roles and positions adopted by both and the degree to which each feels able to relate to the position of the other, for example, woman to woman, nurse to nurse. Potentially positions can influence perceived hierarchical differences such as professional-client, tutor-student. Positions adopted and their influence on interaction is unique to each situation. As a

feminist researcher Oakley (1993) chose to become friends with participants in a study on motherhood to ensure an open-ended interaction. She describes how she related to participants from a number of positions including as a person, mother and friend-advisor. Hamberg and Johansson (1999) highlight issues arising from the influence of professional role on interaction. In this case, as general practitioners interviewing female patients, they found that participants' responses were inhibited by perceived professional judgement of their behaviour. They reported that dilemmas related to their professional role were overcome by openly discussing them with participants following which, responses were perceived to be more honest. Attuning to participants' perceptions of their own and others' positioning can enhance researcher sensitivity to potential hierarchical influences on interaction. Furthermore, facilitating open discussion of perceived role influences can encourage honesty and promote awareness of an individual's right to refuse to participate and to withdraw consent at any stage in the process. It is the responsibility of the researcher to remain vigilant to constraints on participant autonomy and the influence of perceived hierarchical differences and associated domination and subordination within the positions adopted. Even relationships between friends can be influenced by perceived status difference that can affect individual agency.

The aim of the research, the research questions and the interview questions were influenced by my personal experience as a registered nurse. During the interviews I reflected on images of the participants' experiences that derived from my past experience. Clarification and probing was related to comparing my own understanding of a situation with that of the participant, nurse to nurse. I did not find it difficult to relate to participants as a nurse. They all knew my professional background and it

seemed natural to discuss practice situations and participants' perceived experiences of them from this position. I also felt that it put the relationship on a more equal footing than that of programme leader and student. At times my experience as a nurse guided the questions towards feelings. For example, when participants talked about their experiences as agency nurses, referring to my own feelings of uncertainty or anxiety about nursing in unfamiliar situations I asked them about their initial feelings and how these changed. The question 'How did you feel when you first did agency nursing?' prompted responses that described feelings of uncertainty and anxiety about nursing in unfamiliar situations and how confidence developed through repeated exposure to situations and variety of experience. Similar responses from different participants confirmed that this was a common phenomenon and was significant as discussed in the findings in Chapter 5.

Concern about researcher influence, privilege and unintentional coercion related to my position as programme leader and the potential control that a teacher has over a student within a hierarchical relationship. Also enrolled nurses are particularly vulnerable when they perceive their status to be subordinate within a hierarchically structured profession which is predominantly female within a patriarchal hierarchy of the health professions.

4.9.5. Data collection

Identities shape the way that we interpret, construct and analyse data. (O'Connor 2007, p. 267).

Professional identity and roletaking is influenced by temporal, dialogical, subjective and reflexive elements (O'Connor 2007). Clarifying the influence of identity and roletaking on data collection and research findings does not lessen researcher bias but makes explicit the variable nature of influences and provides a more detailed and authentic research account. If, as suggested by Kvale (1996) qualitative research cannot be objective because it concerns human interaction in which participants influence each others' responses and views then there is a need to clarify interpretive influences and researcher subjectivity in the construction of reality (O'Connor 2007). Reflexivity is important in preventing perceptive rigidity, promoting receptivity towards differing and diverse views and adopting a critical approach towards unquestioned assumptions and pre-conceived beliefs about findings (Cohen et al 2000, O'Connor 2007). Critical examination of the influence of different positions adopted by researcher and participant on reactions and responses and influences on positional shifts enhances awareness of self and others (Kvale 1996, Hamberg and Johansson 1999). If the purpose of a research interview is to understand how a phenomenon is perceived then a researcher must be aware of the dynamic nature of the interaction and conscious of any changes in perspective (Kvale 1996). A researcher is responsible for producing knowledge that is worthwhile and data is collected for that purpose. However, awareness of the ethical implications of 'mining' for information (Andersen 2003) is essential particularly when, encouraged to speak openly, a participant may later regret having said something (Oakley 1993). It is important to examine researcher intention and perceived imposition by a participant and to assess the degree to which 'individuals act autonomously and in an interactive fashion and to what degree they merely reproduce dominant social structures and inequalities' (McNay 1992, p. 74).

Candidates in cohorts B and C appeared more self-confident particularly when the interview was held soon after they had received results of an assignment in which they had been successful. Participants in cohort A were initially nervous but all were open about their feelings and experiences. The location of the interviews had a minimal influence on the perceived formality of the situation. A few participants commented that they found the interviews personally beneficial because it stimulated reflection on their past and helped them to focus on their professional identity and what they were gaining from the programme. Despite my attempts to remain objective there was a degree of interaction between the participants and myself, which influenced responses. Although the sample of participants had been selected to include individuals from varying backgrounds according to geographical area and type of nursing that they were involved in, no significant difference was found between them. Different perspectives of a phenomenon were incorporated within the theory under construction and provided a further dimension or elaboration.

4.9.6. Data analysis

Each person perceives phenomena in a unique way (Finlay 2002) and pre-understandings are influenced by epistemological and ontological assumptions. Studying a phenomenon implies a desire to explore one's own and others understanding of it and analysis involves coming to know one's pre-held assumptions through observation and recognising how others' assumptions differ from one's own (Andersen 2003). Becoming aware of meanings that differ from one's own enables one to become conscious of one's perspective. This involves confronting one's assumptions and perceptions and requires one to be critical of previously held assumptions that are

unchallenged. It provides insight into one's own and others' positions within a discourse and enables a researcher to challenge dominant assumptions through recognition of a multiplicity of perspectives.

Analysis involves more than objectively searching through text for common meanings. A researcher's perspective determines that which is regarded as significant and being able to perceive one's own perspective as being distinctly different from that of a participant's requires one to look inward from outside oneself and to become researcher and researched at the same time (Finlay 2002, O'Connor 2007).

> New understandings can arise from a dialectic between the researcher's pre-understandings and the research process; between the self-interpreted constructions of the researcher and those of the participants. (Finlay 2002, p. 534).

Looking inwards heightens awareness of the influence of previously unconscious perceptions on dialogue during conversation and whilst reading text. Becoming 'other to ourselves' (O'Connor 2007) enables a researcher to be critical of their own assumptions and perspective through reflexive professionalism that enables a researcher to become conscious of changes in perspective. Recognition of what is significantly different about an object when viewed from a different perspective enables the realisation of a new meaning and knowledge construction (Andersen 2003).

> The displacement of one's perspective and problem changes not only what one sees but also the ways of seeing employed when reading and analysing. It changes the statements to which one's attention is drawn as well as the connections one sees between statements. (Andersen 2003, p. 23).

During the interviews and whilst reading the transcribed texts I was aware of referring to my own experiences as a nurse in an attempt to identify what participants were saying about their experiences. Using self as other I challenged my own, taken for granted assumptions about people and situations where my perceptions of them differed from those of the participants. For example, participants' descriptions of what it meant to be experienced caused me to reflect on how I had become experienced as a nurse and feelings associated with that. This enabled me to gain new or different insight into what it means to become and to be experienced. Becoming conscious of this enabled me to better understand participants' perceptions of this phenomenon in relation to the new perspective and I was able to construct a theory that incorporated individuals' descriptions of their experiences. Prior to becoming aware of the new insight I had been coding the transcribed texts and again my own experience as a nurse influenced what I perceived to be sufficiently significant to influence the creation or development of a category.

At times the insight gained into participants' perspectives could be personally challenging particularly if they raised awareness of contradictory values. For example, one of the participants described feeling threatened by the tutors' expectations that they would be capable of undertaking university level assessment when they did not have any O levels. The very thought of coming to a university was daunting. Whilst I was reading this text I became acutely aware of my own assumption that the accreditation of experience derived learning and access to university would be valued by enrolled nurses. Awareness of this enabled me to see my approach from a different perspective. I became aware that my own assumptions derived from my acceptance of the dominance of the educational institution over the individual. Consciousness of my perceptions

about experience and the role that I actually played commodifying others' experience grew and I was able to perceive my actions from the perspective of a recipient. As a result I constructed dimensions of the theme of academic credibility as outlined in Chapter 7. This experience has influenced my professional practice, making me much more critical of my assumptions about positions adopted and power relations between tutors and students. I have altered my approach as a tutor and I am more aware of how my thinking and actions impact on students' perceptions of themselves and others.

4.9.7. Transcending description

If analysis is to transcend description it is necessary to look beyond what is being said and to search for deeper meaning relationships. Discourse analysis is

> an analytical strategy that enables us to obtain knowledge critically different from the existing system of meaning. (Andersen 2003, p. xiii).

It exposes power relations that underlie the meaning of the narrative and is relevant to this study where examination of the association between power and knowledge, and in particular, control of the definition, meaning and validation of knowledge and its exclusionary impact is appropriate. Discourse analysis involves development of concepts about an underlying discourse through analysis of participants' statements about an object where the researcher is regarded as the subject and the participants' statements the object. Two concepts within discourse analysis are particularly relevant to this study namely archaeology and genealogy. Archaeology concerns the influence of

unconscious processes that govern what an individual says or does. It enables underlying influences to be examined and illuminated (Andersen 2003).

> Foucault proposes that in all the human sciences there must be quasi-structuralist rules of formation which, unknown to the actors involved, regulate and determine the spectrum of speech acts which can be taken seriously at any given historical moment. (McNay 1992, p. 26).

Genealogy involves analysis of how the present point has been reached by considering historical influences. However, there is no primordial meaning (McNay 1992, Andersen 2003).

In this study I did not consciously use or refer to discourse analysis. However, in retrospect it offers an explanation of the shift from coding data to theory development that resembles the process experienced during analysis of the data. An historical archive of the occupational position of enrolled nurses within a hierarchical structure was developed and political motives of the institutions involved, regarding the validity of experience and experiential knowledge, and the dynamic shift in the control of practice between institutions of higher education, professional bodies and Government, was considered. Analysis of the meanings of the participants' expression of their perceptions of the situation and of themselves and others can be explained through examining them in relation to the underlying discourse. For example, changes in professional values and attitudes and the impact of this on enrolled nurses' status are identified. Historically the Briggs (DHSS 1972) recommendations that there should be only one level of registered nurse was based on the observation that enrolled nurses fulfilled the same role as registered nurses. Professional changes in relation to academic qualifications influenced

the demotion of enrolled nurse status and diminishing opportunities for professional development and career progression experienced by this group of nurses.

This process assumes that the role of a researcher is to perceive phenomena from the viewpoint of the participants rather than to assume a superior stance. It is important to consider meanings that might have been drawn from the data had I not engaged in this process. For instance, I might have merely reinforced my belief that enrolled nurses' perceptions of self and others alter as the progress through the programme, describing the process of change and perceived influences on individual experiences. Engaging in a dialectic process enabled me to go beyond description and to construct a meaning of the experience of enrolled nurses and also made me aware of the assumed dominance of educational values and how this unconsciously influenced my own perspective as a professional. It is important to acknowledge that the sense making derived from a change in my perspective and not from an uncontaminated or pure representation of participants' perspective. My influence within the data collection and analysis is subjective rather than objective.

Examining discourses underlying the different perspectives within the study lends further clarity to analysis. For example, the theory that emerged provides an insight into the influence of experience on judgement in practice and the importance of individual self-appraisal of competence within a given situation based on knowledge derived from experience that has implications for professional education. Participants' perceptions of themselves as experienced nurses were accompanied by the frustration of not having their experience acknowledged in practice. This was influenced by perceived lack of status within a hierarchical structure but also relates to an underlying shift in the way

that experience as competence is perceived. Competence is regarded as a measurable commodity that relates to specific elements of knowledge and skill. Decisions concerning the measurement of competence are controlled by educational institutions and government bodies. Participants within this study illustrate the subjective and situated nature of experience. Competence involves knowing what to do and how to do it within a given situation and knowing from experience what one's needs to become sufficiently skilled and also to be able to manage one's own professional development. Prior to this study I regarded enrolled nurses as experienced however, I also participated in a process of commodification that derives from the dominance of the institution. As a result of the analytical process I am able to see how the participants' view of experience and my own assumptions about this phenomenon were contradictory.

Researchers control the interpretation of meaning underlying the data which is influenced by an ability to identify differences between existing unchallenged assumptions about the underlying discourse and the perspectives of participants that are influenced by their experiences and perceptions of situations and their positions within them. Researcher judgement of what is being said by participants is influenced by personal and professional values, attitudes and beliefs. It is important that a researcher is reflexively critical of influences on their own thinking and the impact that this can have on the interpretation and presentation of the data.

4.9.8. Representation

Issues of representation relate to the power of a researcher to control decisions influencing whose views that are represented in the findings, the extent to which

participants' views are represented and how they are represented by a researcher. Control of data analysis and presentation of findings highlights a potential power differential between researcher and participant and indicates the vulnerability of participants in comparison to the privileged position of the researcher (Mauthner and Doucet 1998). The researcher, as expert, selects, interprets and represents participants' data and is in a position to empower or disempower (Ribbens and Edwards 1998). For example, participants may be excluded from the analysis and may have little or no influence over how they are represented publicly by the researcher. The researcher on the other hand knows the academic language of research that can denote acceptance of the findings as valid and can exclude others whose language is not valued, including participants (Ribbens and Edwards 1998). This can present a dilemma for a researcher who may wish to represent participants using conventional research language but is concerned that this may detract from the impact and value of the findings.

Within a qualitative study the researcher has a responsibility to present findings in a way that will most benefit participants. Yet there is a danger that participants may be excluded from analysis and presentation unless a deliberate attempt is made to include them. One strategy for increasing participation in analysis involves giving participants unedited transcripts of their interviews and asking them to verify authenticity of the content. Studies indicate that participants can feel belittled when presented with their transcripts because the language appears inferior (Oakley 1993, Standing 1998, Hamberg and Johansson 1999). A researcher is morally responsible for ensuring that participants are not exploited or feel undermined and must be receptive and sensitive towards their vulnerability. Participants' voices should be represented

in a way which is faithful to their experience and language but that does not position them as 'other' and reproduce hierarchies of power and knowledge. (Ribbens and Edwards 1998, p. 19).

Reading what one has said can make a person feel uncomfortable particularly if the transcribed text includes grammatical errors, colloquial phrases and hesitances. I chose not to present interview transcriptions to the participants because I thought that they would feel demeaned. Within the presentation of findings it did seem appropriate to illustrate specific points by using extracts from the transcripts provided that individuals' dignity and confidentiality was safeguarded. It would also have been appropriate to present the findings to participants and invite them to comment on the authenticity of meanings represented. The main reason for not doing so was lack of time and it is possible that this could be done as it would enable discussion of the findings and further development and refinement of the theory. However, individuals would be able to choose as freely as possible whether or not they would participate. The extent to which participants are included as co-researchers within the analysis depends on a number of factors including the extent to which participants wish to be involved and to what degree (Ribbens and Edwards 1998).

Researchers also need to acknowledge the place of their own voice within the findings. Transformation of participants' knowledge during analysis will alter to some extent as it is incorporated into theory development. A researcher needs to be aware of the potential for meaning to be unintentionally altered. Researchers may also feel that expression of their own feelings is constrained by academic convention. Acknowledgement of intersubjectivity and the extent to which it influences altered perspective and awareness of differences between perspectives, essential for realisation of a dialectic and the

development of theory is important. It includes reference to the researcher's own experience and the theoretical perspectives of others. However, a positivistic methodology that emphasises researcher objectivity can lead to omission of the analysis of researcher subjectivity within the research findings. Pure representation of participant meaning is believed to be impossible (Ribbens and Edwards 1998, Oakley 2005). A researcher needs to demonstrate how the influence of the voices of the participants, researcher and other theories contributed to the analysis of the data and presentation of the findings and to encapsulate multiplicity of meaning (Mauthner and Doucet 1998). Reflexive analysis highlights the moral responsibility of the researcher to represent participants within the findings in a beneficial way but also in a way that ensures that important aspects of the findings are clear. It must also account for the influence of researcher subjectivity and reference to self as other, the influence of other theorists within and the degree of participant involvement on the analysis.

The main theories that influenced analysis included situated and transformative learning (Wenger 1998), theory of self-efficacy (Bandura 1986), the value of critical consciousness (Carr and Kemmis 1986, Barnett 1997) and consideration of Fenwick's (2003) view of commodifcation in higher education. Prior to this my perspective of experiential learning and reflective practice had been narrowly cognitivist. Examination of the context of professionalisation and academisation raised my awareness of the influence of occupational socialisation on professional behaviour and positioning and how this can result in uncritical obedience and conformity. The value of academic qualification over experience has created a professional exclusivity that has marginalised the status of enrolled nurses. Undertaking the study has made me critically conscious of my own assumptions about learning and the centrality of the individual

and their capacity to control their own learning and development. This altered perspective has clarified the tension between theory and practice and highlighted the importance of the influence of practical knowledge in professional judgement and action. The findings of the study illustrate different interpretations of the meaning of competence and the perceived value of experience and challenge the dominant view. The benefit of the outcomes for enrolled nurses is that they should be better able to demonstrate how their experience influences competence in practice. Self-awareness of the process should enable individuals to focus on controlling learning and managing self-development.

Chapter 5: Being Experienced

5.1. Introduction

Being experienced emerged from the data as a key theme. All of the enrolled nurses who participated in the study perceived themselves to be experienced nurses. Several issues related to being experienced were identified that reflect the tensions inherent within the cultural change associated with the professionalisation of nursing. It is also apparent that, within this study, the concept of being experienced, and related issues, is inextricably linked to academisation and, in particular, the value accorded to academic credibility. The findings have implications for the role of professional education in nursing.

Three aspects of being experienced emerged from the analysis:

- The process of becoming experienced.

- The motivation to become experienced.

- What it means to be experienced.

5.2. The process of becoming experienced

For the enrolled nurses who participated in the study becoming experienced emerged as a process of familiarisation that involves exposure, variety and the development of self-confidence that is required to take control in specific situations both familiar and unfamiliar.

5.2.1. Exposure

Repeated exposure to practice situations provided opportunities for the development and refinement of practice. Learning from 'hands on' practice increased practical knowledge and facilitated the development of a personal theory of practice that contributed to a sense of self-control within particular situations. Repeated exposure to a situation aided familiarity and enabled individuals to recognise what was normal or usual for individual patients and practice situations. Knowing what the norm was meant that unusual phenomena stood out.

> EN. In my own area I feel quite skilled because a lot of the patients have been there a long time and I know them and I know their likes and dislikes and how they'll react…I'll know the things to look for.

> EN. The more that you do something, the more that you are in different situations, it helps you to deal better… you're faster on your feet at thinking. If you didn't have that experience you wouldn't be able to react to situations the same way… You kind of do things without thinking about them, at certain times. I think that kind of thing comes with experience, you just cannot learn it.

Several participants deliberately exposed themselves to unfamiliar situations or those that they felt uncertain about in order to gain experience through becoming familiar with the normal practice within such situations. Repeated exposure to a variety of unfamiliar situations facilitated the development of self-confidence in one's ability to make sense of uncertainty. It promoted the development of self-control through becoming familiar with the unfamiliar. This process of familiarisation was evident in

participants' accounts of doing agency work where they were exposed to a variety of unfamiliar situations and, as a result, developed a way of identifying and making sense of uncertainty.

> EN. I think the skills that you use most in agency nursing are your interpersonal skills because you have got to get on with people. You don't know what situations you're going in to and you have to fit in and you've got to see things to be done and just go and do them. You've got to have the confidence to say well sorry I'm not quite sure about doing that but if you show me what to do I don't mind.

Developing a sense of self-control in situations was an important aspect of becoming experienced. Taking control meant being in charge of the presentation of self and involved clearly identifying and being able to negotiate the boundaries of one's practice. It meant being able to make clear to significant others what one could and could not do; what one was and was not willing to do and what was involved in terms of the demonstration, observation and supervision required to become satisfactorily familiar with a particular procedure or situation.

A number of participants chose to do agency or bank nursing to become experienced or to maintain their experience and to boost their self-confidence. It was also financially rewarding. Ultimately exposure to and familiarisation with situations and individual patients continued until one felt that sufficient confidence was gained in one's ability to 'go in and take charge'.

> EN. I did bank for a while to keep up my practice in general (nursing) to a point where I could go in there and take over.

EN. The agency promised me work on the wards that would get me back into it. So I left theatre and worked on the wards for a few months just to get my confidence back.

EN. The agency has helped as well. Seeing the different areas, seeing how they work and gaining experience in different fields of nursing.

EN. (On joining the Agency) I said that I would work on a medical or surgical ward but nothing too hi-tech. And I thought that I would be a glorified auxiliary because I didn't have much experience…So I went to the ward and before I knew it I was getting involved in it and I thought I can actually do this, I have acquired the skills. Things have changed a lot. Some of the language has changed. But at the end of the day the patient still needs support…There's so much going on here and before you know it you've met all these different people and are going to all these wards… You see a bigger picture of what's going on and you're developing skills that were, not lost, but suppressed because you hadn't used them, and that gives you confidence.

5.2.2. Variety

Variety sharpened thinking and enabled individuals to focus on uncertainty and becoming familiar with the unfamiliar. It also provided breadth of experience, which in turn promoted self-confidence. Participants who felt that they had been exposed to a wide variety of experiences since qualifying believed that they were more experienced and more confident as a result, more so than those who had only worked in one area since qualifying. Other participants believed that familiarity could lead to complacency, especially in areas where there was little variety in the daily routine and, therefore, lack of sufficient challenge to stimulate thinking. Complacency was seen to relate to

performance that was automatic and non-reflective. Participants who worked in continuing care of the elderly were more likely to hold this view.

> EN. I think sometimes I'm on automatic pilot, you do things and say things in certain ways. I think a lot of it is quite routine… I don't think its until you come across something out of the ordinary or something that's changed that you maybe say 'Oh I've never noticed that before, I had better go and see about that.'… Usually things that happen have probably been planned for anyway… there is a care plan for it.

Some felt that rotation provided an opportunity for the development of practice through exposure to a variety of less familiar situations.

> EN. Because she had been there for numerous weeks and she thought that she was fixed there, she stuck to the one thing (task). So then it was decided that we would work out a rota and now we all rotate which is good for the experience.

In addition to complacency, lack of stimulation and challenge contributed to a fear of change.

> EN. Years ago if sister said put something on or do something, you just did it. Now you think 'Why do I have to do it like this?' And that is what I like about students coming to the ward. In the hospital they are wanting to change staff around wards and people are up in arms about it. I think it's a good thing but I'm in the minority. I think new people coming to the ward would be good. The sister and the other two staff nurses have been there for twenty odd years and I've been there for fifteen years. There are bound to be things that we do that someone could come in and say 'Why are you doing that? If you did it this way…' That is why moving round has got to be

better than people staying where they are. You have got to have people coming and going to bring in new ideas. It doesn't matter if you're the best nurse in the world you can still do things over and over again because nobody has ever told you or you have never looked into doing it any differently. It is just the way that we have got used to doing it.

Changes in the organisation of care at ward level, in particular a move from task to patient allocation, influenced an individual's perception of their practice which was stimulated by being responsible for the care of patients rather than a task.

EN. Years ago when you just worked and there was task allocation, I was just going around and doing the obs or whatever… But now I'm doing everything… meeting all the patient's needs and I'm making sure that I have done that rather than going round doing the BP's. I'm just thinking about everything I'm doing to meet each patient's needs.

An example of the stimulation and motivation to learn that derived from the challenge of exposure to a variety of situations could be seen in the course placements. Participants found that the placements were an important motivating influence during the conversion experience. The unfamiliar situations stimulated a desire to know more about what one was uncertain of or did not know. In some instances placements had an unsettling affect by raising an individual's awareness to the monotony of everyday routine within their normal place of work compared to what appeared to be a more exciting and stimulating working environment.

EN. My first placement was community and I think just being somewhere new, somewhere different… I thought I would like to do that. Everywhere I have been I would say that I could see myself there… I could do that, I could make a difference…When I went back to work after my third placement I was unsettled. Things were annoying me in my own workplace… I don't think it was anything to do with the people, nothing to do with the patients. I think it was to do with my need for something different.

Becoming familiar with the unfamiliar in a variety of situations during placements boosted self-confidence. The placements provided an opportunity for individuals to become more aware of their own performance. Within an unfamiliar situation they were more self-conscious. This meant that they were more likely to become aware of their own capabilities and comparing themselves and their performance to that of others could influence self-perception. Placements also had the potential to stimulate awareness of knowing how to control learning for oneself by becoming conscious of the process of learning how to learn. Achieving this reinforced the development of a positive self-image. Exposure to a variety of unfamiliar situations led participants to reflect on what they did and did not know and stimulated a desire to go and find out more about what one did not know.

EN. I've probably developed myself more since I came into the community…things like palliative care you tend to go away and look up yourself and look into them because its an ongoing part of your job.

5.2.3. 'Hands on'

Learning about practice from being 'hands on' influenced the process of becoming experienced and was valued by participants.

EN. Everything that I do now is down to things learned in the past… Its all down to experience. The way I find the best for me to learn is hands on experience, a lot of what I do is down to that.

EN. We had nine midwives to start off with who scrubbed for sections and did the peri-anal repairs and forceps. They were with us for a year and then we moved back there and (now) there is quite a workload. The midwife comes in for the baby… (Initially) I didn't want to scrub but it is actually fine… but it can be quite upsetting as well. I think we all felt the same when we were left… You felt reassured when there was a midwife there. Although we always did anaesthetics for the maternity they (the midwives) scrubbed up…Some people still refuse to take the bleep. Its such an adverse area up there. So much can go wrong.

M. Are you still worried about that?

EN. Sometimes. I gathered enough information like protocols and a book that the midwives left of what they need to put out for certain things. Again it all comes down to being up there and doing the job and (gaining) the experience. You have got to be there to gain the experience. You can't shy away from it…I think its better to see things and be in situations than read it out of a book. You know how you felt at the time and it does make you think.

EN. The first time I had great difficulty in people's houses because some people are lonely and they just like you to sit and talk to them. But I have got the knack now… really just through experience of doing it… The more I visited the more I realised

what I was doing and I got into my own way of working. I think its something you pick up. I don't think its anything that you can be taught…I realised that a lot of the patients wanted you to be chatting and there were certain ways that you'd ask a question and stop a question so that you could carry on and get past that.

Participants found that being in a position to think for themselves, rather than doing something because someone else had told them to, could enhance consciousness about what they should do in a situation. They valued experiential learning derived from practice over 'classroom' learning. However, specialist courses could provide knowledge that aided understanding and enabled individuals to make sense of what they normally did.

EN. I think the ODT course gave me more of a background to some things that you used to do and you maybe didn't know why you were actually doing them. It was just because that was the way that you were taught. I would say that that was a really good course if you are going to work in a theatre. I got a lot out of it.

Being able to consider knowledge from a more objective position facilitated a systematic approach to reflection on the known and unknown that could lead to a change in perspective.

EN. The nurses were endoscopy nurses going on gastroenterology courses. They were boasting that they could actually get a degree through doing their own job… (The lecturer) wanted to set up a (gastroenterology) module and I said to her that I'd done the ENB course… we spoke about it and the sister of the unit was quite keen… so it was going to be mixed and varied to make it more interesting for the people. And it

was going to be hands on. It wasn't going to be just a classroom exercise… it was good… It was hard work (developing the module) because you hadn't even thought about it because, to be honest, you were doing it every day. It gave us time to think about our work practice from an academic point of view… some of our work practices changed because of that.

5.2.4. Consciousness of self-doubt about being experienced

Some participants were conscious of seeking reassurance about their decision-making even although they knew that their rationale was sound. The act of seeking reassurance was perceived as a weakness in professional ability and they felt that they should have and would have liked to develop greater self-confidence in their decision-making.

> EN. I'm always quite happy that I phoned (for reassurance). But looking back you think maybe I should be able to do this on my own and I shouldn't phone. But there's always this dread at the back of your mind, 'You better phone and get it checked.'

> EN. I'm constantly seeking reassurance. I find myself doing it all the time. I am doing something and I ask one of the staff and say can you just check that I'm doing this correctly? I'm hoping that the course might alleviate that… I should have confidence in what I'm doing because I do really know what I'm doing…its just having the confidence to say well that is correct and that is what I am going to do. Instead of always thinking… I think that comes from being an enrolled nurse though.

Others perceived seeking reassurance initially as a normal part of the process of becoming experienced.

EN. When I first went into community I remember the day when I would go to the door and not get in. And then finding myself at the door and not getting in and being able to deal with it and at the end of the day realising that the person was safe. I think that you are given opportunities like that, knowing that there is somebody there if you feel that you need them. I think that I had a lot of opportunities like that and it really increased my confidence.

EN. Thinking back, for a long time when I was working in ward A and in that year I was still trying to slot in. I did probably ask all of the time. I don't do that now. So I'm probably quite at home with my decisions.

5.2.5. Opportunities and limitations of becoming experienced on night duty

Night duty was perceived as providing more opportunity for exercising agency in decision-making and therefore influencing one's ability to be in charge. Less medical staff on night duty meant that the nurse decided when medical intervention is appropriate.

EN. I feel quite skilled in my own area. A lot of that was gained in the ward and probably because you work night shift you are isolated a lot as well. You do tend to do a lot more things than if you were on days because there is no medical staff about.

Having no first level nurses to consult or answer to gave participants on night duty a greater sense of self-control.

EN. From the day I qualified I've never really worked under anybody. I worked in A and had my own shift and then I went to work in a nursing home. I was the first nurse

they'd ever employed, so I was doing my own thing there… Then I got a night duty post and I've been in that post for twelve years and I've always been in charge of my own shifts.

However, on the whole, participants regarded the breadth of experience available on night duty as limited. In particular, there was little opportunity to work with other members of the multidisciplinary team or to gain experience of consultants' ward rounds. Involvement in care-planning and discharge planning, and the organisation of treatment and diagnostic tests for patients was also noted as limited.

EN. Because I was on night shift you are not really dealing with anybody but when I went on to day shift I was dealing with the multidisciplinary team. I didn't even know these people to see. I had their names written down and their notes but I had never ever met them. So it was getting to know all the faces and then having the confidence to speak to them because on the night shift you are isolated. You maybe speak to a doctor on the phone but you are not really dealing with people. I had no problems with clients or patients but it was just other members of staff and fitting into the team.

Most of the participants who were on permanent night duty had already transferred before commencing the course or intended to do so. They did so in order to broaden their experience through exposure to a greater variety of practice situations.

EN. I think one of the reasons that I've gone on to days is to make sure that I know all of the things that are going on in the ward so that I can contribute towards everything. I don't like not knowing what I'm doing so I think just going back doing days will help give me the experience in different areas I'm not sure about. I think that will help.

Those who had already moved to day shift reported that the transition had been difficult because of the need for them to relinquish their control over decisions that affected their own and others' practice.

> EN. Until I came onto the course I was night shift… and for six and a half years I was left in charge of a ward and then moved to day shift. It did take me a while to adjust with not being in charge… and having to step back and not just being able to lift things and go and do them because obviously there's senior ones above you and I don't want to stand on their toes. I don't want them to think 'Oh she just thinks that she's going to walk in here and take over.'

> EN. I think I've probably got less responsibility on days because there are more staff around. You don't tend to be in charge of a team, which is quite nice sometimes. It means that you can step back and look at what you're doing and watch everything else that is going on and go down to theatre and things like that, that I haven't done for a while.

5.3. The motivation to become experienced

Motivation to become experienced appeared to be driven by professional accountability and the need to be competent that involved having sufficient and relevant knowledge, skill and experience.

5.3.1. Lack of familiarity with situation or patient

Participants were aware of the professional responsibility to have sufficient relevant knowledge to be able to perform competently and to become familiar with practice normally through 'hands on' experience. They were also aware of the risk associated with relying on others to identify what is normal or usual.

> EN. At the start with the haematology patients and I'd just moved to that ward and I felt if anything goes wrong here I haven't got a clue what I'm expected to do here which is really worrying… I spoke to the sister about it and said that if I was going to be in charge of these patients and this patient's having chemotherapy and this happens and that happens I'm not competent about how I would manage these problems…she was really good and we got out our policies and she brought in a load of information for me and I went away and I took the time to find out more about it.

> EN. This morning I had to go somewhere else. The senior nurse was away and I had to go over and take charge of the ward for an hour while she was away. In that hour the doctor came in and there were medications still to give out. And you're not really sure… people can be so unpredictable and you're relying on an assistant nurse to go with you and to tell you a bit about the patients.

5.3.2. Lacks skill and has a professional responsibility to ask for help and to develop the skill where possible.

Recognition of being sufficiently experienced was perceived to be important, not only in seeking help but also in developing, updating and maintaining skills.

EN. When unusual situations happen… you've got to go in there and defuse the situation…(The residents) are unpredictable in their moods so you don't know what kind of challenging behaviour you are going to meet with. You are unsure if you are going to be able to deal with this situation or are you going to have to bring somebody else into the situation, ask another member of staff for help.

EN. We learn from one another. I actually do feel quite skilled. I'm not frightened to admit that I don't know how to do something. I would telephone another ward and ask. Some of the machines that you get nowadays for long term patients… like a syringe driver. You don't use it for another ten months so you're not going to go up to that machine straight away and think 'oh I know exactly what to do here because you don't… being shown again how to do something is better than doing it and not knowing what you are doing.

EN. There is a new policy out recently about blood transfusion so I have been wanting to go on a study day for quite a while. I haven't actually been on it yet. So at that moment that is one of the things on my mind because we constantly put up blood and I want to be sure that I follow the correct procedure and find out what I've to do.

5.3.3. Put in a new situation where experience is expected.

For one participant moving to a new area stimulated a need to become familiar with practices and to develop skills expected of an experienced nurse in that area.

EN. When I came back obviously so much had changed in five years. The nursing hadn't changed just progressed. I will never forget… the syringe drivers, infusion pumps… these weren't in use when I left and that scared me for a week or two.

Being in a more senior position and the most experienced member of staff within a particular area another participant felt that as a role model she was expected to be experienced.

> EN. Because I work nights all of the time anyone that comes on is usually a less experienced nurse than myself especially in medicine and I feel as though I try to learn a lot more quickly in the last year. Because I am not now the junior person, I am the more senior person on nights now, so they are looking to you to lead them. I find that quite difficult. It was difficult to begin with because you think 'the buck stops here'.

5.3.4. Need to constantly review and develop knowledge and skills.

Participants recognised that knowledge and skills relevant to practice were constantly changing and that changing practices that had become automatic could be difficult.

> EN. I do feel skilled after nearly 30 years but it doesn't stop there. I always feel there is room for improvement. I feel the scope of practice is changing. There are always new things happening, new methods, new drugs. Nursing is always developing.

> EN. I'm getting good now that I'm doing it. I've stopped lifting patients. That was very difficult to get into. We'd done it that way for years. It's automatic now. I just go and get the hoist but initially, I had to stop and think but no I've got more used to it. I didn't know how to use them properly right at the beginning, now I know how to use them. We had fun and games on nights, on the hoists practising with one another just to get into the way of doing it, so that we knew how to use it before we used it on a patient and so that we knew how we felt on it.

5.4. Being Experienced (What it means to be experienced)

5.4.1. Ability to identify something unusual or out of the ordinary

Familiarity with patients and situations meant being able to identify and focus on something different.

> EN. Just years of being in the job and knowing certain things like, 'Is he walking a bit to the side today?'... Using previous knowledge... if you think that something is not the norm and there is a change in them. Because you know your patients you get to know if there is a difference in them. But I think that that is just through experience.

Knowing patients for a long time and knowing them well meant that participants knew what to look for and could observe for difficulties and focus on problems. Also being in an area for a long time meant that they knew what to do in specific situations.

5.4.2. Ability to assess, plan, implement and evaluate and problem-solve

Knowledge of what to do in specific situations facilitated the assessment of problems and decisions about actions.

> EN. If we have a bad bleeder coming in I'll be asked to go to the room to be part of the 'resus' team because I've done it before and I know what the set up is. They exploit the experience and I'm very conscious of that...but I allow it because it suits me, it gives me a chance to develop and to keep my skills up to date.

EN. In Recovery they're (the patients) absolutely terrified and most of the scopes that we do are looking for cancer… so I try to (find out if) they know why they're here… and if they do know well that's great, we've got this mutual area that we can start from and we can say this is what they are going to do and this is why they're going to do it. If they don't know why they're there its not really my place to tell them, it's the consultant's, that's the doctor's role.

EN. Because they are always here in this department it is very repetitive. Its predominantly all the same. It does change because peoples' personalities are different and the injury is probably slightly different. I suss out the person that I'm dealing with rather than the actual injury and once I know… (how) they're dealing with what's wrong with them, then I move on to what is wrong with them.

Knowing staff and being familiar with working with the multidisciplinary team promoted confidence which was recognised through others who lacked experience.

EN. I don't have a problem with any of them. I suppose coming from that environment, working in the stroke unit with the multi-disciplinary team, I am quite involved and relaxed around physiotherapists and occupational therapists, speech and language… it was something I noticed in here that the girls…there are physios in and out with the elderly all the time now… I think maybe it was a lot for the girls at first.

5.4.3. Ability to think rationally and to take a systematic approach to solving problems

This included not jumping to conclusions, standing back, thinking about situations and weighing up consequences of actions.

EN. Stepping back and looking at the situation and thinking about what I am going to do before I actually plan it out. Think about the best way to handle a situation, and the correct way to handle it. You're constantly thinking 'Am I doing the right procedure here?' I constantly seek reassurance that I am doing the right thing. Sometimes I rely on other people for a bit of advice depending on the situation. Most of them are situations that I have dealt with before and I feel quite confident about what I am going to do next. But occasionally you come across situations and think I'm not sure about this. It is reassuring just knowing that you can ask other people. There is always somebody around who is going to know the answer for you or help out in that situation.

5.4.4. Ability to self-monitor and critically evaluate own practice in accordance with policies, guidelines and codes of conduct

Participants were aware of knowing what they could do and having responsibility for using policies and guidelines.

EN. We interpret the practice as a group for example, the patient has his throat sprayed and in some places, after the procedure they're offered a glass of water straight away. If they swallow that and everything is fine they go home. We always wait half an hour. We know that they have their swallowing reflex back but just to make sure that the local has worn off.

There was a consciousness of acting in automatic pilot in emergency situations.

EN. In emergency situations I don't really think you have time to think you just seem to be in automatic pilot, you just seem to get on with things. I don't know, maybe its just practice.

Being responsible included being aware of the need for accuracy when teaching and acting as a role model to others who regarded them as experienced.

EN. I only have a keen interest but I find it quite stressful at times because everyone is short staffed. The pressure on infection control nurses just now is incredible. They want handwashing to be taught… I have never done any teaching and you can't suddenly be a teacher plus it is the responsibility of what I am taking on…the microbiologist said there was a teaching package on the website just use that.

EN. I feel quite comfortable with my practice. Like that I wouldn't do something that I wasn't completely sure about. I am quite happy to teach the students and that has been a lot to do with the ward as well… I didn't have any teaching experience because you were the bottom rung in the ladder whereas now I'm not a junior member of staff I'm one of the most experienced members of staff on the ward so people (expect) you to teach them.

5.4.5. Relationship with medical staff

Being experienced was perceived to have influenced the nature of relationship with doctors. Participants felt more equal to medical staff, possibly due to maturity and age. Doctors seemed younger and their status was perceived to change.

EN. My attitude towards them has changed quite a bit because I'm quite a bit older than them now. When you first start you're quite apprehensive about speaking to them because they seem a bit older. I'm not afraid to ask them anything now whereas before you thought you would look stupid and think you shouldn't have said that. I'm quite free and easy about asking them things and they are usually very helpful. You can help each other out with both experiences. Some of them are very junior and they do rely on you quite heavily which you don't mind.

Relationships with medical staff included guiding doctors' decisions and supporting them on night duty when asked for advice.

EN. The doctor on call isn't always orthopaedic, sometimes its urology, so they really rely on you quite a lot and say 'What's the procedure? What do you do now?' and 'What should I be writing down?'

M. How do you feel about that?

EN. Fine because I have a lot of confidence. I do know what the procedure is. Obviously if there was something I wasn't sure about it would mean checking up and letting them know that I'm not sure either and just finding out. Most of the time its fine.

EN. Junior doctors some of them are very good, some are not quite so good, you feel as though you are nagging at them constantly. But they appreciate your experience. They quite often ask for advice…on the whole most of them are good.

One participant described a need to become 'established' with the medical staff .

EN. When you're established you're okay… you're less likely to be questioned… If I go to a GP and give him a scenario and tell him what I want, I may not always get what I want but I get an explanation as to why, which is what you're looking for… and that's bestowing a bit more knowledge on me too…its not an issue now… in the past it was definitely an issue.

M. Because you hadn't demonstrated that you were competent?

EN.Yes, oh yes… that took hard work, it definitely took hard work. When I make a decision now nobody doubts it… if I'm in doubt then I push it on to somebody else or ask for help.

EN. Half of them (the doctors) don't realise that you are an enrolled nurse…you're actually doing the job of a staff nurse so they don't really know. We're all wearing the same blues.

5.4.6. Perceived by others to be experienced and is reputed to be experienced

Others sought advice and help from experienced nurses, who were perceived as problem solvers.

EN. I find that where I work quite a lot of the nurses come to me and say 'Something has happened would you come and look at this?' and there are maybe two or three other people on that they could go to.

Having a reputation for being experienced was related to familiarity of the nurse to staff and also length of service.

EN. I'm such a familiar face here. If there's any problem 'Go and ask A. She knows how to do it.' And 'A. can you help me with this?'

EN. I get a bit more respect. 'Ask B. she'll know.' On nights years ago I was quite isolated. We never joined with the day staff or anything. It was very much them and us. It was an awful situation at that point. But I was actually thinking 'I'm part of the group now the staff are rotating onto nights. So we're working more together.

Health care assistants asked for information from participants with whom they are familiar rather than newly qualified staff nurses.

EN. Unfortunately for one of the staff nurses who is just through a year, they (health care assistants on the ward) tend to come and ask me things and I feel a bit sorry for her but it is because I have more experience they're coming and asking me instead of going and asking her.

Reputation was associated with being perceived by staff as a specialist, which was defined by the area an individual had worked the most often.

M. 'When you're working in theatre you said that its orthopaedics, is that where you work mainly?
EN. Not now but you're still looked upon as an orthopaedic nurse because you were in the theatre in the old hospital and they will say 'Oh you're orthopaedics.' And you tell them that you haven't been in there for about four months. It's the same when you're on a back shift or at the weekends it is just whatever comes in the door so you get the orthopaedic stuff then as well.

Surgeons did not know that a participant was an enrolled nurse.

> EN. I think because I have been known in there for so long I don't think anyone is aware that I am an enrolled nurse apart from the nursing staff. I don't think the consultants are aware and there will be situations and there are E grade staff nurses there who have maybe only been there for a couple of years and you hear (the consultants) saying 'Get B…' But it is only because I have been there so long.

Being the most experienced member of staff could be related to being the longest serving member of staff and being more established and respected for that.

> EN. I feel as though I'm one of the most experienced practitioners in the ward. I do get a lot of recognition for that… I don't feel like I'm just an enrolled nurse and I think I'm a valued member of the team…people do value your opinion and always look on your experience particularly the junior members of staff. I feel confident and capable in everything that I do.

> EN. I have more skills than some of my staff nurse colleagues because I've been here slightly longer and have gone on other training courses… people come to you for advice.

5.5. Being Valued

5.5.1. Being acknowledged by others as experienced and knowledgeable

Participants felt that having their experience and knowledge valued by others reinforced their perception of themselves as experienced. Acknowledgement by credible others validated self-belief and enhanced self-esteem. For example being perceived as experienced by an adaptation nurse with a degree.

> EN. What did worry me was that these people all have degrees and I am an EN… and one of the lads I had, when everything was over and he was ready for moving on, we had quite a good relationship, and I asked him if at any time he had a problem with me being an enrolled nurse and him having a degree. He said 'No' and that he would be 100 before he had my knowledge. He said that I had taught him a lot and I thought that was nice. It gave me a bit of encouragement for myself.

Perception of self as experienced was also reinforced when junior staff sought advice.

> EN. I think my opinion is valued especially when the junior nurses on with you know that you've been there a long time and they feel that they can come and ask you things that they're maybe not too sure about.

Participants who worked with others who perceived them as experienced regarded themselves as lucky.

EN. There are nurses who do respect that you have twenty years experience and there are others that don't. I am very lucky that where I work they do respect the experience.

EN. I have been lucky that the girls that I have worked with have always valued the experience that you had.

5.5.2. Being perceived as being the same as a first level nurse

Being valued could also be influenced by being perceived as being the same as a first level nurse and positively influenced self-esteem and enhanced one's perception of self as being experienced. This was demonstrated through being left in charge, which was perceived to imply trust in one's ability and experience.

EN. If I'm on at the weekend and the care manager is off, I'm in charge of the two units… I'm really quite independent then. On night shift as well you've got to make independent decisions.

Being in charge could lead to other professionals perceiving participants as the same as first level nurses. Participants' perceptions of themselves as experienced was also enhanced where they were given the same opportunities for practice development as first level nurses.

EN. When I went there I was learning to do ECG's and they were teaching me to do bloods. At first I was like 'Am I allowed to do this?' And they said as long as you feel comfortable and competent enough we will not restrict your practice in any way. I feel that they have given me a lot of confidence because they encourage you to do things.

They push you, not to do anything you feel uncomfortable with but just to try new skills.

5.5.3. Attitudes of staff

The attitudes of staff, and in particular the ward managers' attitudes towards participants influenced their perceptions of themselves as being valued. In places where it was perceived that staff worked well as a team and respected one another's opinion, participants felt that they were valued members of staff. A feeling of being listened to meant that participants were more likely to perceive that their voices counted and that they could influence situations. Also feeling treated as an experienced nurse and as an equal, enhanced participants' sense of belonging.

> EN. I really, really like it. A lot of people have been there quite a long time, which shows that it is quite a good ward to work on. We all do work well together. We respect other peoples' opinions and the nursing care is excellent. That's one of the reasons why I stay where I am… people know my experience and know my capabilities. I know that if I moved somewhere else they may treat enrolled nurses differently.

One participant felt that the nursing profession was valued more than in the past and that nurses were being listened to.

> EN. Nurses used to be seen as a doctor's handmaiden. I think it has changed dramatically. Nurses are the biggest group in the NHS… they're in an ideal position to promote health and I think that they're taking on a lot more responsibility and do have

more say in things. I think they're now being heard and consulted a bit more rather than just following doctors' orders. Their opinions are valued now.

5.5.4. Work-role satisfaction

Participants expressed greater satisfaction with their role where the perceived level of control over their own workload was high. For instance, being responsible for the assessment and planning of care and being in charge of the team were valued aspects of one's role. Variety and a one to one relationship with clients enhanced satisfaction. Challenge and feeling supported by colleagues was also perceived as positive. The following examples provide an illustration of the nature and extent of individuals' work and the perceived degree of responsibility involved.

> EN. Because I am on nights and there is less trained staff on nights, I am always usually in charge of a team. Because of that I got a D grade about two years ago. There is quite a big responsibility. I'm usually on Wednesday and Thursday nights, which are the main theatre nights, so I've always got post op patients in my care… you're usually left to your own devices about how you spread your workload and how you decide that you are going to work.

> EN. I work from the Health Centre with the district nurses in the morning…it is kind of task orientated in a sense. You have your visits and you go out to see your patients but I quite enjoy it from the point of view that I've always been used to continuity and I just like to get to know my patients. When I go out to patients you're looking at them holistically and you get to know them quite well. I quite enjoy that because you do get quite a bit of variety of different things…In the afternoons I'm up here with the health visitors… and its mostly the over-75 assessments and referrals from GP's anybody

over 60 that's got any problems… I'll go along and see them. So its quite busy and I quite enjoy it because there is quite a lot of variety.

EN. I work in the day hospital to which patients come when they are referred from other hospitals. Once we get the referral and the patient is home we go and do a home visit and introduce ourselves and tell them a bit about the day hospital, what happens and what sort of therapy and treatment they will get, how long they are in for and just explain and make them feel comfortable about coming to the day hospital. Once the patient is in they come to us for a period of six weeks, some are longer and some are shorter. They regain their independence and confidence that they have lost, maybe due to a stroke, or just generally being unwell, or just old age and they need a bit of rehab. We maybe do a lot of blood tests and once you have got people in here there are maybe some things we can pick up - other small problems that they have and things that they can maybe tell you and you can deal with them and sort them out for them and refer them on to somebody else. You have a bit more time here, even when they're speaking to the physiotherapist they like a 'one-to-one'. The physio and the speech therapist liase with each other and that way the patients are getting good care. Then we have every Wednesday, a review, a multidisciplinary review with the consultant to see how the patient is progressing, to see whether they are ready for discharge or further treatment and it is good. They do some social activities as well when they come in. That is the day hospital. When I work in the out patients there are a variety of specialised clinics that we have and it is always busy and it is a great place to work as well. You learn something different every day. You are left yourself a lot, you work closely with the consultants and they are all good. You have got a whole range of different clinics for different problems. We have a one-stop clinic as well on a Thursday morning where… it used to be called the 'lumps and bumps' clinic people

for minor surgery. And we went to X Hospital to learn how to scrub up and learn how to do procedures with the consultant. So that was good experience for us as well.

EN. I really enjoy my job, I love district nursing. I think probably when I came into district nursing, which was maybe about seven years ago I just loved it. It was as if it had been there waiting for me and once I got out and built my confidence up in the community I realised that that was where I wanted to work and not in a hospital or whatever. I have been there for a year and previous to that I worked for three years in a smaller team…I think these three years were the happiest years of my adult working life…I loved everything about it, it was my first permanent job. It was a tremendous experience there was a lot of positive feedback… there was a confidence there that I never felt before and I think a lot of it came because I loved what I was doing, I was really happy doing it, there were new challenges there for me and I had, from a district nurse team point of view, met tremendous girls that were happy to give you one hundred per cent support. That allowed you to build your confidence, learn new skills, watch these people going about their everyday work and they just encouraged you all the time.

5.6. Experience Unacknowledged

Participants felt that their experience was not always acknowledged by others and that strongly influenced self-perception and the level of work-role satisfaction. It was assumed that occupational socialisation within a hierarchical structure had also influenced self-perception through internalisation of values associated with positional status.

5.6.1. Speaking out when disagree with decisions by seniors and colleagues.

Participants found that some staff were reluctant to take advice from them which could be frustrating.

> EN. A lady was admitted and she was mute and she wasn't eating or drinking. She was going for ECT on Monday and this was Friday and she was dehydrated. I spoke to the staff nurse and she said well we'll re-assess it on Monday with the Doctor and I thought, by Monday she could be worse. I felt like stepping over her, she was in the wrong but she was new. I thought what am I going to do. By chance the ward sister came in and I got her and she took it up. She was put up on a drip so that way she was fit for the ECT. I felt really good… I felt as if I had stepped on the other girl's toes but sometimes you've got to do that. I tried to make her see that she was new here and not to patronise her. Its quite difficult.

Part of the problem appeared to be that new staff or staff nurses with less experience did not recognise the participants' experience. Participants developed ways of dealing with situations where lack of recognition of their experience by new staff or newly qualified staff nurses was problematic. There was also a feeling that staff nurses needed to demonstrate their authority and may have felt threatened by participants' knowledge.

> EN. We've had three new staff nurses and like I say its difficult for them because obviously it's a new area, a new ward and they do rely on you quite heavily for advice and things which is fine. They seem to have settled and I just give them as much support as I possibly can but they don't always ask me. They try to ask the staff nurses rather than me. Sometimes that feels a bit… I don't know… Sometimes the staff

nurses haven't been here quite as long as me, so sometimes it's a bit difficult to deal with.

M. How do you deal with it?

EN. I just let them know that I have got experience in orthopaedics and if there is anything that I can help them with then obviously I'm more than willing to help them and if I can't or don't know then I'll try and find out for them or advise them where to go and find out the information. But just being approachable, making sure that they know that you're around and they can ask you and let them know that you have been there for a while and you do know stuff about the running of the ward, I'm pleased to help them out.

M. How do they take that?

EN. They take it fairly well… I think they sometimes feel less intimidated and some of them do latch on and do ask.

EN. Back in 1977 when I qualified there were plenty of job opportunities for enrolled nurses but as the years went on these jobs became less and less and then you got people coming into the job who were just qualified and treated you as if you were nothing and didn't take into consideration that you had been qualified for 10 or 12 years and they were just out of college. I'm not saying that I wanted them to come and ask me things but instead of making a mistake, it would have been better if they had come and asked. There were some things that they just didn't take on board.

EN. There are people coming to the Department maybe banking or new to nursing and who think that they know everything and… they treat you with less respect than you expect… I don't like people putting me down…I find its mainly the junior staff nurses fresh out of university. They think that they know everything… their attitude is a bit derogatory and sometimes you feel as though they treat you like a care assistant.

5.6.2. Sending a first level nurse to cover the ward.

Participants felt demeaned and angered when a first level nurse who lacked experience and did not know the ward or the patients was sent to 'cover' them.

> EN. I do get angry if the staff nurse is off and I get a phone call from the co-ordinator to say I'm sending you a staff nurse to take charge of the ward but that's on paper only, you're in charge. I don't think that's right. I know I can do it but it's the principle of the thing.

> EN. When I worked in X sometimes the ward was quite big so there were always two trained nurses on each side and if they were short staffed they would bring an agency nurse in who would be a staff nurse and I was the one that knew the ward and I would have to show her around and show her everything that was to be done but I wouldn't be able to take charge.
>
> M. How did you feel about that?
>
> EN. I thought it was a waste of time… you just spent so much time running around with the agency nurse showing her what to do. I suppose that would happen whether you were a staff nurse or an enrolled nurse. But it was the fact that you had to have a first level nurse on with you. We always had to have.
>
> M. You felt that you were capable of doing it for yourself?
>
> EN. Yeah, it was your ward and you knew it quite well.

5.6.3. Attitudes of the Health Board (employer)

Policies affected what participants could do. Where restricted practice was involved it could have a demotivating effect. There was a lack of clarity about what enrolled nurses

could do and this could cause others to doubt their ability. Also, policy changes were often introduced without consultation even although it directly affected what enrolled nurses could do.

> EN. Occasionally people do have this thing about looking at enrolled nurses differently because they've only done a 2-year training and are not quite a registered nurse. And there is always that in some peoples' minds, not very many but some people don't really know, not so much what the enrolled nurse training was like, but they forget its more to do with when you've qualified, how you've used your training and experience you've got. They just sort of see it that you are an enrolled nurse and you won't know that.

5.6.4. Staff undermining colleagues

One of the participants was qualified in a specialist field and with a colleague had been involved in writing a degree module for specialist nurses. However, it made no difference to the person's standing as a grade D enrolled nurse.

> EN. I felt a bit miffed about it because I felt we put a lot of hard work into this and I learned more … how to negotiate and how to put a point across. (The lecturer at the University involved) is the type of person that unless you justify why you want to do something just says 'No!' I was quite naïve… and because my education background wasn't that good compared to hers, I was limited because I couldn't talk the same language… but we got there in the end… Doing that did give me a boost but it was just deflated as soon as we got back into the old routine again.

Another participant whose experience was unusual was asked to speak at a medical conference. However, he felt that this influenced a negative attitude towards him from some of his colleagues.

> EN. It was really unusual for a male nurse to be in colposcopy and the consultant at the time was president for the year of the Royal College in London… she asked if I would go down and speak about the role of the colposcopy nurse being male, because that was relevant to the topic. So I did it. Thousands of people sitting in the auditorium, all prominent physicians and I spoke and I painted a picture of what the role was and it was great, it was really funny… at the time I was a nervous wreck… and after that I thought well the doctors can see the potential, why can't the nurses… I can remember saying to the consultant at the time 'Things are getting a bit tough for me here and there are quite a lot of boundaries going up.' And she said 'Well I wouldn't worry about that because at the end of the day… you've developed the skills and you've got the knowledge.' I really thought that was quite kind of her.

5.6.5. Devaluation of enrolled nurses in general

Some participants felt that experience was not valued and work at first level not acknowledged including being treated as a staff nurse but without the recognition or opportunities.

> EN. I do feel sometimes that you can be devalued as an enrolled nurse. I just feel the whole system doesn't value the experience. Most enrolled nurses have a lot of experience.

EN. I think they are devalued. They do a lot of the work that the staff nurse does, maybe not all but most of it. And they are devalued.

EN. I'm doing the work of senior nurses here and I'm not getting the recognition that I thought at that time I deserved.

EN. It is very frustrating because you're seen as a staff nurse and that's what I think anyway. They use you as a staff nurse. You might be in charge, you have to do various things like a staff nurse but you're not getting the same recognition as a staff nurse. It's very frustrating that way. I've been stuck in the same area for a long time and I can't really move on to other areas and that's very frustrating as well.

5.6.6. Discrimination and prejudice

Participants encountered discrimination through policies and others' behaviour towards them.

EN. Every time an enrolled nurse left she was replaced by a staff nurse and it became very difficult for me to get a job anywhere else as an enrolled nurse. I did once decide to try and applied for a job that didn't state the level of nurse. I was lucky enough to get an interview which I was told by the person was because of the reference from my ward sister, the way that I had put myself across on the application form and the length of time that I had been working in the ward. But because I was an enrolled nurse and there were a few students who had just finished and she would give the job to one of them. Basically she said it was because I was an enrolled nurse. It was very difficult to move job.

M. How did you feel about that?

EN. Horrible. I didn't let on to anybody… I hadn't been for an interview for a long time and I actually did quite well. I just felt that I had enrolled nurse written across my forehead so it didn't matter what I said.

EN. Different things like meetings to go to. A person might telephone to ask if we are sending a representative to this meeting today, who is on and when I say just myself the reply is 'Oh an enrolled nurse, well you better not come, you are just an enrolled nurse.' I am as much a part of this ward as anybody else is and sometimes I am in charge of the ward.

EN. I looked forward to it greatly. (Pupil nurse training). I thought this is definitely the right choice of career. The first day we were all in the same boat, the uniforms, the black cape, it all seemed… unreal, kind of like playing at being a real nurse but you weren't really… We were told that we were not students we were nurses. I thought I was going to be a real nurse until I went to the wards and… it was very much known that enrolled nurses were not real nurses… I don't know about other hospitals… I remember thinking that I was quite naïve going in … I didn't realise until I was actually in the hospital that there was a divide, yes, oh yes, very much so.

M. In what ways?

EN. I think it was them and us… there was a bit of a stigma that you were perhaps not quite as clever to do the student nurse but you could do the enrolled nurse. We were a bit second class and I think it does rub off as much as you would like to think that it didn't. I think it quite probably did. It made you think perhaps you weren't quite as clever or credit wise you were not up there with the students. You were a more hands on person and that aspect I liked. I did find… biology and things like that, not so much difficult but I had been away from school for nearly ten years… I found it quite difficult but definitely not beyond what I was capable of, definitely not. I certainly

wasn't a high flyer but in the class I think I was probably fairly average, along with everyone else and I think that if you'd been pushed a bit more, you were capable of doing other things.

EN. For a long time I felt, not that I was thick but that you didn't really matter… Most of the time I have been very lucky that I haven't had any prejudices… that the girls I worked with always valued the experience and very occasionally… one a few years ago a student nurse who said 'Oh you are just an enrolled nurse.' I said well I am in charge of these patients. She was nearly finished (her training) and she was doing the obs and I asked her to write down anything abnormal…We were very busy and when I went round to check the obs a patient had a temperature and I asked her why she hadn't reported it… She said you are just the EN and not the sister so why are you pulling me up for this? … I was really quite taken aback.

5.7. Changing occupational status of enrolled nurses

Participants perceived that the grading had had a significant impact on the occupational status of enrolled nurses. In particular they felt that their role diminished as a result of grading and many reported changes such as no longer being allowed to take charge of the ward or to hold the keys. They were no longer allowed to teach or supervise students, administer medicines or be involved in the administration of medicines or the keeping of controlled drugs. In reality these changes had often been difficult to implement due to lack of first level nurse cover and adherence to the policy often depended on the nurse manager.

EN. When they first brought in all this first level, second level registration, all of a sudden overnight I couldn't give out the medications. I couldn't do this and I couldn't do that. I laughed… because when we sat our finals we had a practical (exam) and we did a drug round and there were more drugs than you've ever seen because it was a research unit. In the end we had to go on a drug administration course before they would let us do them again, which is ludicrous… It was just a case of you can do it one day, the next day you couldn't.

EN. Through the years as an enrolled nurse once the grading came in, people would say 'Oh you're just an enrolled nurse' just different comments that they would make. Like going from running the ward, being responsible for your patients, staff and everything else that was happening. They take the keys off you, don't let you do medication. I think if they take them away from you and you are being told that you are not good enough to be doing that, then you really do think that you are not good enough.

An increase in the numbers of staff nurses was perceived by participants to be part of the reason that enrolled nurses' responsibility had diminished. They felt that they had been displaced by the staff nurses. Those who received a C grade successfully appealed against it and received a D grade. However, it was felt that not many enrolled nurses could go further than a D. The job description for enrolled nurses was limited and most were not able to do what they trained for. They were not allowed to supervise students. Some participants felt disempowered and de-motivated.

EN. (I feel) disillusioned. I've seen our role being undermined over the years. I think the worst thing that ever came about was the first and second level. I just feel second best and yet I've seen qualified nurses come on and they come to you for advice and

within a year they have applied for an E grade post. One had been so nervous when she came to our ward… and it was just confidence that she needed and being familiar with the ward. (I said) 'Come on and I'll show you how to do this'…It rubbed off and I could see her getting more confident and ready to go for an E grade and she got it. That's when I realised I'm standing still.

EN. The students come to the ward and they shouldn't be working with enrolled nurses. I have only come across it a couple of times. And one of the times it wasn't the student, it was the staff nurse and she said well she shouldn't really be working with you because you are only an enrolled nurse… I said that I don't think it's fair…it is only because of the colour of my trousers that you are going to move this girl. I have more experience than the staff nurse.

5.8. Powerlessness

Some participants felt powerless and unable to influence decisions about care or their own practice. They were more likely to be associate nurses rather than named nurses, which, they perceived limited their influence.

EN. You can make up care plans but, at the end of the day, if they (named nurses) don't think its necessary they discontinue it.

EN. The value of the job goes down. There is nothing in it any more. You would take a pride and you would feel part of a team. But why should I bother because at the end of the day my voice doesn't count.

5.9. Relationships with other members of staff

The relationships that participants described with other members of staff were not clearly hierarchical, however, particular tensions related to perceived status differences did emerge especially in relation to consultants and newly qualified staff nurses. A review of the relationships that were identified as significant provided some insight into workplace relations, organisational processes and occupational values that could influence participants' experiences of conversion.

5.9.1. Nursing auxiliaries and health care assistants

Some participants perceived health care assistants as a threat. However, there was a common feeling that auxiliaries needed some form of training to equip them adequately for the role expected of them as carers. There was also a perceived threat that health care assistants were encroaching on the role of the enrolled nurse which some felt undermined their professional status. In some workplaces nursing auxiliaries were accepted members of the team and were perceived as colleagues and sometimes also as good friends. In other places they were seen to hold a great deal of power and were perceived to be getting above their station particularly when they tried to tell enrolled nurses what to do and did not afford them the same respect as the ward sister. This could be frustrating and some participants felt that nursing auxiliaries needed careful handling.

> EN. I think they're eventually going to train the auxiliary nurses… I don't think there will be a need for enrolled nurses.

5.9.2. Consultants

Consultants were perceived to have a patriarchal role and held the greatest degree of power within the workplace. They made decisions often without consultation, that no one appeared to challenge and staff were expected to make the best of it even if they disagreed. Some participants were apprehensive about interacting with specific consultants, which derived from past experience of difficult incidents with consultants whose expectations were perceived as unrealistic. Others described incidents where consultants were helpful however, it was apparent that consultants were regarded as most dominant members within the organisation.

5.9.3. Managers

Managers were also perceived to have the power to make decisions and to control others' workload and practice. Managers' decisions were often seen as disempowering but they were not overtly challenged. However, whilst the authority of managers was generally accepted individual actions were discussed and criticised by staff. Some participants felt that specific managers had a positive attitude and were particularly supportive. Others felt abused by managers especially when staffing levels were low. It was also commonly perceived that enrolled nurses were expected to do the same job as a first level nurse without the remuneration. One minute they could be in charge and the next they were treated as health care assistants

> EN. It can be one extreme or the other, I can be in charge of the shift, I can run the unit, I can do all this and the next day I go in and I am just one of the numbers.

EN. When it suited the employers you were given responsibilities, when it didn't suit them you were just a pair of hands.

5.9.4. Medical staff

Participants were mostly all core members of staff and had often been in the same post for a long time, sometimes more than twenty years. Being established in this way influenced the nature of the relationship that they had with other members of the multidisciplinary team. Their perceptions of working with medical staff were divided between those who had a positive working relationship with them and those who had had specific difficulties.

EN. My attitude towards them (doctors) has changed quite a bit because I'm quite a bit older than them now. Whereas, when you first start you're quite apprehensive about speaking to them because they seem a bit older … you thought you would look stupid and think you shouldn't have said that. I'm quite free and easy about asking them things and they are usually very helpful. You help each other out. When they're very junior they rely on you quite heavily. They ask you 'What's the procedure? What do you do now? What should I be writing down?

M. How do you feel about that?

EN. Fine. I do know what the procedure is.

5.9.5. Staff nurses

The members of staff with whom participants appeared to have the most awkward relationship with were newly qualified staff nurses. It is possible that the staff nurses

felt threatened by the level of practical experience and competence of enrolled nurses, especially at a time when they were trying to establish themselves as qualified nurses who were able to cope with taking charge of situations. Their limited experience and practical knowledge meant that they were also vulnerable. Tensions in the relationship stood out in the participants' descriptions of situations especially where they felt that the staff nurses did not acknowledge their experience. Some older staff nurses were also occasionally perceived to act authoritatively and to question participants' competence or abilities. Participants felt that they had always been more practical than first level nurses who were often perceived as being more involved in paperwork. However, participants felt that there was little difference between first and second level nursing and where it did exist there was little justification for it.

> EN. Wherever I have worked there has been very little difference between my role and the RGN's role until it comes to something silly like one job I had in health screening where an RGN was allowed to take blood whereas I wasn't. You can take someone off the street and train them to be a phlebotomist why can't enrolled nurses do it?

5.9.6. Students

Most of the participants felt that they should not be involved with students because it was not part of their role. Some had negative feelings about the restriction. Others were critical of the perceived confidence of students and their values, which differed from past tradition. Participants believed that not being allowed to teach or supervise students was related to the grading however, D grade staff nurses do supervise students.

> EN. Up until I came on the conversion course I avoided them (students).

M. Why was that?

EN. I don't know if it was a bit of insecurity on my part… I felt that it was the role of the staff nurse but the staff nurse could have been someone with six months experience and I had twenty but I still felt like that.

M. So why did your attitude change?

EN. I think being a student and also gaining that bit of confidence now, being able to speak and to say 'Well yes, but why are you doing that?' They don't challenge they constantly ask questions.

5.9.7. Ward sister or charge nurse

The majority of the participants perceived that they were treated as an equal member of staff by the ward sister or charge nurse in their workplace, and that they acknowledged the knowledge and experience of enrolled nurses.

5.10. Summary

Being experienced emerged as a key theme because all of the participants perceived themselves to be experienced. What is important about these findings is the demonstration of the use of knowledge derived from experience of practice to inform discretionary judgement and the way in which individuals can control experience in order to gain sufficient knowledge to practice competently in specific situations. Three aspects of being experienced emerged:

- Becoming experienced

- Influences on the process of becoming experienced

- What it means to be experienced.

Becoming experienced emerged as a process of familiarisation involving exposure to practice situations that is influenced by the number and the variety of situations and cases that an individual is exposed to. Becoming experienced influences the development of self-confidence that enables an individual to take control in familiar and unfamiliar situations. Exposure to cases and situations provides opportunities for the development and refinement of practice and learning through 'hands on' practice promotes the development of practical knowledge and construction of a personal theory of practice. Repeated exposure aids familiarity to the point where unusual phenomena stand out. Some participants described how deliberate exposure to unfamiliar situations enabled familiarisation to the point where they felt able to anticipate and to deal with any difficulties or emergencies that might occur. Ultimately individuals become skilled at controlling familiarisation and experience is gained through exposure to a sufficient number of cases and situations. This ability promotes self-confidence and a sense of control over situations that enables individuals to negotiate practice boundaries and to make clear to others what they are or are not willing to do. Deliberate exposure in order to familiarise is accompanied by recognition of sufficiency and saturation. Participants perceived that exposure to a variety of practice situations was important for professional development and those whose experience of nursing had been varied believed that they were more experienced and confident as a result. It was also perceived that a lack of variety could lead to complacency and fear of change due to lack of stimulation and challenge.

The motivation to become experienced was driven mainly by an individual's need to be perceived as competent, influenced by awareness of professional accountability. Individuals were aware that decisions are based on their own judgement and perceived a

need to feel confident in that judgement. Being experienced is socially constructed and the meaning of competence within a specific situation is negotiable. There was recognition that competence is a constantly changing rather than a fixed phenomenon. Issues about being experienced related to the extent to which participants felt able to negotiate the meaning of competent practice, for example, where others do not recognise enrolled nurses as experienced registered nurses or do not value knowledge derived from experience of practice. Individuals felt positive about themselves where others perceived them to be experienced and also where they perceived themselves to be as experienced or more experienced than other nurses or doctors. The status attached to being perceived as experienced stimulated a desire to appear competent and confident. Being perceived as experienced also influenced the extent to which one's contribution was valued and participants were aware of the potential dangers of not being taken seriously by others. Exposure to variety is stimulating and can raise awareness of the monotony of everyday practice. This was the case for some participants returning to their own area of practice following placements which were stimulating and which challenged their assumptions and uncertainty about their ability to practice competently outwith a familiar environment. Variety also stimulates a desire for learning where new or different experiences lead one to seek knowledge and understanding. This is an important stimulus for learning and involves being in a position to think for oneself rather than following instructions or orders. For example, participants described the value of decision-making autonomy in becoming experienced and for personal development. Formal learning, in the form of factual or technical information and courses, was perceived as important in clarifying the rationale for practice and enabling critical objectivity, which involved making sense of, and validating, one's assumptions about practice derived from experience.

Being experienced means recognising what this means for oneself. Most participants made reference to being able to identify unusual phenomena in relation to specific patients or situations with which they had been familiar for a long time. Being experienced also involves being able to solve problems because one has knowledge of situations that enables one to rapidly focus on assessment of a problem and identify possible solutions based on past experience. Being perceived by others as experienced was valued and positively influenced self-esteem. Not having one's experience acknowledged or judgement valued was perceived to derive from a hierarchical structure which constrains what one is allowed to do. Perception of self as 'only an enrolled nurse' derives from hierarchical power relations in which enrolled nurses hold a subordinate position that has been reinforced through becoming de-skilled and devalued following grading. Within a hierarchy individual self-perception is influenced by a code of behaviour related to an underlying structure of power relations.

These findings are supported by Dreyfus and Dreyfus's (1986) theory of skill acquisition in which they claim that experience is acquired from repeated exposure to situations that enables the development of familiarity and outcome prediction. The rapidity with which experienced practitioners focus on unusual features relates to the development of a holistic and intuitive perception of situations that enables them to act automatically and without need of detached deliberation. In an application of this theory to nursing, Benner's (1984) findings suggest that reference to exemplars of past situations influence the speed and precision with which experienced practitioners execute skilled judgement in decision-making. Kolb's (1984) theory of experiential learning offers an explanation for the development of a personal theory of practice through processes of assimilation and accommodation influenced by the unique

perspective of an individual. Theories of cognitive development in adulthood provide clarity of the nature and significance of practical intelligence derived from years of exposure to poorly defined problems and the important influence of tacit knowing on analytical, creative and practical skills in adulthood (Torff and Sternberg 1998). Furthermore the findings indicate that it is important that professional educators acknowledge the potential for metacognitive development in adulthood that can enhance individual ability to control learning through the development of learning strategies that promote empowerment and a sense of agency (Nelson 1999, Sternberg 1999, Granott 1998). Control of the construction of meaning and the management of learning by the individual is believed necessary for the development of self-direction and critical thinking (Garrison 1991). Meaningful learning is more likely to occur where an individual has a specific interest in the subject and, where learning is tightly controlled and instrumental it can be superficial (Granott 1998). Learning from active problem-solving is believed to enable individuals to generate and test their own theories developed over time. However, there is a need for the promotion of critical reflection to make explicit thinking in action and enhance the development of metacognitive ability and understanding of the personal, situational and cultural influences on professional judgement and decision-making (Granott 1998, Eraut 1994, Barnett 1997, Schon 1983). Professional education should facilitate the development of individual ability to challenge and negotiate the meaning of competence if it is to be transformative (Wenger 1998).

Reference to my own experiences as a nurse influenced analysis of the data and the development of this theme as described in Chapter 4. As the theory developed it also challenged my assumptions about my role within professional education and I became

aware of a more active and radical perspective that made me critical of my normally passive approach. Changes in nursing through professionalisation and academisation have eroded the status of enrolled nurses who often feel powerless and perceive that they have no voice and no choice. Lack of opportunity for individual development and career progression means that their experience has been undermined and undervalued. Overall these findings have significant implications for professional education and for my own professional practice. It is important to acknowledge individuals' experience and the validity of personal theories of practice. It is also important to provide opportunities that facilitate professional development and confidence. In this role the educator does not judge practice, but acts as facilitator in order that the individual can critically appraise for themselves the assumptions underlying their practice.

Chapter 6: Academic Credibility

6.1. Introduction

The enrolled nurses who participated in the study perceived themselves to be practical rather than academic nurses. This is an important distinction to make in view of the current shift in professional values, particularly in relation to the process of academisation, a key element of professionalisation. The fears and concerns of participants were related to professional identity within a changing professional culture dominated by academic values. The main fears expressed were failure of the conversion programme and an inability to write academically perceived to be related to a lack of formal academic qualifications or credentials of academic capability. There appeared to be an underlying assumption that being academic meant being able to write in a particular convention of language and style. Accessing the conversion programme was viewed with apprehension. Most participants had delayed their application due to family commitments where the roles of mother, daughter and carer took precedence over individual career development. Many had encountered difficulties with prior attempts at accessing conversion programmes that were physically and financially impossible to undertake. However, the main prejudice faced by them in relation to conversion programmes was institutional doubt over the academic credibility of enrolled nurses, which reinforced their self-doubt. Potentially internalisation of these beliefs could adversely influence learning and it is important to examine difficulties and self-doubts as individuals embarked on the experience of conversion, and how perceptions altered as they progressed and proceeded.

Most of the participants left school with few, or no qualifications. This was often due to economic circumstances within the family, which necessitated leaving school for work as early as possible in order to earn and contribute. Culturally, earning a wage was valued over education particularly for females who, it was expected, would be married within a few years of leaving school. Most participants applied specifically for the pupil nurse training because academic qualifications were not required and because of its emphasis on hands on nursing.

Many participants were afraid that they would not be able to meet the academic level required of them by the conversion programme. They perceived that they had come into higher education without any 'O' levels and were expected to perform at diploma or degree level. Tutors were perceived to have unrealistic expectations of participants' academic abilities. Few participants had any previous direct experience of higher education and the most common reference was the conversion success of other enrolled nurses. As they progressed through the programme feelings of inadequacy and the need for external indicators became less important as self-esteem and self-confidence rose. An important measure of development that positively influenced self-perception was the growth in confidence and an ability to express themselves verbally and in writing.

Tutors' values differed from those of the participants in relation to the perceived importance academic credit and its domination within higher education. Tutors valued educational points and student performance was geared towards demonstrating achievement at different academic levels. Participants perceived that their experience as practical nurses was unrelated to the academic credit process. Tutors, suggesting to participants that they might consider undertaking degree level studies when they didn't

yet feel confident in their ability to write at diploma level, were perceived to have expectations that participants felt unable to reach and increased feelings of inadequacy.

The main reason given for not having applied for conversion in the past was family commitment. The role of mother was particularly important and the pursuit of self-development over child rearing responsibilities was regarded as culturally unacceptable. Similarly, caring roles associated with being a daughter, wife or a close relative, were also highly regarded. Other reasons given for not accessing conversion programmes earlier included social and financial difficulty particularly in relation to bridging courses where enrolled nurses were expected to give up their employment and become full-time students. Also cited was a reluctance to convert especially where employment suited domestic circumstances that might be affected by the increased responsibilities of the role of a first level nurse. Finally, rules and regulations often obstructed application to conversion programmes and deterred even the most determined participants.

As participants progressed through the programme their self-perception in relation to academic ability altered with growth of self-efficacy. Influences included experience of academic success and positive feedback on written work in particular, the stimulation of experience in different environments, observing others' successes, and being able to participate in situations in a different way because one is familiar with the language. These changes are discussed in more depth in the section on conscientisation.

6.2. Academisation

Participants perceived that professional values were changing. Some of the changes were perceived to have influenced a drop in professional standards whereas others were upheld as positively enhancing individual standing within the profession. These views provide an important perspective on the process of professionalisation and academisation within nursing.

6.3. Practical rather than academic

Participants perceived themselves to be practical nurses rather than academic. Many left school with few or no formal qualifications. Some regretted this now and in retrospect felt that they could have achieved more if they had been given the opportunity or incentive. However, economic circumstances, family expectations and cultural values had strongly influenced them.

> EN. I left school when I was fifteen. I was in junior secondary for two years and because of the grades that I was able to get I was put in senior secondary. But unfortunately I didn't come from a home or circumstances where staying on at school was greatly encouraged… it seems like a ridiculous amount now, but the amount that I could earn was far more important to my mother than staying on at school and I was more than happy to go along with that at that particular time… I wish I had been encouraged a bit more. Having said that I have to take some of the blame myself I was happy to go… You could leave at fifteen, if the leaving age had been sixteen it would have given me a lot of confidence as well as results.

EN. I did a pre-nursing course at school, which was a very basic career module. From sixteen to seventeen you had to attend pre-nursing college. Unfortunately my family circumstances meant that my Mum and Dad couldn't support me during that. I had four brothers younger than me so the emphasis was on me to get a job right away.

EN. I was going to have to go back to college to get some O levels.

M. How did you feel about that?

EN. Well it would have been difficult financially because my parents were going through a rough time and I don't think that they would have been able to support me going through college. So it was always going to be night school.

Many chose enrolled nurse training because academic qualifications were not required for entry and because it led to a professional qualification.

EN. I came to be an enrolled nurse just because I wanted to be a nurse. I wasn't career minded I just wanted to become a nurse. I should have gone back and got the academic qualifications but I didn't. I came in and I enjoyed being an enrolled nurse… All I needed was one higher and I would have been accepted (for the three year training). I don't know if it was immaturity at the time but I said no I just want to come into nursing.

Many elected to do enrolled nurse training because of the emphasis on the practical or 'hands on' element of nursing, even when they were offered the three year training.

EN. I wasn't very academic at school and I didn't feel I wanted to do a great deal of study. I knew I just wanted to be a hands on nurse and that is what enrolled nursing is about…At the time of the interview I was actually offered registered training but I was

adamant that going on this course was what I really wanted. Obviously, now I wish I had done it at the time.

A few participants chose enrolled nurse training because it was shorter even although they had or could have acquired the required qualifications for the three year programme.

EN. I regret to this day I started as a student and gave up after six months because I met my husband and wanted time to go out and to get married. I got married at eighteen. I remember talking to one of the tutors at the time and saying that I was thinking of giving up. She said that she thought that I would make a good enrolled nurse because I had a nice nature and would make a good bedside nurse.

EN. Nobody in the family was a nurse and at the time I remember thinking that the three year course which I did have a couple of highers for, and a year and a half. I thought I can commit to a year and a half and if I don't like it then that's it. How can I commit to a three-year course, give up and have nothing. So naively I went for the enrolled nurse course.

M. How do you feel now about that decision?

EN. It was the wrong decision. Fundamentally it was the wrong decision to make.

Few participants realised that the difference between first and second level would be so great.

M. Did anyone explain to you at the time the difference between the qualifications?

EN. No you just knew it was the fast track eighteen months for enrolled nurses or three years for RGN. At the time there wasn't all that much difference between enrolled nurses (and RGN's).

EN. At the time I didn't even know there was a difference. It was just the fact that I'd got an interview. She said if you hold on you could probably (get the qualifications). But I said no I couldn't wait to start.

M. What qualifications were they looking for?

EN. I think it was probably five O grades and I had four at that time.

EN. I think that you had to have three highers and I only had two. At the time I think if I had pushed it I probably would have got it because some of the girls did. But I was so young it didn't really matter to me. I didn't understand… I just went with the flow. They said you're going into the enrolled nurse (course) and that was that.

6.4. Doubting academic ability

Participants doubted their academic ability, in particular the ability to write academically. Most feared that this would mean that they would have been unable to complete the conversion programme. Many perceived themselves to have poor writing skills either because they were incapable or had not had an opportunity to practise in the past or for a long time.

EN. It's forty years since I left school and I'll never do this. I'll never be able to write academically as you should.

EN. Its putting your thoughts down on paper, getting used to doing that again, writing things down and trying to make it flow.

EN. I lacked confidence in myself. Not anything to do with the job… more the academic side of it… I was never very good at English at school and that was always at the back of my mind.

M. Can I ask you why you felt that you might not cope with the course?

EN. Academically and having to do written work. Even though I was writing on the ward, notes and things, it was really just the same thing you were writing all the time. You weren't really pushing yourself.

Some held a more balanced view of their ability.

EN. I just have some reservations about the fact that I haven't studied for quite a while and I think it will need quite a bit of input from me. I know that the support is going to be there but I think I will obviously have to go back to study, start opening books again which I haven't done for quite a while…. I think hopefully my attitude will change towards studying once I start the course.

As the programme progressed participants felt more confident in their abilities.

EN. I am more relaxed about the course now. Although I had done my homework on it I was unsure about whether I had the academic ability. I did question that. Now when I look back, when I did the AEDL and I think of the things that I had written then and the way I am writing now… there's still room for improvement but even just the style, just the way I write things down now.

M. How do you feel now that you've completed the in depth study?

EN. I was hoping to pass. I would have been really disappointed if I hadn't. I did very well I was so pleased. But now I think I've got to keep this standard up so it has put a bit of pressure on me because I would like either to keep the same standard or do better. If I could that would be fantastic. I always said that it shouldn't be an issue, but now I really want to do well. Not for anyone else because no one else will ever know. It is just me, I am going to try and do better.

EN. I find it a lot easier because you have got the goal of the in depth study…The reflective practice is along the same kind of lines, you write your essay and take it apart. I know exactly what I am supposed to be doing and because of this I feel a lot better.

EN. It was a relief to hand my module in. It was a lot of writing and a lot of work… Already I think that I am thinking differently and writing differently… I think probably at my age I felt as if it had been so long since I had studied and would I be able to take everything in again? But I'm actually finding it quite exciting.

Most participants feared academic failure due to not being able to meet the expectations of the programme or the tutors.

EN. I wouldn't say that I was very academic and that side of it worries me. because sometimes I feel if someone's trying to get something out of me my mind just goes blank and I can't even think.

EN. It would have been easier if I had done it shortly after I qualified. I think as time goes on you tend to get a bit complacent and frightened of change because I know I was thinking 'What if I fail? What if I start it and I can't do it?'

EN. Just let me get to the end of it and give me a pass. That's all I'm looking for. I'm not looking for any great results, as long as I get a pass at the end of it.'

EN. I still find it a bit daunting. But I worry about what I am writing. 'Is it right?'… As your confidence grows I think it will come. Before I thought that it would never come whereas now I think it will come.

EN. In the beginning I felt intimidated and slightly scared and you fear failure, you fear other people knowing that you had failed. Even when you hand something in like your in depth study you think 'What if I fail?'… It all passes once you get your marks.

Most participants undertook conversion because they wanted the professional qualification. Some did not necessarily want the academic qualification. In this respect their values differed from those of the programme tutors and higher education institution. Some tutors' expectations were perceived by learners as unrealistic.

EN. People are saying to me what about the degree? Let me get my diploma first. I'll wait and see how I do with this.

EN. It was going to university that frightened me for a start, even the logo. 'When you do the course this is all the points that you'll get.' So before we were just talking about maybe O grade material but we're talking university standard here. Am I going to get through this?

Some participants wanted the academic and professional qualification to prove to themselves that they were capable of doing it. This was more likely to motivate those who had commenced the three year programme initially and failed, discontinued or

those who felt that they should have done the three year programme but were not given the opportunity to do so or chose not do so and now regretted that decision.

6.5. Accessing conversion programmes

Some participants had encountered difficulties in the past when applying for bridging or conversion programmes. Bridging programmes existed prior to the introduction of the Project 2000 curriculum. They enabled enrolled nurses to access the second stage of the three-year programme after completion of a shortened bridging module. Constraints on accessing bridging and conversion programmes can be categorised as internal and external.

6.5.1. Internal constraints

Internal constraints involved individual perceptions of self and included social role within the family, fear of failure, fear of occupational role change, challenge of interview or presentation, lack of confidence and lack of motivation.

6.5.2. Family role

Accessing bridging or conversion programmes, although important, were secondary to the responsibilities of an individual's role as mother, daughter or carer. Family reasons often influenced decisions about undertaking conversion and it was the main reason given for not undertaking conversion before.

EN. My domestic commitment meant that I was doing night duty to accommodate my son being at school. I couldn't take up being full time so my hands were tied really.

EN. I didn't think about it seriously… it is quite difficult when you've got a child.

EN. I actually got the opportunity a long time ago. Well, I couldn't say it was an opportunity. There were a few of us who worked in a nursing home and we thought about doing it by open learning but I couldn't do it at all. I maybe did about 8 months but there was no support there. It was really difficult having to arrange your own placements and things so I abandoned it… I thought well I tried it and it wasn't working then but I knew why. The kids were young and there was so much going on in my life that I couldn't handle it but in saying that one of the girls out of the four of us did complete the course and she must have done it on her own.

EN. Before the conversion came up here and there was talk of it, I thought I would like to do it but then my children were babies. My oldest was five and my youngest only one and a half. I've got three so at that time there is no way that I would contemplate it… I wasn't going to take an opportunity for myself and ignore them.

6.5.3. Fear of failure

Hearing from others how difficult the course was deterred some from applying.

EN. I had heard about it before. I had heard stories that it was really hard and so difficult to do… this was about five years ago but I didn't bother doing anything about it because I was happy the way I was.

EN. I had thought about it but I hadn't had the confidence to go (ahead). I had heard someone talking about it at work and saying 'I wish I hadn't started it.' And it put me off.

6.5.4. Fear of role change.

EN. I was comfortable being an enrolled nurse because I was comfortable in my role and the job I was doing. I was probably scared to go for anything further up the ladder, more responsibility, although everybody had responsibility… I was a bit wary of doing that.

6.5.5. Challenge of interview and/or presentation

Some courses and employers selected enrolled nurses for conversion by interview that sometimes involved a presentation that was perceived by participants as an ordeal. In some instances they had had to re-apply if they had been unsuccessful in securing a place on a programme.

EN. It was a couple of years ago I wrote an essay… but I didn't get on that course. It was the second one, the second essay that I put in that I got on… there were certain things that I had done between when it was first written… I had done an RCN Career Connect course. It was designed for enrolled nurses.

EN. I had applied the previous year and I never even got an interview. And this year I decided it was now or never, if I don't get in this year I am just going to be an enrolled nurse. I felt it was an achievement even getting an interview. I was really apprehensive about it because I had to do a presentation.

6.5.6. Lack of motivation

Some participants felt that where they had a great deal of job satisfaction as an enrolled nurse and were treated as a first level nurse there had been little incentive to apply for conversion.

> EN I might have done my conversion sooner but where I worked you were never really made to feel that you were second best.

> EN I hadn't made the transition earlier because I have really been quite happy with my lot… and I've been happy doing hands on and with the way my career has gone because I have done so much and have been to a lot of places and have had lots of opportunities to do things and I hadn't actually felt the need to move on.

> EN. Maybe a few years ago when the girls started to do it I kind of thought about it but then my daughter was quite young and I didn't take it seriously. I have to be honest I was always fairly happy.

6.5.7. External constraints

External constraints on access were perceived as being imposed by others that participants had felt powerless to do anything about. Most external constraints took the form of rules and regulations laid down by colleges of nursing or employers.

6.5.8. Rules and regulations

Employers developed waiting lists to manage the demand for conversion places. Several 'rules' were devised that determined and justified an individual's position on the waiting list.

> EN. There was a list and a pecking order… all of the nurses in theatre were to write a letter to say why they wanted to do it. But, even before the letter was written they had picked who was going to do it… I was told that because I was a failed student nurse I would have to wait until all of the enrolled nurses had been through because I'd had a chance and I thought fair enough… Another thing I was told was that it would be based on your time keeping and sickness rate… So that's fair enough at least I knew where I stood… I can remember thinking that the people that were in front of me had been off sick… and I don't have a sick record.

Other rules and regulations included participants having to apply to their initial training school, not being able to undertake the course with part-time hours, an imposed age limit on entry and being informed that they lacked the appropriate experience.

> EN. When my son was a baby I couldn't leave him with my parents. They both worked… I did apply at one point and was told that I would need to apply to your training school and that they only trained their own enrolled nurses. It didn't matter that I worked for them. And I thought 'Come on I have a baby.' To have to go to Glasgow to train again… there's no way that I could do that… and I didn't bother or show any interest again for a long time.

EN. I started here in 1989 so that would have been about 1990. They said they had too many still to put through that were already on the list so they weren't adding to it. Then I just had get on with my job. At one point I did apply to go back to Edinburgh but I was married and I was living through here and my husband's job was through here… my college of nursing were very good and said 'Yes, come here.' But again my Mum said 'You have got to be realistic your husband is going to be here and you are going to be living in Edinburgh.' So the more I thought about it I telephoned them back and said that I didn't think that it would work. I had only been married a year.

EN. The issue about being part-time came up. 'I don't think you have enough hours to do the course.'

EN. I applied for it when I was forty and was told that I was too old and they were only giving it to people under forty. There were others that were told the same.

EN. It was around 1989 or 1990 I applied to do the bridging and I was told that I had no ward experience. I had to get more general experience because I had only worked in theatre even although I did Recovery and anaesthetics because it wasn't separate. I went to speak to the nursing officer and she could only give me the Renal Unit and that was specialised again. So I kind of gave up.

EN. I did think about going on and trying to become a staff nurse. I started to go to night classes and got one or two 'O' levels. Then it started you needed five 'O' levels, and then it went up to highers and I thought this is just one jump ahead of me so I gave up.

EN. I did keep trying, I discovered that you could do a test and I wrote to the College and I got knocked back again.

M. Did you sit the test?

EN. No I kept getting in touch with a certain tutor and… she answered my letters and she kind of knocked the stuffing out of me with some of the things she said.

6.6. Motivators

Motivation was often stimulated through encouragement from observing others successfully complete the conversion programme and their career progression following conversion.

> EN. My friend took a gamble and she has done very well for herself. I do look at her and career wise where she has gone and I think … I'm doing it now.

Being selected for the conversion programme also boosted self-esteem and gave a sense of elation and belonging, being one of those who had been selected to do the course.

> EN. I must say I felt absolutely delighted… when people asked did you get accepted for the course it was nice to say 'Oh yes.' Because it meant that you were one of the gang, you were going to do it.

External factors that influenced access to the programme also acted as motivators. The stand alone conversion programme meant that participants did not need to give up their employment and therefore there was less financial constraint involved.

> EN. I thought about the bridging course … you had to leave your post … I don't know if that was my excuse but that is what stopped me from doing it.

EN. If the conversion course hadn't been made simpler because you didn't have to give up your job I would still have been an enrolled nurse... Financially I couldn't afford to do it. But they made it easier for us to access and that was the reason I decided to do it because it was easier to access. You weren't losing your job, you weren't having to give up anything and you still had your wages.

EN. I was probably thinking about it for quite a while but before the only opportunity was to give up your job and go and do the course... I couldn't financially give up my job to do that so you just carried on.

Other external factors influencing motivation to convert included perceived threats that acted as incentives.

M. Why did you apply for the conversion programme?
EN. In all honesty it was because the hospital was closing and I knew that I would have to move on... where do I go from here? They will take a staff nurse before they would take an enrolled nurse with eighteen years experience.

EN. The manager upgraded some of the staff nurses that have only been in the place six months and you just felt that experience wise should you not be upgraded?

6.7. Professionalisation and academisation

Participants remembered and were more likely to experience tensions associated with traditional values. Some believed that there had been an adverse trend in professional standards related to changing values and attitudes including assertiveness, loss of respect for the uniform, old school and being less hands on.

6.7.1. Assertiveness

Younger staff were perceived to be more forward. They questioned more and were more likely to answer back. Nursing auxiliaries also questioned what they were being asked to do by the ward sister and would answer back when they were told to do something. Student nurses were perceived to have more autonomy and could decide for themselves whether or not they wished to do something.

> EN. When I was an auxiliary I would never have dreamt of questioning anybody's authority that was above me. They question things and fair enough at times it should be questioned, but at other times the things that they're saying are just daft. At the end of the day what the manager of the ward, the sister, what she says goes.

> EN. Youngsters now are more forward… when we wanted to be nurses it was all that we wanted to be. It has definitely changed. There seems to be, not quite an arrogance… maybe they're just worldly wise… They question more. We were just told to do something and it was done. Whereas, now, they do question more.

6.7.2. Loss of respect for the uniform

In general it was perceived that there had been a loss of respect for authority. This was coupled with more relaxed relations between staff that resulted, for instance, in staff addressing each other by their first names. Although some believed that attitudes should be more relaxed the use first names was negatively perceived.

EN. First name terms, I don't like that at all. I feel quite insulted when a stranger comes in and says 'How are you X?' because you've got your first name on your badge… In a hospital you need a certain amount of respect.

EN. I couldn't believe that an F or G grade was calling me by my first name. I think it should go back in some way.

6.7.3. Old school

Some participants preferred older values of obedience. Others felt that there was a need to value change.

EN. I think things are far more relaxed than what they were. For instance when matron came in everyone was standing waiting for her. Everything was ship-shape.

EN. As much as I liked the sister she was very much stuck in the old way and wasn't very happy with change… It's sad because she was one that knew all your families and always asked after them.

6.7.4. Less hands on

Some perceived that the essence of nursing care was being hands on and that paperwork detracted from practical caring. First level nurses were perceived to be more involved in paperwork and less in hands on nursing and sometimes this was negatively perceived which could lead to divided loyalties and dissonant values.

EN. There is a time when you can stand back and go and do notes but first thing in the morning you need everybody on the floor.

EN. I am always conscious of staff finding that you were writing all of the time instead of working with the patients. Just in the last couple of years I have thought 'Who's the daft one here?' I should be able to walk away and write something down but I have trained myself not to do that. I know how important that part of the work is but before I was too focused on working with the patients and what other people thought of me. Anywhere you go people say things like 'She hasn't touched a patient today.' And I think that I was always in the middle before, I was expected to work and I was expected to do the paperwork. Where I was expected to work with the patient and the staff nurses were expected to do other things I felt that I had to do a bit of each… At least I'm not going home at night and remembering something that I hadn't written down.

Participants were concerned about a perceived shift in emphasis towards academic qualifications and education to the detriment of practical experience. Entrance qualifications could be perceived as a barrier to motivated individuals entering nursing, continuing to develop professionally and from preventing nurses from getting involved in work that they are interested in. Pressure on staff nurses to get degrees excluded enrolled nurses from professional development because their experience is not academically accredited. In some instances inexperienced staff nurses were being promoted over those with experience because they held an academic qualification.

6.7.5. Entrance qualifications

Academic qualifications were perceived to be of value but not at the expense of practical experience.

> EN. I did the First Steps at the university and I can see the advantage of it but you need the basic qualification and experience… I think they're going to change it (pre-registration nurse education) again to diploma and degree nurses. The qualifications are unbelievable…. Sometimes qualifications aren't everything.

6.7.6. Degree qualifications

There was pressure on qualified nurses to continue to learn and to develop professionally. Where that involved further academic study participants felt excluded because they did not perceive themselves to have a piece of paper to say that they are experienced. They felt that there was too much emphasis on paper at the expense of experience and that inexperienced staff being promoted on the strength of their academic qualifications undermined experience and was perceived as threatening.

> EN. With the pressure on staff nurses to get degrees where does that leave enrolled nurses… it was easier to look at enrolled nurses as a dying breed, something that wasn't going to be there in the future.

> EN. But that's one thing as an enrolled nurse, over the years you've got all this experience, you've done all of these things and you don't have the pieces of paper to back them up. A piece of paper saying I have finished this course and I've done that

course… I know how to take plasters off properly, I know how to put a back slab on… there's nothing like that.

EN. In every job now they're asking you to be more academically able… that's the way that employment is going… you need to have a degree of some sort in any job. Sometimes I think nursing is going the wrong way… pieces of paper mean so much, whether you can do the hands on work or not is a different matter… Its good that nurses are going on as many courses but so much time is spent on doing the academic courses and not enough on the practical skills. I feel that we're moving further away from the patient all the time.

EN. I feel that they don't allow for experience. It is very academic nursing now. Even the staff nurses that trained the older way are feeling it now with the new nurses coming in with their qualifications, diploma, degree level and now they're actually asking that even for an F grade. So there's probably a few feeling that experience doesn't count for anything… the manager upgraded some of the staff nurses that have only been in the place six months… they were still needing supervision. Everyone needs supervision when they start but they were upgraded quicker because they were first level… And others because they were working towards their degree they were upgraded to an F grade over people with experience.

Participants held positive attitudes towards continued professional development and learning that reflected modern professional values related to professional accountability and the need to meet the PREP requirements. It involved recognition of individual responsibility for learning and the potential for the improvement of practice. It would appear that managers' attitudes towards professional development were more positively

focused. However, participants acknowledged that not all enrolled nurses or registered nurses were aware of the need for continued development and reflection.

6.7.7. Professional accountability

As registered nurses participants were accountable and responsible for their own learning and perceived that it was important to keep up to date and to be interested in professional development.

> EN. If you sit still you lose a lot because you don't learn… you're supposed to be a trained nurse and responsible and accountable…. Its not really knowing so much as being interested in what's happening… with PREP you're reading things, you're getting stuff sent to you from the UKCC and you read it and realise where things are going.

6.7.8. Potential for improvement

Participants appreciated that learning does not stop and that an open-minded approach and recognition of what one does not know is required.

> EN. I feel that everybody can improve, you can never stop improving… as people say you pass your driving test and that's when you start to learn. It's a bit the same with nursing, you've finally qualified but that's when you really start to learn… you're always learning… you've got to continue learning and you've got to have an open mind.

> EN. I always tell people we don't know everything, we can't know everything. We're always learning, nursing is an ongoing leaning process.

6.7.9. Changing attitudes

Learning is stimulated in an environment where it is valued and supported. One participant identified a change in culture that resulted from a new manager with a more positive and encouraging approach to professional development.

> EN. We all had our professional development plan and to be honest it was only the second one that I had ever had. Everything was very different from what we had before… there was never anything set out… she was just listening to what people were trying to say and encouraging them to try.

6.7.10. All nurses don't share the same values

Participants were critical of other registered nurses, both first and second level, who were perceived to do a minimum amount to meet the PREP requirements. There was a feeling generally that some nurses did not appreciate that professionals are individually accountable for their continued development.

> EN. Some (nurses) are a bit laid back and maybe don't want to do too much. They do enough for their portfolio.

Participants perceived themselves to be accountable registered nurses. They questioned their own and others' practice and reflected on their actions. In the past first level nurses

may have been held responsible for enrolled nurses but it was clear that as registered nurses, enrolled nurses are accountable for themselves. Participants recognised the importance of being conscious of what one is doing and the reason for it.

> EN. In the environment that I work in I have as much responsibility as the others because I am accountable for my own actions as is every nurse, regardless of what status she is. In the theatre they tend to remind you that you are accountable for whatever you do.

> EN. We're doing this so why are we doing it? What is the easiest way to do it? … to make our job as safe as possible and safe for the patient… If I was going across to help out I would say that this is not right and question it.

> EN. Reflective practice to me means to look at what you're doing, why you're doing it, how you're doing it and how you can better it… you put doubts in your mind and you've got to justify it whereas before you never really bothered.

6.7.11. Use own initiative

Participants felt that in the past they may have been restricted from using their own initiative because first level nurses were regarded as responsible for practice. However, they felt responsible and accountable for their own practice now.

> EN. Although you were always told that you were accountable for your actions the staff nurse would say 'It wouldn't be you that got it, it would be me because I am over you.' Nowadays it wouldn't be like that it all comes down to yourself… I don't think

enrolled nurses would actually realise because you were always put down as the bedside nurse.

EN. A lot of it is habit because it is quite repetitive and you have really got to remind yourself that you will see five to seven children in a day and they are all individuals and there is a potential that something could go wrong… I do look at my practice… I read a lot more… when a child comes in with a complication the anaesthetist will maybe talk through it … but I will go and find out a bit more about it myself. In the past I would have (taken the anaesthetist's word for it) but not now I like to read it for myself.

6.7.12. Learn from experience

Learning from experience was regarded as essential in reflective practice for individual development and professional accountability. The process of critical reflection requires stimulation. Participants had become aware of changes in their consciousness of professional accountability and more critical of practice since the beginning of the programme.

EN. I feel more responsible in my job now. With all the reading that I have done throughout the course my knowledge has been enhanced. Before I did things without even thinking whereas now I am thinking about what I am doing.

EN. Since I started the course I question whether I am doing this the best way that I can? Am I doing it right? Or is there something I could improve upon? If there's something I'm not sure about I am more likely to look it up.

EN. When I first started in the ward it wasn't very nice to work there, I wasn't very well accepted. I had come over and had taken someone's post… so I thought even before I went over this is going to be horrendous, they are not going to take to a stranger coming in and they weren't very helpful to begin with. There were a lot of small things on the ward that I didn't like but it wasn't anything where patients were at risk. It was just silly things but I thought I can't bulldoze in here because of the type of people… they are really strong characters the people I work with and I thought if I do bulldoze in here then I am going to get no help from them whatsoever. So I had to take things really slow. My in depth study at the time was on communication and that was a big problem in the ward with the staff and the way that they spoke to the patients, especially patients that were aggressive and their approach to them. I needed to go about it very carefully. Our ward is run on a standard at night anyway, which I think is quite a high standard for what we've got, two nursing assistants and myself. I gained their confidence and asked them if they would help me with my study and they spoke about their approach to patients... and they tried different things. Because my study was on communication I tried to involve them in it and make them feel as if they were helping me with it. I think it helped a lot… Even when I'm not there now they will tell others that we all work together and say 'Well X does this.'

6.8. Summary

Academic credibility emerged as a theme because the majority of participants perceived themselves to be practically orientated and 'non-academic' in relation to learning and practice. Three important aspects of this theme stand out in relation to being 'non-academic'. Firstly, for a number of participants, self-doubt about their academic ability derived from a personal history of leaving school at fifteen with few or no qualifications influenced by economic circumstances and a social background in which academic

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qualifications were not highly valued. Secondly, many had delayed applying for conversion because family commitments and the strong influence of social roles and values and maternal and parental responsibilities took precedence over personal career development. Thirdly the majority of participants expressed anxiety about doing the course due to fear of failure related to perceived inability to meet university requirements. In particular, a fear of failure derived from lack of self-belief in being able to write academically and in accordance with the required convention of style and language. Having few or no qualifications on leaving school was perceived as further evidence of inability and lack of academic credibility.

Participants' fears and concerns must be considered within the context of shifting professional values within nursing in which academisation has influenced the accreditation and validation of professional qualifications and experience. This has led to a shift towards domination by scientific values and a technical rational approach to practice over the value of tacit knowing and experiential learning in professional judgement. Furthermore, participants perceived that the position of enrolled nurses within the professional hierarchy had been further devalued following grading and the move to one level of professional registration and the academisation of the nursing qualification. Opportunities for professional development and career progression had been limited and restrictions could be interpreted as reinforcement of the diminished value of practical knowledge and experience. The expectations of nurse education within a university were perceived by many of the participants to be unattainable given their lack of qualifications and low professional status within nursing. Prior to commencing the course most of the participants had doubts about being able to meet the level expected by the university.

Participants' accounts of their experiences and feelings of subordination demonstrate the power of the academic institution over what constitutes valid knowledge and assumptions that it has legitimate authority to judge what is valid. The power of educators over individuals can be seen in their control of access to courses and the accreditation of experience. Those participants who had tried to access conversion courses in the past had been unable to do so due to the inflexible nature of the programmes and rules governing entry criteria that made it impossible. For most participants, having to give up the security of one's post and become a full-time student meant that it was not an option. These experiences had left individuals feeling that they had been incapable of accessing the opportunities available.

Participants' perceptions of their experiences challenged my assumptions, in particular, those associated with the dominance of academic validity of professional knowledge and the accreditation of experience. This was important because of the extent to which I was involved in accrediting experiential learning and presenting the process of learning inherent within the programme for institutional validation. I became aware of the degree to which the accreditation process that I was involved in led to the commodification of individual experience in order to fit the dominant values of the institution of and perceptions of legitimate knowledge. Also, I realised the implications of representing individuals' learning as measurable, objective outcomes in order to demonstrate how experiences could fit, sometimes with difficulty, the theoretical disciplines of the current discourse of nurse education and higher education. Furthermore, it suggested that I did not have the courage to challenge my own and others' assumptions about the nature of learning in professional practice.

Fenwick (2001) suggests that, whilst experiential learning is that which occurs outwith the formal confines of the academic institution, it is managed and controlled by educators who shape experiential knowledge to fit the requirements of what the institution perceives as legitimate knowledge. Accrediting experiential learning by focussing on mental processes decontextualises the individual from the learning situation and separates them from their experience rendering experience itself a depersonalised commodity with which the individual can trade for academic credit. The validity of the experience is judged by the educator, influenced by the institution, which disempowers the individual. Furthermore, it undermines and devalues the importance of tacit knowing, derived from experience, in professional judgement and decision-making. Fenwick (2003) recommends that educators adopt a more critical stance in relation to the accreditation of experiential learning. In particular, educators should recognise their potential to act as a catalyst in the realisation by individuals of the perceived constraints and possibilities and their ability to influence these. Processes of accreditation should be designed to be as flexible and inclusive as possible, avoiding decontextualisation and constraints on what is perceived to be legitimately valid knowledge. This would include prescriptive rules and guidelines about how the experience is expressed and presented. She urges educators to attune to others' experiences from the others' perspective and to avoid decontextualisation as far as possible. Also others' perspectives should be valued and not judged from one's own perspective. Educators should challenge their own and others' assumptions about the accreditation of experience and the extent to which it is influenced by powerful academic and political objectives (Fenwick 2003).

These findings indicate that educators need to become aware of the negative impact of the power that they hold over students who are vulnerable to the judgements made about them that they have little control over. Furthermore educators must develop an awareness of their own epistemological assumptions and recognise the extent to which these derive from the dominant values of the institution. They should also consider the extent to which these values exclude those whose values are different. Critical examination of one's assumptions about the nature of experiential learning and its value compared to the dominance of scientific objectivity and technical rationality is necessary if professional education is to be inclusive. Assumptions about adult learning need to be challenged if the fears and concerns of students are to be taken seriously. Brookfield (1986) suggests that lack of self-belief and lack of confidence in one's ability can adversely influence learning in adults. A non-judgemental and non-hierarchical approach that focuses on the importance of practical intelligence and tacit knowing to solve problems in practice should raise individual awareness of ability. Adopting a scaffolded approach to enable confidence in the use of language should facilitate learning autonomy (Granott 1998)

Chapter 7: Motivation

7.1. Introduction

Challenge is necessary for transformative learning and to meet that challenge one needs to be sufficiently motivated.

> The challenges are on the one hand such that they not only require transcendence of the previously developed comprehension but also the fundamental premises of this comprehension – and on the other hand they are perceived as imperative, i.e. that there is an unavoidable motivation, anchored either in a strong personal interest or in a perceived obligation to do something about conditions that are deemed unacceptable i.e. a form of social responsibility.
>
> Illeris (2004, p. 58).

As the participants progressed through the conversion programme their perceptions of themselves as learners were transformed. Self-esteem was positively enhanced accompanied by a growth in self-confidence. Participants discussed those aspects of the conversion experience that had positively and negatively influenced their learning. Analysis focused on the significance of the learning and its impact on perceptions of self and others. Influences on motivation were categorised into three main aspects:

- prior perceptions
- significant processes
- impact of the experience of conversion on perceptions of self and others.

Prior perceptions included reasons for undertaking conversion and expectations of the experience. The most significant processes that were identified related to the programme assignments, tutorial groups, the residential workshops and the placements. The impact of the conversion experience emerged from perceived benefits and difficulties and the growth in self-confidence, self-efficacy and self-esteem.

7.2. Main reasons for doing conversion

7.2.1. Encouragement from others

Colleagues who were doing the course or had completed it in the past encouraged individuals to do it by telling them that they should do it. This implied that their colleagues believed them capable of doing it, which was regarded as authentic and credible encouragement, because these colleagues were perceived as having the same level (of intelligence) as themselves. Also, descriptions of the experiences of current or previous students had sounded interesting and positive.

> EN. He says you must do it… he's quite open about telling you how he felt himself and he said 'You'll think at first what have I done but looking back I realise how much I enjoyed it… it is a good experience.' and he feels that he has gained a lot from it.

> EN. I spoke to other students who had done the course and they really encouraged me and made me think if it is as good as they say it is I'm going to do it.

Managers also encouraged individuals to do the course and this was perceived mostly as positively encouraging and signified that the manager felt that the individual was capable of doing it.

> EN. When X was made charge nurse the manager said to me 'If you'd been a first level nurse we would have considered you for a post like that, I think you've got it in you.' It made me think.

> EN. It was due to the ward manager. I think she saw the potential in me. She saw how keen and hard working I was.

7.2.2. Observed others doing it

Individuals noticed changes in their colleagues such as growth in confidence and promotion at work as they progressed through the programme.

> EN. A few of my colleagues did the course and they really enjoyed it and they would come back and say 'You should do it. You would really enjoy it.' So it was always at the back of my mind and when I saw the same people a year or two later and they were all moving on and enjoying their new jobs and they'd been promoted, I thought 'Right, I think I'll go for this.'

7.2.3. Future uncertain for enrolled nurses

Most participants felt under pressure to do conversion because of the uncertainty of their role and associated lack of employment opportunities and job security. Conversion

to first level means more opportunity for career progression, a greater sense of responsibility and control over decisions.

> EN. I really don't know what is going to be there for the enrolled nurse in a few years time. I really don't know what way it is going to go if they are going to bring in SVQ's.

> EN. I want to go and do other things. Being an enrolled nurse you are stuck. I've always been lucky enough to have been a D grade. If I went elsewhere I probably wouldn't get a D grade and I can't afford to reduce my salary.

7.2.4. Desire for self development

Most participants desired further professional development. Some were aware of a change in expectations of nurses in relation to continued development through the introduction of PREP and also because of the growth in organised systems of personal development within the NHS. To some extent participants felt under pressure to continue to learn and to keep moving forward. Some had a specific goal that they had wished to achieve such as a specialist nurse qualification or promotion which was only accessible to first level nurses.

> EN. Once I have finished the course I want to go on and do my degree and I would quite like to work abroad for a few years.

> EN. I have two part-time jobs and I would really like one full-time job and I know I'm not going to have that unless I have the qualification.

7.2.5. Personal growth and self-confidence

Most participants wanted to undertake the programme for their own personal satisfaction, to see if they were capable of doing it. Gaining knowledge was believed to boost self-confidence and enabled the demonstration of knowledge to others. It was also perceived to counteract 'years of not feeling good enough as an enrolled nurse' and feelings of being 'second class' or 'second best.'

> EN. I just wanted to prove to myself because of the mistake I made years ago, I could rectify that and I think years of feeling not quite good enough because I was an enrolled nurse.

> EN. I think my main motive is personal satisfaction. My next was that I wouldn't be left behind as nursing progressed through this academic thing. Definitely, if I do not want to be left behind, I need to do this.

7.2.6. Age related concerns

One of the concerns that participants had about doing the conversion programme was being too old. This was related to uncertainty about academic ability and fear of failure. Being too old was perceived to be associated with being less flexible, unable to adapt readily to new ways of thinking and being less receptive to others' ideas. Lack of ability to be disciplined as a student was also an age-related concern, which meant that participants were uncertain about having the ability to cope with studying. Some participants wanted to do the programme before they became too old.

EN. I want to do it and I'm ready to do it now while I've got the motivation to do it.

EN. Hopefully I'll gain more knowledge and confidence and I suppose in a bit of a way status and for me personally. I feel I want to do something else. I'd like to gain experience in different areas of nursing and in future maybe do something else. I think it will open more doors for me. I'm quite restricted as to what I can do as a D grade enrolled nurse and to what areas of nursing I can go into. I feel I've come to that point in my life that I'd like to get my teeth into something, studying and learning again. All those things really are the reasons that I want to do it.

7.3. Expectations of conversion

Most participants commenced the conversion programme with mixed emotions about the experience ahead. Lack of familiarity and self doubt contributed to anxiety. However, the desire to achieve first level registration was strong. Positive expectations about the experience included placement experiences and learning itself. Learning about new developments and about the process of learning and also learning how to write and reflection were valued and perceived to be important for promoting positive self-esteem and raising self-confidence. Increased knowledge included recall of what was learned in the past. Placements provided experience in other areas and it was expected that new skills would be learned in addition to reviewing existing ones. However, some expected initial apprehension about the experience of placements. In general, the programme was expected to be hard work and challenging but enjoyable. Trying to balance family, work and study commitments was perceived to be one of the most difficult challenges. Most participants felt that others would support them, mainly through moral support and encouragement from colleagues and regular contact with tutors. Negative expectations

focused on the written assignments and a significant number perceived academic writing to be the most threatening aspect of the programme. The majority did not know what to expect and reported that they found the programme difficult to comprehend initially.

As participants progressed through the programme their expectations changed. There were variations in perceptions of the support received and whether it had been more or less than expected and whether or not the programme had been more or less demanding academically or more or less time consuming. Time proved to be the most defeating element of the programme and the greatest anxiety derived from a sense of having insufficient time to complete the work satisfactorily. This was influenced by financial pressures and role conflict. Participants often worked extra shifts or did bank or agency work to supplement their income. When they commenced the conversion programme they were under considerable pressure to complete assignments and also felt under pressure financially. The guilt associated with not being able to fulfil roles as mother, daughter, wife or carer also contributed to the psychological pressures that they faced as students on the programme. Family crises had to take precedence over study. Pressure from the unrealistic expectations of tutors including expectations that work had to be word-processed could induce a high level of stress and led to feelings of inadequacy. Most participants did not feel that they could discuss these perceptions or negotiate with tutors. Those most affected by pressures perceived their relationship with the tutor as passive.

> EN. I don't perceive that it will be easy at all... I'm going to be working full-time, I have my home life and I may have to cover extra shifts at work.

EN. I really don't know what I expected. I knew it was never going to be easy but the lack of time is the biggest problem I would say for me. It is hard to fit everything in.

EN. Listening to other people when they were talking about the course, maybe near the end of it, the jargon and words they used, they talk about assignments and different bits, and I think as much as you think you are part of it you're not really until you are actually in the process of going through it.

EN. Its not what I expected it to be, it is so different. I look back at what I have done on it and if you had shown me the work involved before I started I would have said that I couldn't do that. I would definitely have said that I would never get through that. But I have got through it and I can't really believe that I have come this far.

EN. I don't think that I have ever really thought about it. I would say that it is harder than what I thought, it was quite stressful. I don't think you can avoid the stress. It is a strange thing, it was the type of stress that after you've been through it you actually feel quite pleased with yourself.

7.4. Assignments

Assignments have an important influence on self-perception. The in depth study stands out as having the most significant impact and it is important to consider possible reasons for this. The duration and structure of the assignment enabled participants to develop through the process. It was considered challenging by those who perceived it to be the first academic piece of work of the programme. The main aspects of the in depth study that participants identified as important included getting started, the process of implementation and the results.

7.4.1. Getting started

Initially the process seemed daunting and participants were apprehensive and doubtful of their abilities. Having had little or no experience of this nature to guide their performance meant that they were uncertain of what to do and what was expected of them. Initially they were reliant on their tutor counsellors' direction and later sought direction from peers and students who had previously undergone the process. Thinking was described as 'chaotic' during this stage. Choosing a subject stood out as being difficult because finding one that was appealing and original was perceived as difficult and it was common for participants to change subjects during the early phase. Gathering information and reading as much as possible and in a different way than reading for pleasure were also perceived to be significant elements of the process.

> EN. I think the hardest part is actually finding a subject, something that you're going to be able to get information on.

> EN. At first I didn't know what I was going to do… it ended up that the majority of us changed (topics) so I wasn't the only one. I was expecting the tutor to be a bit annoyed about it but it was nothing like that.

> EN. I have picked another subject for my in depth study because the one that I was going to do originally I couldn't find any literature on. I know I should be under way with that but I'm still gathering the information.

> EN. You start to get the information, different bits and pieces that allows you to start to read. You read in a different way from what you do on holiday. I found the first part

probably the most difficult because it is an academic piece of work and I have never really produced a piece of work like that before.

7.4.2. The process of implementation

The in depth study involved implementing change in practice within the workplace so the process involved an authentic experience.

> EN. The in depth study just felt like a challenge. The subject I chose was something I really wanted to do and it was something that had bothered me for a long time. And I thought 'Well now you've got the opportunity to do something about this.' I was quite disappointed a few times though… I had an oral assessment tool that I wanted everyone to use and everyone said 'Yes, we'll use it, no problem, leave it there.' I had photocopied loads of them and left them there to be used and they gradually got fed up using them and I was getting annoyed. 'You need to use these tools.' And they were like 'Oh here she comes again.'… It has definitely made a great change. Although the tool hasn't gone down too well, people are taking their time and they're identifying problems a lot more quickly and the documentation has definitely improved. I'm really happy about that.

7.4.3. The results

Significance related to the impact of actions on practice, which positively enhanced self-esteem, self-confidence and assertiveness. Other perceived benefits included improved interprofessional collaboration and co-operation in practice. Participants became aware of the potential for change and their ability to influence this. Confidence

in writing ability and change in language and style of writing were significant aspects reported. Essential elements of successful achievement included support from tutor counsellors in the form of feedback and from colleagues through co-operation in the workplace and sharing experiences with peers.

EN. Before the in depth study I probably would have been terrified to do anything like that. I've really come out of my shell… the staff are quite willing to listen to you and now, because of that, I feel that I'm not frightened to speak up about anything… I've become more assertive.

EN. I have changed quite a bit. I know a lot more of them (physiotherapists). I know them to speak to now rather than just say hello. If I have to call them in at the weekends I know them more on a personal level and one of the physios actually comes to our nights out because we're all involved with each other. Its more of a team rather than 'Oh that's the physios job.' And let them carry on. We all help each other so it has worked out quite well.

EN. I just enjoy writing. It may not be right and I know it could be greatly improved but I think I'm proving something to myself. I found it very satisfying and enjoyable. It was a long time since I'd put pen to paper. Looking back at my AEDL I thought 'Oh my goodness how immature that sounds in comparison to what I have written now.' I showed my in depth study to one of my friends and she said 'How did you think of all these posh words?' And I think just the fact that somebody else thinks its quite good makes you think 'See you can do that.'

7.5. Tutorials

The majority of participants found the tutorials provided an invaluable opportunity to discuss the course work and placements and to share experiences and problems with peers. At a personal level they were perceived to be helpful for talking through anxieties and 'getting things off your chest.' Participants supported and motivated one another because they were experiencing 'the same thing at the same time.' And individuals perceived peers to be most empathic. Some participants found that tutorials lacked structure and direction especially at the beginning of the programme, but as it progressed they felt that they were more beneficial. A small minority reported that strong personalities often dominated tutorials resulting in feelings of intimidation and avoidance of tutorials preferring one to one meetings with the tutor counsellor.

> EN. I really want to go, I need to go for that support and to meet the other girls on the course. There is so much support to gain… you are all doing different things and get good ideas from each other.

> EN. I haven't missed any because I felt that I needed to hear what other people had to say, to participate and to know how other people are doing. I think they are really important because a lot of times I have felt that I have been really struggling with certain aspects of the course, or I am not sure how to go about doing this part, or I can't do it and everybody else can. I think it is reassuring to know that everyone else has been in the same boat. I really wouldn't have survived without them.

EN. The first few tutorials that I went along to I thought they (peers) knew so much. 'They are so clever. I will never get through it, I am too thick.' … I did feel intimidated by some people, they were very adamant about what they were doing.

EN. There are certain ones in our group that are a bit overpowering and they always tend to get their neb in. And there are others that tend to go a bit over the top, anything that you've done they've done it ten times better. It's a bit off putting.

EN. Sometimes I feel that we don't get a lot out of the tutorials and we're not really doing anything either because the tutor keeps saying to us 'What do you want to do?'

EN. At first I felt that we didn't get much out of them, whereas now I can see where its all falling into place… You share a lot of your anxieties with each other and if you have any problems you can discuss them with your tutor. We've got each others' phone numbers and if you need anything you've got contact with people who are doing the same course… It's a big support, you feel that they know what you're going through because they're going through the same as you at the same time.

7.6. Residential workshops

All of the participants who attended the residential workshops found them to be a positive experience. They were described as helpful and encouraging because meeting with others on the programme raised awareness of a much larger group of students and a feeling that everyone was doing the same thing. Prior to the workshops individuals could feel quite isolated. They provided opportunities for participants to get to know each other and to exchange contact details. The workshops were perceived to stimulate

learning that was relevant to a specific point in the programme, for instance, finding out about the in depth study and what to do in each section.

> EN. The weekend was good I enjoyed that. I was glad that I had gone to that before I started my in depth study because I came away from there thinking 'I'm going to get through this… everything just fell into place and I knew exactly how to set it out and what I was expected to do in each section.

> EN. The study weekends were good because it gets everybody together and you all realise that you are all doing the same thing.

7.7. Placements

It is important to explore what was perceived by participants to be beneficial about the placements and the nature and value of the learning involved. What emerged from the data was the need for individuals to be free to learn what is important to them for their own development. Goals helped to focus learning and reduced the risk of wasting valuable time or leaving it entirely to the nurse in charge or the placement mentor both of whom were often uncertain about the learning needs of experienced enrolled nurses. Using goals also made explicit the purpose of the placement without necessarily being too specific and avoided or minimised the risk of participants being 'used as a pair of hands' whilst on placement.

7.7.1. Student role and identity

Before the programme commenced some participants were wary about becoming a student. The role was unfamiliar to them and they did not know what was expected of them. Age and experience were the main factors influencing this anxiety. Many perceived students to be young and lacking in experience which was an image that they could not identify with easily. There were also concerns about feeling inadequate and of not being able to meet others' expectations of experienced enrolled nurses.

> EN. I think the first placement that I went to I felt a bit 'Oh, I'm a student, I don't want to wear this badge.' But then I came across a lot of students of a similar age who were actually doing the easier course as mature students, so I quickly realised that there are quite a lot of us.

> EN. Sometimes you feel like a fish out of water, a bit uncomfortable and afraid that you are going to be asked to do something that you don't know how to do. That if you've been a nurse for twenty years then you should know. But I think people quickly make you realise that if they were in your field, they would feel exactly the same.

> EN. When people said where are you going I quite liked the sound of saying that I was going to A&E because I never had the opportunity when I was an enrolled nurse. I thought it sounded important but I was petrified inside and I felt sick in the morning when it was time to go. It was just nervousness. When I went I found most people were accommodating and helpful. I think if you show a willingness to work most people are happy to take you.

EN. It is probably quite a relief when they are finished. I think its only then that you look back and realise that it was worthwhile to get a taste of different departments and what happens. That for me was quite important.

7.7.2. Identity on placement

Many participants found that being a student on placement felt like being a pupil nurse all over again whereas, by contrast in their own workplace they were often in charge.

EN. I feel like a student only when I'm on placement. I'm like two different people… you reverse your whole role… like being a pupil nurse all over again.

EN. When I'm in my own ward I'm confident and I know exactly what I'm doing whereas when you're a student, you've got a student badge on, you can step back and say I'm not responsible for anything. I know I shouldn't look at it like that but that is the way I feel sometimes and to me I am a totally different person. I feel quiet and stand in a corner somewhere, I mean that's what I felt like all these years back. I'm trying but its hard not to when you don't know anybody… and I don't know what I am doing.

Not having the anonymity of other students could be difficult especially in areas where a participant was known to staff who did not treat them like a student and who also expected them to share in staff values.

EN. Going to the placements was hard because you were an enrolled nurse but you were also a student. It was especially hard working with people that knew you. You were thinking 'what are they going to expect of me?' I felt that when I went into

placements like that I should have more knowledge especially in X where I found it really hard to speak to the patients, they were so young and a lot of them had drug problems. I was listening to staff and they were saying that the patients were in and out all of the time and that made it difficult. I remember I was speaking to a patient for quite a while and the staff asked 'What are you sitting talking to him for?' …You can sometimes lose your compassion when you've been in a place too long and you're seeing the same faces in and out.

In rural areas where a participant was known within the community as a registered nurse, taking on the role of student was confusing and embarrassing.

EN. When I was out on community I felt really uncomfortable because I was going into peoples' houses that I'd known for years and they had known me as a nurse for years and here I am as a student and they're thinking 'I thought she was a trained nurse. What's she doing now?' It was belittling and so embarrassing… Probably because I give an air of confidence in my own department and to actually have people think that I'm not as competent or not as well trained as they thought.

Participants generally felt positive about placements and staff where they were treated, or introduced to patients or clients, as qualified and experienced. Where placement staff delegated care to them this was perceived this as an acknowledgement of competence and it enhanced their self-confidence.

EN. He introduced me … as a nurse from X hospital doing extra training… I'd just been introducing myself as a student nurse.

EN. Usually the staff nurse that's working with you in resus will give you credit and say this is such and such who actually has a lot of experience but is doing a course. Before they wouldn't have said that so their attitudes are changing and its because their own enrolled nurses are doing conversion. I think that senior nurses that have done the course support the enrolled nurses. The mentality is changing.

EN. You'll maybe go into a placement and they say 'Well what do we do with you?' They are not sure of what to expect of you but in another way they don't want to treat you, I don't mean this badly, like a wee first year student in off the street who doesn't know anything.

EN. The community nurse was brilliant. She let me palpate and showed me how to do it… and I took bloods and she made you feel part of the team and not just a silly girl.

However, in some instances participants felt that they had to remind staff that they were on placement to learn and not there as a pair of hands.

EN. One of the staff nurses asked me to do all of the TPR's on the ward. I told her that I wasn't prepared to do that but I would do the post-op patients because that was pertinent to what I was doing. I certainly wasn't running around doing the TPR's when there were other members of staff there to do it.

EN. You're not treated as a student really. Particularly on placements where they recognise you as a qualified nurse and they know you. You have to draw the line so that they know 'I'm not here to do the obs.' Remind them that you're not cheap labour.

7.7.3. Positive placement experiences

The placements provided a valuable opportunity for participants to experience workplaces other than their own. Most had worked in the same area and sometimes even the same shift for years. After the initial anxiety it was evident that many found the change and variety stimulating. Also realising their ability to work in other areas boosted confidence and self-esteem. However, the experience also could have an unsettling effect.

> EN. My first placement was community and I think it was just being somewhere new, somewhere different, being a student again and applying yourself… I thought 'I would like to do that.' … I could see myself there. You feel I could do that, I could make a difference.

> EN. I went to work in care of children. It was not a placement that I was really looking forward to. I have never had a notion to work with children. It was the best placement that I have ever had. I would love a job there. It was so good, I picked up a lot of information. I had a lot of time for them… I could feel myself getting drawn in.

Being a student affords a degree of freedom from responsibility that a number of participants identified as important to placement learning.

> EN. It was strange but enjoyable. There was no expectation of you because you were there to learn and they were giving you a lot of information. Whereas I think if you had gone as an enrolled nurse they would have thought 'Well you know so much we don't really need to tell you very much.'

EN. I probably did feel like a student because paediatrics is something that I didn't normally deal with… Because you don't know anything about it you have to go along like any other student nurse and I did enjoy it.

EN. It was terrible at first. I felt totally like a fish out of water. And I think so long in the one place as well you're used to your own environment and your own staff and I felt like a student I really did. I felt like a wee girl on my first day. But then it wasn't like that, it was fine. Everybody was really good. I think the placements are alright. I think the staff are kind of worried because they know you as well. I think they were worried about what to do with me more than I was worried about what I was going to be doing… It was good that I had my goal and action plans because then I knew exactly what I wanted to do. They were quite happy that I knew what I wanted to gain and they were really good at setting things up and suggesting places to go and people to see.

7.7.4. Negative placement experiences

Negative experiences were mainly encountered in maternity and care of children specialities where the negative attitudes of a small minority of staff could mar perceptions of the experience.

EN. It was myself and another student. We had got the report that said that the baby had vomited during the night and the mother was quite nippy. So we had gone into the ward after the report and the mother just blew up. She went on about her baby, about how she hadn't settled, how her temperature was high and she screamed the night away and the nurses had had to change the bed. The mother hadn't been able to go for a cigarette or a cup of tea. So we just gave the baby a sponge down and changed the

bed and said to the mother 'Go and have a wash and some breakfast and away for a cigarette and a walk.' So then we were told to go for our tea and when I came back the student said 'You are going to get spoken to.' And I said 'You are kidding.' It's the mother's responsibility to look after the child not theirs (nursing staff), they were not there to look after the parents… I thought the child was that way because the mother was uptight.

EN. The preceptor actually ignored me and never answered my questions. Another staff member said that that person didn't like students and I should probably stay out of her road… sometimes you feel totally out of place.

EN. Going into wards and people ignoring you…You would go in and introduce yourself and you felt a bit of a bind. It was 'Well who can we get you to go with?' There was nothing more off-putting… Now I do try and make sure that there is a nurse on the ward that is expecting them (student nurses)… I certainly do mother the students now because I know what it feels like and every student has said that they felt so welcome.

7.7.5. The value of placement experiences

The placement experiences were highly valued by participants who found them stimulating and interesting. Experiences that challenged assumptions influenced changes in perceptions of self and others.

EN. It has raised my awareness of what's happening in other areas rather than your own ward where you don't see anything else that's happening around you. It has given me a wider knowledge of what's happening. I've been in A&E this week which is

good because in your own ward you tend to see the same sort of things all the time so you're not really learning much… It broadens your horizons. Before I was in a rut, I was on automatic pilot… this (placement experience) makes me want to do things better, to improve myself. I'm not sure if it's the change of scenery… its because you're not in the same routine all the time and you're seeing things happening and you think 'Do I do that? Or 'Maybe I shouldn't do that.' I really like going out and about and seeing what is happening elsewhere. I am learning when I am there.

EN. I have enjoyed all my placements and it has been really nice going out around the different areas and seeing how everybody else works. It does make you realise that your place is not the most important area in the place…What I have got from my placements is that I probably feel more confident about patients coming (to theatre) from the wards…I feel more confident looking for things.

EN. It is refreshing. I did enjoy the placements. I felt as if I was reborn. Maybe its because I wasn't doing anything before… It opens your eyes as well. Particularly the community… once the patients are discharged from us we never see them in their own homes. After eighteen years I was going to visit them and they remembered me. It was really quite emotional… It was an eye opener to see how things worked outwith the hospital environment.

EN. I went to the alcohol problems clinic… We get a lot of clients that have alcohol problems so it helped to see first hand people that were acutely ill…The last time I was in acute admissions was about twenty years ago. I've been in rehab for 10 years and you do forget what it is like when people are acutely ill…It was a shock to go back to that. It reinforced it and helped me to remember.

EN. I really enjoyed the placements. It gave me a chance to see patients going through things like an angiogram for instance. I usually nurse these patients before and after they've been. But being on placement gave me a chance to go and witness all the tests and examinations and minor operations… I could see what was involved and it gave me more information to relay back to patients who were waiting to go for things. I could tell them a bit more about what was involved, especially in cardiology where patients were maybe going for a by-pass graft… Now I've been and I've seen it and I've read the information I feel more confident to answer their questions and any worries that they have about it. I know where to find the information and I refer people more now because I know who to refer them to because I've met these people…So I think it's a big improvement.

EN. I went out with the specialist nurses like the diabetic nurse, stoma care nurse, all the specialist nurses here as well which was fantastic. It was really good for me and it helped me on the ward because things have changed so much.

EN. It was quite good if there was something on that I did want to see like a CT scan… there was somebody going for a CT scan and I went down with them which was quite good.

EN. I now see X (own workplace) as insular and see it from a different perspective. There are more options for people with learning disabilities as long as the care package is correct. Relatives worry about the change… if they had a chance to see the options available for themselves they would feel better. I have suggested this at the transition group.

7.8. Perceived difficulties during the programme

Aspects of the experience of conversion that participants found most disabling related to perceived expectations and feelings of helplessness and inadequacy.

7.8.1. Having to ask for help

Participants felt most like students when they had to ask for help or were unfamiliar with the role or environment. Having to ask for help was perceived as being unable to help oneself. For example, being unfamiliar with the library.

> EN. I'm not used to going to the library. Maybe its trying to find a certain thing and it not being there and having to go and ask somebody because I'm not very good on the computer. So I feel as though I'm always asking 'How do I get this? How do I go about this? How do you turn this on?' That's when I feel like a student, when I'm needing help with the course.

> EN. Going to the library was a big thing… my husband came with me the first time… now it doesn't bother me.

Participants who had no prior experience of higher education or of being a student found the university environment unfamiliar, in particular the library. As open learning students there was no need for them to physically attend the university, which meant that they were less likely to visit the library on a regular basis. Accessing library resources online was also difficult for those who had restricted access to a computer and lacked the relevant skills.

7.8.2. Access to computers and assumptions about IT literacy

Not having access to a computer and not being able to use one effectively caused stress because participants perceived that course work and assignments had to be word-processed. Time spent typing meant that they felt behind with their work and that they were not meeting tutor's expectations. Not being able to access or use a computer led to feelings of inadequacy and guilt.

> EN. The time I got my computer I just felt that I wasn't going to get anywhere… one of the girls at work is very computer literate and was more than happy to look stuff up for me so that was a help… she is going to show me (what to do).

> EN. Because I don't have a computer in the house I feel that I am getting held back because of that… I have been going to libraries and my brother-in-law's and doing bits… its just getting my head round the computer and how to present it on the computer. Its my fault for not updating. I have been practising but I still need a hand.

Participants felt stressed by others' expectations of their academic ability particularly when they did not feel confident themselves. For instance the suggestion that someone should complete a degree when they feel that they still haven't mastered work at diploma level increased feelings of inadequacy, which were demotivating.

> EN. I am struggling so much with the work and he said to me if you do get through this you better think about doing your degree straight after this, don't stop… At the moment I can't even see myself qualifying.

EN. People are saying to me 'What about your degree when are you doing that?' Let me get my diploma first.

EN. Before it was always I'm going to have a damned good try and I'm going to do my best and if it means cutting corners here and there I will do it. There's not much point in going through all this doing it the way I'm doing it half-heartedly.

7.8.3. Lack of tutor support

Expectations of participants that they would be self-directed from the beginning of the programme when this was not the case can also lead to feelings of inadequacy. Participants did not feel able to discuss this with tutor counsellors.

EN. Personally I can't get used to not being taught and I know we need to get round that. I think its just the way that you've been brought up… She (the tutor counsellor) never makes you feel as if she's the teacher because she keeps saying 'I'm not here to teach you. You're here to teach yourself. Tell me what you want to do.'

EN. I think one of the most difficult things to come to terms with certainly in the first year is the open learning… I think learning to manage your time has been very difficult… It has been a whole new experience and I struggled with that at the beginning. This is not the way that I have been taught.

In the early stages of the programme most participants needed assistance to make effective choices regarding learning.

7.8.4. Role transition

Some participants feared that they would be insufficiently experienced to take charge in other areas when they qualified as a first level nurse. They had experience of this in their own workplace and in some other areas as enrolled nurses, but seemed to feel that expectations of them as first level nurses would be different.

> EN. The fact that you could be left as the sole person in charge would worry me. The fact that now you've got other people that you can ask their opinions and go to. If I did take a job as a staff nurse in a ward I would want to have had some experience. (Theatre nurse)

> EN. I felt that the staff nurse course was more management oriented whereas the enrolled course wasn't.

7.8.5. Superficial learning

The biological science workbooks comprised of structured activities such as labelling a diagram. Correct answers were provided on the next page. Some participants perceived these activities, and the need to demonstrate that they had been completed, pointless and demeaning.

> EN. The biological sciences, although I did them, all it proved was that I had done them… I didn't find it rewarding to do.

EN. The biological sciences were a chore. The fact that the answers were below really

annoyed me… I didn't need to learn anything, all I needed to do was to copy the

answers. I felt it was pointless.

7.9. Benefits of the conversion experience

Perceived benefits of the conversion experience included recognising the value of one's

own experience and knowledge, speaking out about, disagreeing with and questioning

practice compared with not doing so in the past, discovering that learning is self-

motivated and empathising with student nurses. New skills developed through doing the

course related to managing information and included searching for information, IT

skills and using the library and also recognising that using these skills had become a

normal part of one's practice.

7.9.1. Recognising that one has experience and knowledge

Becoming familiar with and attuning to others' language significantly influenced

awareness by participants that they already had sufficient knowledge and skill but had

not recognised it previously. Brokering was also an important aspect of placement

experiences that involved bringing back practices and language picked up whilst in

other areas. This knowledge and being able to share it with colleagues boosted self-

esteem.

Participants felt that they had become more conscious of what they were doing and of

doing something because they felt that it was the right thing to do rather than being told

to do it by someone else. There was an associated rise in awareness of responsibility

and individual accountability. Consciousness also involved an awareness of what one did in the past that was different.

EN. An enrolled nurse is a good thing to be. You have got the knowledge… over the years you're like a sponge and you've absorbed all this knowledge and experience. It is not until you get into the big world that you see things and you say 'I know what this is about. I can actually do that.' In the enrolled nurse training you might not have used the same language but it is quite easy to pick it up… All of a sudden here's us and we're actually talking the same language and the thing is we're talking the same language with experience and in some cases more experience than the people that you have been working with.

EN. I knew that I had developed skills but never really looked at what I had achieved until I started the course. It has made more me aware of everything I am doing… Doing the AEDL's … makes you more aware of the things that that you have actually achieved. I found that a lot of the things that I did I just did them as part of my nursing care but you don't actually think about what skills you use… even communication, you just take it for granted … now I actually think about how I go about it and how successful it was.

EN. The staff I work with are very conscious of the language that I use now that I never used before… The things you see on wards you actually take back to your own department and before you know it you're actually doing what they're doing. So you're picking up quite a lot of what goes on.

EN. The conversion course I feel empowers you to say and do things where you wouldn't do it before. It gives you a chance to express yourself and you have the liberty to say I don't agree with that.

EN. I think maybe I value myself a bit more or value my opinion more. I have seen me saying things to people in the ward whereas before I probably would have said to one of the staff nurses 'I don't feel something is right could you have a word with them?' Whereas now I think why shouldn't I say that I am a nurse after all. If I'm not pleased about something I find I say so more, if I don't agree with something.

EN. The conversion course dangles the carrot and you go for it. When you're doing the AEDL's you look back on what you've done and I found that scary because I hadn't had to think about things before like 'Why did I do that or what could we do in that situation?' So you've dealt with the past then… you've got rid of that baggage.'

EN. Before we would have had to follow instructions… someone would tell us. We wouldn't have to work it out for ourselves in the past… Now I have a deeper understanding of why the practice is what it is… now you're thinking about it and you're questioning it and that's not a bad thing. And you're questioning other peoples' practice… Before we didn't do that.

EN. People say to me 'Now that you're doing that course you're thinking about it. Before you wouldn't even bother so why bother now?' Its just because you're in that mode.

EN. I hardly read a newspaper before to be honest with you. I feel that this is new. I am studying because I have to but I am doing it because I want to as well and because it is interesting.

EN. It is refreshing. I really do feel as if I enjoy studying. I enjoy the placements and I just feel as though I have been reborn. Maybe its because I wasn't really doing anything before so I really have enjoyed it. I have enjoyed everyone that I have met on the course and on the placements so it was quite refreshing and it opened my eyes as well.

EN. If I hadn't been pushed I probably would still be happy where I am but I'm glad that I have done it because I am a totally different person now. (In the past) I just went to work and thought that nothing was my responsibility and there was always someone higher up that has got that responsibility but now I'm more interested in what is going on. It changes you.

EN. It has changed me through updating knowledge and learning a whole load of new skills since I started on the course. Like the computer, I had no idea about it and going to the library and learning how to use the library. That shows you how limited my skills were when I came on this course.

EN. I have found that study has become a way of life and I don't find it a chore especially the critical incidents we're doing just now. (reflective practice assignment).

EN. I can relate to the students more… just simple things like making sure that they're not left standing on their own… Being back to being a student again I can remember what its like.

7.10. Self-efficacy, self-confidence and self-esteem

The concepts of self-efficacy, self-confidence and self-esteem are interrelated and each concerns a different dimension of personal growth. Self-confidence is illustrated in the ways that confidence is demonstrated whereas efficacy relates to the processes that contribute to confidence. Participants derived confidence from knowledge and they perceived that this enabled them to speak out more and to be more assertive. It also involved being more aware of their capabilities and encouraged individuals to stand back and to work things out for themselves. Self-efficacy derived from successful achievement and the motivation to continue to meet challenges. The process involved experiencing stress and self-doubt prior to achievement. Feedback increased confidence and encouraged persistence. Participants described achievement as a sensation of moving forward. Growth in learning capacity stimulated a desire to continue to improve and grow. Self-esteem is linked to confidence. Having the confidence to stand up and speak out and to be assertive derived from valuing one's own opinion. In this study what stood out as important was the relationship between self-esteem and a personal sense of being the same as or equal to others. This involved individual realisation of self-value through critical self-reflection. What was also important was recognition by participants that increased self-confidence and self-esteem could influence the way that others responded to them.

7.11. Self-confidence

Self-confidence was demonstrated in being confident in one's own knowledge and having the confidence to be professionally assertive. It developed from awareness by participants of their own capabilities and it stimulated a desire to continue to learn.

7.11.1. Confidence in one's knowledge

Participants became confident in their own knowledge through self-appraisal, from others' acknowledgement and through recognising how their own knowledge could benefit patients. They often realised the extent of their knowledge when they were on placement and away from the familiarity of their own workplace. Learning was valued because it contributed to their knowledge and therefore enhanced confidence.

> EN. It is recognising the confidence that I have in myself as an enrolled nurse… that you have got the knowledge.

> EN. I possibly have a bit more confidence in my own knowledge… there is a slight acknowledgement of my knowledge.

> EN. I think you get too comfortable when you have been there a long time… before you move to another ward you are frightened of change and think that you're not going to be able to do the job. Since I started the course I've been better… I think its just that you've been out. That first couple of days when you think what if I say something or what if I do something then you realise that you had nothing to worry about.

EN. Experience makes you learn more. I would say it makes you more confident and increases your capabilities… I am learning more on the course. I have been A&E the last two weeks and I have learned much more. Different things that I didn't know anything about. Sometimes in my own place of work different things happen and you learn more about it… I would say that my knowledge has improved… I have been made aware of what is happening round about and I'm not in a cocoon in my own ward. I have grown more confident in myself.

7.11.2. Professional assertiveness

Professional assertiveness was demonstrated in the participants' perceived abilities to disagree with others, suggest changes and to admit to not knowing something. It also involved having the confidence to speak to other professionals and being able to use one's initiative.

EN. I am more inclined to speak out now… I will put my point of view across and I am less hesitant about speaking up or speaking out about something. I am happy to go to the matron or a doctor and say 'I am not managing this.' Or 'I think there is something wrong here and I am not sure. Please come and check.'

EN. Because I am more confident in myself, I am more approachable. People ask my opinion whereas before they would have gone to the matron.

EN. I used to be really quiet and I just went along with things the way they were but now I've become more assertive.

7.11.3. Awareness of capability

Participants' awareness of their capabilities involved being able to stand back, think things through and work things out for themselves. Increased awareness of problems involved thinking about them more deeply and being more aware of the different aspects of them. These changes in cognition were perceptible to others and were perceived by participants to signify progression towards first level.

> EN. You are more aware of your own capabilities and deal with situations differently… In the past I might have passed it on to someone who knows how to deal with it… I am more willing to put myself forward now and deal with the situation myself.

> EN. I deal with situations in a more thought provoking way…I feel I am able to work it out more. I am able to look at the situation as a whole and decide what I am going to do about it. I just feel that I am more aware of different aspects and things that are going on. I think it is confidence.

> EN. My current boss said that I had changed so much and that I was much more professional… he said 'You are a lot more confident.' He said that he had seen a vast difference in my reports.

> EN. I would say that I have changed because in the past I would have gone to the clinical manger all guns blazing and just made a fool of myself. But I stood back and thought about what I was going to say and planned it out and I think I dealt with it really well and professionally because I looked at the issue rather than going in and saying that I didn't want to do night shift because I had children.

EN. I don't mean that I have lost the title of enrolled nurse now but I almost feel as if I have and I am really progressing to being a first level registered nurse. I definitely have become more confident.

7.11.4. Confidence to go on learning

EN. There are things out there that I want to explore a bit more and things I'd like to change and I feel that I've got the confidence now to do that which I didn't have before.

EN. As an enrolled nurse I would just get on with my everyday work but now I feel that I want to be more aware of things. I want to learn more. I just want to be aware of more things that I can learn.

7.12. Self-efficacy

The processes that influenced the development of self-efficacy included achievement of something that previously participants would not have thought themselves capable of. It was perceived that a degree of stress could enhance achievement. Feedback was an important motivator in the process. It increased confidence and encouraged persistence. Achievement provoked a sense of moving forward and stimulated a desire to keep learning in order to improve.

EN. I actually find the work not too big a problem and that has given me encouragement, because you sometimes think that you can't do it and that it will be too difficult. But it makes you feel quite good about yourself, especially the second one that I did, I felt really pleased.

EN. I felt under pressure but it is much better now. I am happier now. It was a relief to hand my module in. It was a lot of writing, a lot of work.

EN. It was the type of stress that after you've been through it you actually feel quite pleased with yourself and you say 'Well look what I've produced, look what I have done.' And you feel quite proud of yourself at the end of the day.

M. How did you recognise that you were changing?

EN. Probably during the AEDL. I think to go along to interviews and be able to tell your story, to get positive feedback and encouragement, was really good for me and made me want to go on and do the next step.

EN. I feel as if I'm moving forward, I really do and I feel each step of the course that I've learned something different each time and I'm ready to move on to the next step.

7.13. Self-esteem

Self-esteem involved participants valuing themselves and their opinions, which was influenced by being self-critical and self-aware.

EN. It makes you value the qualities that you have and value yourself more. It also makes you more critical too… I don't think that I have been so aware.

EN. I find the ones who have always been staff nurses want to know what you are doing and if I say that I want information on something they will help you whereas before they would say 'What do you want that for?'

EN. I would say that I think more of myself. I am not just a dogsbody, I know more than this. And if my qualification isn't going to allow me to do more than this I will proceed to get first level registration.

EN. When I finish the course I am going to do the degree so my confidence can't be that bad… (At the beginning) it was hard to even visualise getting to the end of the course never mind thinking about doing the degree.

EN. Before I thought that I wasn't as good as the other nurses but I now feel as if I'm on a par with them so I'm quite confident.

EN. If you think something you're more likely to say it now as opposed to keeping your views to yourself.

7.14. Summary

Motivation emerged as a theme because the motivation to succeed was influential in individuals' perseverance amidst doubts and fears associated with the unfamiliar experience of being a student. Individual motivation to succeed was strong and was influenced by a desire for self-development and to prove one's capability to oneself and others. A desire for self-development was influenced professionally by the need for continuous professional development and in some cases by specific career development goals. Gaining knowledge was an important motivator and was perceived to increase confidence. Different aspects of the experience of the course positively or negatively influenced individual motivation and learning.

Successful achievement of perceived challenges enhanced self-esteem and self-efficacy and positively influenced motivation. Reasons given for undertaking the conversion course included being encouraged by others to do so which individuals perceived as a positive indication that other people had confidence in their ability to do the course. Being encouraged by others' success and being deterred by others' failure or negative experiences also influenced motivation. Perceptions about the course influenced how individuals felt about it prior to commencement and included concerns about family commitments, financial pressures and self-doubt about academic ability and ability to study related to age. Most participants anticipated that the course would be challenging and hard work, however support from tutors, colleagues, family and friends was expected.

Self-efficacy theory (Bandura 1986) provides an explanation for individual motivation in relation to prior perceptions and the sense of achievement experienced by participants as they satisfactorily overcame perceived challenges. Experience of success positively motivated individuals to continue with the programme and to persevere in spite of negative influences. Observing others' success vicariously influenced motivation particularly where those being observed were perceived as being 'at the same level'. The influence of verbal persuasion by others was stronger where persuaders were perceived to be credible.

Individual self-esteem increased as individuals progressed through the programme and all participants exhibited some degree of change in perception of ability and self-confidence as they progressed. Through critical examination of practice, participants recognised that they were already experienced and knowledgeable registered nurses.

Active participation in practice boosted confidence and promoted meaningful learning for example from undertaking the in depth study and the experience of brokering as individuals moved from one area to another.

The impact of enhanced self-efficacy enabled participants to achieve things that they had not believed they were capable of, challenged negative self-assumption and altered perceptions of self and others. Successful achievement motivated achievement of further challenges and this was described a sense of moving forward. Individuals were aware of a growing learning capacity and became more realistic about their capability through self-appraisal and others' acknowledgement. Recognition of the benefit to others of their knowledge enhanced the value of learning. Altered perception of self was evident in being more assertive and participants perceived that they valued themselves more and felt on a par with others. Professional educators must acknowledge the contribution of constructive feedback on self-efficacy and in facilitating student self-awareness and self-appraisal. Change in self-perception was encouraged by positive responses from others.

Perceived negativity towards enrolled nurses adversely influenced motivation, particularly discrimination against enrolled nurses by other staff. Negative influences also included expectations by tutors, perceived by some participants to be unachievable and unrealistic. Perceptions of self and others varied according to the point in the course at which the interviews were held. Due to initial self-doubt and lack of familiarity with the course, those in group A were less positive than those in groups B and C. Uncertainty about academic ability and achieving a balance between family, work and study caused the greatest concern. Other perceived difficulties included feelings of

helplessness, having insufficient time to complete academic work satisfactorily and financial pressures of being prevented from working extra shifts or undertaking agency work due to studies. Guilt associated with feelings of not fulfilling the maternal or parental role adequately continued throughout the course. These findings support those of other studies. For example, Dowsell, Hewison and Millar (1998) also reported the negative impact of conversion on home life and family relationships and the pressure and guilt associated with perceived parental role inadequacy.

There is a need to address the cognitive, social and emotional influences on learning and programme design must consider the need for flexibility to enable social role fulfilment. An option to complete the conversion course over a longer period of time was available however, this has to be balanced against anticipated loss of earnings and the potential psychological impact of not being able to keep up with the group. The curriculum also has to achieve a balance between alleviating excessive pressure and providing sufficient challenge to motivate through a sense of achievement. The negative perceptions of participants associated with time pressures did challenge my assumptions about the flexibility of the course. Other implications of the findings for professional practice include the need for awareness by educators of the existence and perceived influence of hierarchical power relations. Participants who felt that the expectations of their tutors were unrealistic did not feel able to discuss this issue with them. As a tutor one needs to develop an awareness of one's own positioning and that of students and attune to pressures exerted on students by one's perceived expectations. Promotion of an open and negotiable relationship between tutor and student would minimise hierarchical barriers. Educators also need to achieve a balance between being over-prescriptive and providing sufficient support to enable successful achievement by an individual.

Developing an open and honest relationship with students would enable negotiation of support and a sense of self-control and self-management by the student.

Chapter 8: Conscientisation

8.1. Introduction

Conscientisation is an educational process that raises peoples' awareness of the mechanisms of oppression that influence them, in particular how their own behaviour contributes to their oppression. Awareness enables people to overcome oppression through social action (Freire 1972). Coming to awareness and overcoming oppression results from social action and is not an individual phenomenon (Fenwick 2003). Conscientisation offsets individual aspirations to become oppressive through facilitating the development of a critical consciousness of the use of power and its implications and an awareness of a 'capacity to change society.' (Brah and Hoy 1989, p. 73). Consciousness of the reality of power relations emerges through dialogue with others that enable an individual to become critical of their own perspective and to learn from the experience of social action (Freire 1972, Fenwick 2003).

> The actual knowledge people learn through social action experience, according to Foley, is self-confidence, critical understanding of how power works in society and the resources and flexible process required in direct action. They learn the need to support each other, the nature of the stress involved, how action can polarise a community and reveal its structures, and how unsettling it is to challenge your own and others' assumptions. Their learning demystifies how authority works, and helps them appreciate people's very different perspectives and the extent of their reconcilability. Perhaps the most important knowledge is people learning that they *could* act and that their action *can* make a difference. (Fenwick 2003, p. 167).

Freire (1972) perceives education to be a potential liberating force that, through dialogue with others, enables a person to look critically at their world and the contradictions inherent within personal perceptions of social reality. In relation to nursing, education has the potential to liberate nurses from the cultural constraints of occupational positioning on agency. These occur through the influence of social and political values and norms on perception and behaviour that can be harmful to clients' interests where they support unquestioning acceptance and conformity. Professional education can facilitate or inhibit awareness of a critical consciousness of the constraints on individual professional responsibility and accountability, the role of professional assertiveness and the implications for client care.

As participants progressed through the conversion programme their awareness of individual beliefs, values and attitudes and professional accountability on practice was promoted through critical reflection. Although not an explicit aim of the process it was important to consider the extent to which participants developed a consciousness of self and others that contributed to perceived occupational position and how that influenced the degree of control over practice. It has already been demonstrated that, as participants progressed through the process of the conversion programme they became conscious of the knowledge and skills derived from experience that influenced their practice and that this awareness enhanced self-confidence and promoted self-esteem and a growth in efficacy. In addition, a number of the participants in the study described how they became conscious of attuning to others' conversations and discussions and were aware that they had not done this in the past. Furthermore, they perceived that they participated without hesitation in these interactions. The realisation that they knew, and could use with confidence, the language of others was an important element of this

process. Also important was the realisation by some individuals that they had excluded themselves from participating in the past. The main reason given for doing so was the belief that as enrolled nurses the conversations of others did not concern them and feeling that they had insufficient knowledge and understanding to engage in others' discussions or being concerned that others might hold that belief. It is important to examine the process of these changes in perception of self and others and the constraints imposed by self-belief.

The process of self-consciousness involved the realisation that occupational socialisation influenced self-belief and actions according to role and position within an occupational hierarchy. The recognition of self-denigrating assumptions that acted as self-imposed constraints on perception and behaviour was an important realisation. In this section the process of becoming conscious of self-oppression will be outlined paying particular attention to the ways in which it became apparent and the reasons given for its existence. Consideration will be given to possible influences of becoming conscious on perception and behaviour.

8.2. Processes of self-depreciation

Referring to self as 'only an enrolled nurse' was a common demonstration of self-depreciation and reflects Freire's (1972) reference to those who are oppressed.

> The peasant begins to get courage to overcome his dependence when he realises that he is dependent. Until then he goes along with the boss and says 'What can I do, I am only a peasant?' (Freire 1972, p 37.)

The title of enrolled nurse was sometimes used by participants to avoid responsibility that was normally the remit of a first level nurse or where a participant wanted to take a stance against being used as a first level nurse.

EN. I think a lot of it we bring upon ourselves as enrolled nurses… How many times have people called you staff nurse and you reply 'Oh I'm only an enrolled nurse.'… When I was on placement I met one of the doctors from my own ward and he said 'What are you doing here?' and I said 'I'm a student again. I'm doing the conversion course.' And he said 'Are you not a staff nurse?' and I said 'No, I'm only an enrolled nurse.' …He said to me 'Don't ever say that. I have spent six months working with you and until today I wouldn't have known that you weren't a staff nurse. You've done everything that everyone else has, you've done everything that I've asked, so don't put yourself down and say that you are *only* an enrolled nurse.' Later that night I thought 'He is right.' We do bring it upon ourselves without realising it… I think when you first qualify you go into the wards and people say 'Oh you're only an enrolled nurse.' And you get an inferiority complex so I think I have brought it upon myself.

EN. I think its just because I'm a bit unsure at that time and I just need someone to say that's alright and it probably wouldn't be any different but you think 'I'm doing the right thing.' And then I think 'When I'm a first level nurse I cannot do that.'

EN. Over the years as an enrolled nurse once the grading came in, people would say 'Oh you're just an enrolled nurse.' … you're being told that you're not good enough to be doing that, then you really do think that you're not good enough.

EN. (Enrolled nurse mentality) is being very blinkered and blind… its partly the philosophy of being an enrolled nurse and partly personality. We don't really have an understanding of the bigger picture as an enrolled nurse… The conversion course I feel gives you the power, the chance to express yourself and you have the liberty to say 'I don't agree with that.' At the end of the day the first level nurses are not that bothered about it. The thing is we've been carrying this problem around with us all the time. I think it is because we have been so negative for such a long time and we have never seen the positive side of it. Now there's light at the end of the tunnel and you can do all of these things that you couldn't do before. Its up to us to grab them because at the end of the day you don't want to go through the conversion course and still have that enrolled nurse mentality. That has got to go. At the end of the day you're a different nurse.

EN. Once I qualify I think I will still be the same person, I can't see me changing any. I don't really want to work my way up the ladder.

Participants sometimes doubted their ability to make decisions. Even when they were certain that they were making the right decision they felt compelled to have it checked by a first level colleague. This was linked to the uncertainty surrounding what it is that enrolled nurses are officially allowed to do and over which enrolled nurses themselves appear to have little control. For others the conversion programme provided an opportunity for them to reflect on their assumptions and self-belief.

EN. I'm constantly seeking reassurance. I find myself doing it all the time. I am doing something and I'll ask one of the staff nurses if she can just check that I am doing it correctly. I'm hoping that the course might alleviate that a little bit. As a staff nurse I should have confidence in what I'm doing because I do really know what I'm doing,

it's just having the confidence to say that is correct. That comes from being an enrolled nurse…You always think that the staff nurse will know but really you know just as well as they do. It's a lack of confidence that causes that.

M. Why do you think that enrolled nurses lack confidence?

EN. I think at some point someone says 'You shouldn't be doing that' for some reason, or maybe its your own (reason).

EN. I'm always quite happy that I've phoned but looking back you think maybe I should be able to do this on my own… but there's always this dread in the back of your mind and you think you better phone and get it checked.

EN. When I was out on the community placement I met a lot of people that were in really good jobs, higher grades, and it was girls that had done their training with me and they had worked their way up to G grades… I thought 'I have been so silly.' I always run myself down and I didn't think that I'd be able to do that type of job. I should have done something. I feel like I've wasted so much being on night duty for so long.

EN. Doing the conversion has opened my eyes, I feel that I can move forward now… I was getting into a rut as an enrolled nurse doing the same things… Everybody else seemed to be moving on and I felt as if I was always kind of left behind… I feel as if I've been held back that way.

8.3. Becoming conscious of self-exclusion

Being familiar with, being able to understand and recognising the language spoken by others were perceived to be important influences in participating in conversation and

discussion and self-exclusion. What is important in this study is how, through a process of self-reflection individuals became conscious of having excluded themselves in the past.

EN. I think the course has allowed me the confidence to be able to speak out whereas before I wouldn't… perhaps what I had to say was important but I would keep it to myself because it was not my place to speak out… I feel happier now … everyone is allowed to make their contribution and everyone's contribution is equal. You might want to take it or you might not want to take it and that is okay…. I think reflecting on practice has made me much more self aware and has made me address things in my own life that it is not always easy to address and that part has been very important to me. It has made me more aware of how other people see me as well.

EN. To produce and get feedback on some of the work and to know it was successful, and you were on a par with other colleagues and you were beginning to discuss things, it encouraged me. And it made me want to read more, it made me want to listen more when people started to talk. I could hear talk about the White Paper and different things that before had gone over my head. I had always felt that they didn't include me but perhaps it was me that had decided that, because it was not as if I was not included, I just looked upon it as if it wasn't part of my remit or my job. And then these things started to take on a whole different meaning. Part of your day, your job, your study, who you are, the community outside your family. It starts like a ripple and just gets bigger and you want to be involved in it.

EN. Almost all of the nurses are working their way towards degrees and modules and now I can get involved with that more, whereas in the past I couldn't. If a conversation got up I couldn't join in but now I can, and even the newly appointed sister when she

was talking about doing something on referencing, I said that I would be able to help. Yes, I can join in more of these sorts of conversations.

EN. You're moving towards being a first level nurse now because you know the language and you develop that skill to talk the way they talk. It was all there before but you weren't bothered you just got on with your job and that was it. From the beginning the conversion course opens up the whole thing to you and its not being registered its something bigger that you just happen to be doing through the course.

EN. Part of it is knowing that it is not always going to be good… but you're liberated enough to think about it whereas before you would never question it because that took you into a different sphere and you couldn't go that far.

EN. The only time that I don't feel confident is when I think that we should stop at a certain stage and the doctor has baffled me with some medical jargon to say that we should carry on. The patient is really uncomfortable, the patient's miserable, is this really worth it for the patient? … One of the consultants said to me once 'Its my name that's on the patient's bed not yours.' But its only because I question what he does… that's part of being skilled, you have to be vocal… I have a deeper understanding of why the practice is what it is… now you're thinking about it and you're questioning it… you're questioning other peoples' practice.

8.4. Becoming aware of changes

EN. I'm very vocal. Before I wasn't bothered about it but now I just say the thoughts that would have been at the back of my mind. And the conversion course has brought that out … Without a doubt it makes you do things that you wouldn't do before and I

think its all to do with the power. I don't know if that's supposed to happen. Because I'm reflecting on how I see things there's a change in me.

EN. Since I started the course I don't feel undervalued because I feel that I can say that I have actually got a lot to offer whereas before I didn't. I just went along on a daily basis. I was aware of what I could do but I didn't actually think 'I can do that.'

EN. I want to broaden my horizons educationally and understand when someone throws a term at me, and I can turn around and say 'Oh yes that's such and such.' And have them look at me as if 'She knows that.'

EN. Once I started speaking to my colleagues I suddenly realised that everybody had a fear of being handed an ampoule and having to cope with it. And I thought if I hadn't come along and said look I am lacking this knowledge and I don't want to be in this position, I wouldn't have known that everybody else felt like that. So that's brought it all out into the open knowing that everybody else probably has the same fears and intimidation that you do but somebody's got to voice them somewhere along the line to do something about them.

8.5. Perceived changes

In addition to the aspects of the process of becoming conscious individual participants noticed changes in the way that they behaved that demonstrate an altered perspective. Changes included feeling unsettled and an expressed desire to move on.

EN. I went through an unsettled period at work. It couldn't have been a coincidence that I had just started the course. It must have been seeing different things, seeing different places, seeing how different people worked. It made me start thinking… Nothing else had changed, no one else had changed it was me, I felt that I had changed… when you're bringing up your kids it just becomes a job and you go in and you do the job and you go home. Then all of a sudden you start doing these things and you think 'Oh that's interesting.' You start looking at things and seeing different places, different people and realise that I could bring something to that place.

EN. Since I have started the course I do want to move on. It's a case of I have done that part. Over the years since I have been an enrolled nurse I have enjoyed it but I think the older that you get and the longer that you do the job you feel that you have more to give. And I feel that I am on a mission… I need to try something different.

EN. As an enrolled nurse you can't move on and I don't know, at the end of the day… although I probably will. Actually I feel a bit better now because I know that it is not the end. It could actually be the beginning of something better. I might not move but it is going to give me an option.

EN. I know now that when I finish the course, I don't know when, but I do know that at some point I will move on.

8.6. Becoming self-critical

All of the participants believed that they were becoming more critical of themselves as accountable registered nurses and of their own and others practice. They were conscious of actively reflecting on practice and aware that they were more vocal and questioning.

EN. The AEDL's began to make me look at my working days in a different light… to look at my practice, myself, my patients, my own behaviour and it started a process that there was no stopping and … it was probably the start of becoming more confident and more assertive.

EN. I think before I was just going along and I wasn't really thinking about where I was going… but now that I have started the course I'm not going to do night shift. I want to be more involved with doctors, physios and social workers, that would be interesting. I feel that I have been dead for twelve years… I have enjoyed what I have been doing and it fitted with my family commitment. But now I feel that I would like to be involved in other things.

EN. It probably wouldn't have occurred to me that there could be a better way of doing things, because that was the way that it was done and you didn't really think about why or what you could do to change it. I think probably because of the way that you are writing things, the way that you need to back up what you are doing and you question things more than before. You read a lot more widely than you would do normally.

EN. I have to say that before I started the reflective practice assignment I thought it was a load of rubbish. Since I started the course I see that I do reflect and whereas before I did this I used to think if something goes wrong, I'll not do that again. Now I think well, why did it go wrong… I probably tend to think a bit more about it. I am more conscious of doing it than I was before because I probably did it at a very superficial level whereas now it's deeper.

EN. I feel that when you are working you are constantly analysing… Even on the good days I say that was good and then, what made it good… I don't think I have ever been so aware.

EN. Standing back and looking at myself… 'Why am I doing this?' I will question myself, my practice, try different things and look for alternatives… I started questioning as soon as I got the hang of critical incidents.

EN. For quite a while I just nursed in my own world and never bothered who was doing what around me as long as my patients were fine and I was doing my job the best that I could. Now I am widening out and that is a big change whether it is confidence I don't know, I don't know if I know more.

8.7. Summary

Conscientisation emerged as a theme during the interviews as I became aware of elements of participants' growing consciousness of self-constraint and it drew my attention towards this aspect of change whilst I was reading the transcibed texts. Not all of the participants demonstrated this awareness, however, in those that did, it was often accompanied by some insight into the influence of occupational socialisation and the internalisation of others' attitudes towards enrolled nurses. Individuals' accounts of conscientisation and associated influences stood out because they presented a different perspective of the conversion experience than I had been conscious of previously. I had been aware that individuals' perceptions of self and others had altered as they progressed through the programme, but I had not considered the nature of the alteration or its impact on individuals in any depth. Insight into conscientisation raises awareness

of the potential for professional education to facilitate individual consciousness of hierarchical relations and how they can influence agency. It also emphasises the importance of enabling experienced nurses to become conscious of potential constraints imposed by self and others on the use of discretionary judgement and decision-making derived from experience of practice.

Individuals' consciousness of processes influencing them as enrolled nurses derived from their membership of a subordinate group within a hierarchically structured profession. The main elements of the process of conscientisation included individuals challenging their own assumptions about being an enrolled nurse through critical self-reflection that promoted an awareness of their own values, attitudes and beliefs in relation to professional accountability. Reflection also raised individual awareness of the knowledge and skills derived from experience, which enhanced self-esteem and confidence. As their confidence grew, individuals became conscious of attuning to others' conversations and spontaneously engaging in discussion in ways that they had not done in the past. This was influenced by perceived familiarity with the language and having the confidence to participate in discussion. Furthermore, for some, self-exclusion in the past was perceived to have been influenced by a belief that, as an enrolled nurse, one did not have sufficient knowledge and understanding to contribute meaningfully, nor was it one's place to offer an opinion.

The process of self-consciousness involved realising how occupational socialisation influenced self-perception and positioning and the social construction of the role and positioning of enrolled nurses within the hierarchy of nursing and its historic derivation. It also involved awareness of the internalisation of inferiority from others'

subordinating attitudes towards enrolled nurses. Lack of confidence and uncertainty about capability was perpetuated by a lack of role clarity following grading and influenced what enrolled nurses were perceived to be able to do and over which they had no control. Individual awareness of becoming self-critical and of questioning and analysing thinking and action grew. In some instances individuals were also conscious of challenging others' practice. This was accompanied by recognition that they had not critically questioned themselves and others in the past. Most were aware that they were changing and some identified that they felt unsettled as a result. Others expressed a desire to move on from being an enrolled nurse.

Confrontation by others about self-subordination influenced the development of self-consciousness. Feedback on an individual's successful achievement promoted a sense of equality and legitimate belonging. Participation in the conversion course provided an opportunity for individuals to become familiar with specific knowledge and language that facilitated the ability to converse with others and to participate in discussions with confidence.

Although in the past I had been aware of the benefits of the course in terms of increased self-confidence and self-esteem, I had not been conscious of the importance of conscientisation and awareness of an individual's behaviour on others' responses.

Competence based and outcomes led, curricula that focus on the objective assessment of experience may mean that critical consciousness has been neglected within professional education in nursing. The implications of these findings are that a potential exists to focus deliberately on promoting individual self-consciousness and confidence.

Wenger (1998) suggests that education should be concerned with the opening of possible identities and 'new ways of being.' Professional nurse education then should provide opportunities that promote transformation through critical consciousness that enables individuals to develop insight into the constraints that influence how they perceive themselves and others. Furthermore, in the interests of equality it is important that suppressed individuals and groups are enabled to participate fully within professional practice without constraints that are unnecessary and unjust (Carr and Kemmis 1986). Transformation requires educators to facilitate awareness of self and consciousness of the emergence of other possibilities that are open to an individual without manipulating choice or imposing one's own perspective. Therefore an open and honest relationship between educator and student is essential.

Chapter 9: Discussion, Conclusions and Recommendations

9.1. The context of the study

The particular direction that the professionalisation of nursing has taken in recent years has led to the development of two cultures with differing values and norms of professional behaviour (Salvage 1992). Traditional nursing values are perceived to derive from a position of subservience and include unquestioning obedience and conformity which perpetuates the subordination of the nursing role (Clark, Maben and Jones 1997). New nursing, on the other hand, promotes values of professional autonomy and individual accountability that have implications for the self-regulation of practice (Tiffany and Lutjens 1998). The Strategy for Nursing (SOHD 2001) reflects these values and emphasises the centrality of the nurse-patient relationship and the importance of interprofessional collaboration, client empowerment and the promotion of social justice. According to Salvage (1992) new nursing is required to improve the status of professional caring in order to address issues of recruitment and retention in a competitive labour market. However, difficulties with the assimilation of new and traditional values have created tensions between the two cultures (Salvage 1992, Maben and Clark 1998).

This study examines enrolled nurses' experiences of transition and altered perceptions of self and others as they progress through a conversion course designed to promote reflection and encourage questioning of the values, attitudes and beliefs underpinning practice. It involves an exploration of internal and external forces perceived to facilitate or inhibit change and reflects the nature of professional tensions inherent within the

current cultural transition. Enrolled nurse training was introduced to address a shortfall in recruitment and the development of a qualification for practical nurses was opposed by those seeking professional status (Bendall and Raybould 1969). The recommendation of the Briggs Report (DHSS 1972) for one portal of entry was influenced by a perceived similarity in role, but inequality in status, between enrolled nurses and registered nurses, and led to the demise of enrolled nurse training. Subsequently the enrolled nurse qualification was devalued and the occupational status of enrolled nurses further undermined by the introduction of grading (DHSS 1983). Although opportunities for conversion to first level were available access was problematic (Seccombe et al 1997) and little provision was made for those who did not wish to convert (Webb 2001). Studies report low morale and lack of confidence among enrolled nurses due to role erosion, role ambiguity and lack of job security (McKenzie 1997, Dowsell, Hewson and Millar 1998, Allan and McLafferty 2001, Kenny and Duckett 2005). Many enrolled nurses feel under pressure to convert despite fears about being able to meet academic expectations and stress due to the impact on family life (Dowsell, Hewson and Millar 1998). This chapter explores the key issues that emerged from the findings.

9.2 Being Experienced

All of the study participants perceived themselves to be experienced nurses and from their accounts it was possible to construct a theory of what being and becoming experienced meant to them. It emerged that becoming experienced was a continuous process stimulated by a desire to be competent. A complex mix of internal and external

forces influenced individual perceptions of being able to control the process of becoming experienced.

9.2.1. Being and becoming experienced and traditional nursing values.

Becoming experienced involved a process of familiarisation over a number of years during which repeated exposure to cases and situations led to recognition of what was normal which meant that unusual phenomena stood out. Variety provided breadth of experience, which enhanced self-confidence. Deliberate familiarisation was undertaken where there was uncertainty concerning a client or situation. The process of exposure continued until an individual felt sufficiently familiar to be able to be in control of their own actions, negotiate with others and to take charge of a situation. Participants' accounts of agency nursing (sections 5.2.1. and 5.2.2.) illustrate the process of familiarisation and the influence of variety on self-confidence. Continued exposure until saturation is achieved is demonstrated in the accounts of the theatre nurse and community nurse (section 5.2.3.) both of whom believe that 'hands on' experience is necessary to gain the relevant knowledge and skill to practice. Both of these participants were already experienced and the examples concerned their ability to learn from practice when confronted by a new or different situation.

Participants' accounts of the meaning of being experienced are comparable with Benner's (1984) level of proficiency or expertise in relation to the rapidity with which an experienced nurse identifies and reacts to problems within a familiar situation compared to the slower deliberation of a novice. Recognition of this experience is evident in the endoscopy nurse's account of being asked to participate in situations

where potential complications are expected (section 5.4.2.). Being experienced was influenced by emotional and social factors including respect associated with age, length of service and reputation, for example, being referred to as 'orthopaedics' because it is known that a person has worked in that speciality for a number of years (section 5.4.6.). Knowing the norms of practice within given situations meant knowing what was to be done and how it was to be done and also influenced one's reputation (as demonstrated in other examples in section 5.4.6.). In addition, confidence associated with maturity and being 'established' was perceived to influence an individual's reputation with medical staff (section 5.4.5.). Within a given community being identified as an experienced nurse enabled participation, promoted a sense of belonging and was perceived as being accorded status within the workplace.

Participation contributes to knowledge creation, development of understanding and theory construction. According to Wenger (1998) competence derived from knowledge of practice gained through participation shapes identity, belonging and the ability to influence the meaning of competence. Internal and external forces influence the extent to which an individual can negotiate meaning within a community and therefore influence perceived identity. Enrolled nurses' perceptions of loss of role identity and devaluation of their professional qualification (McKenzie 1997, Dowsell, Hewson and Millar 1998, Allan and McLafferty 2001, Kenny and Duckett 2005) was evident in the tension between participants and newly qualified staff nurses who had little awareness of the history of enrolled nursing and the qualification. Most participants were graded C or D and had remained at that level for twenty years on average and many were no longer involved in the supervision of student nurses or the administration of medicines. This made it difficult for newly qualified staff nurses to appreciate the knowledge and

skills of enrolled nurses. Staff nurses may also have felt insecure about their own level of competence as they struggled with the responsibility of being in charge. Evidence (section 5.6.1.) suggests that some participants perceived newly qualified staff nurses to be inexperienced and expected them to seek guidance.

Being experienced, in terms of knowing what to do and the norms and conventions of practice, is important and in the best interests of clients. However, it is problematic when experience is not recognised or perceived to be valid and where the individual does not have the confidence or feel that they have sufficient authority to speak out. This is demonstrated in one participant's reluctance to 'step on the toes' of the staff nurse when it was clearly in the patient's interest to take action (section 5.6.1.). Furthermore, knowledge of norms and conventions can be conformist and uncritical of others' assumptions, which could be detrimental to clients' interests. Conformist thinking can be narrow and inflexible and unreceptive to other ways of practising. Challenging unquestioned practice requires confidence and a sense of agency, which can be difficult within a hierarchical structure. Enrolled nurses are experienced and have gained important knowledge from experience. However, the traditional culture into which they were socialised may have encouraged uncritical conformity and their occupational standing and loss of status may mean that they do not perceive that they have sufficient authority or confidence to challenge others' practice. However, there was some evidence that participants' perceived the culture to be changing, for example (section 5.5.3.), the perception that nurses are no longer 'just following doctors' orders.'

9.2.2. Devaluation of learning from experience

The academisation of nursing has influenced adoption of the positivistic values and technical rationality of biomedicine whilst at the same time disassociating with non-academic intuition, experiential learning and tacit knowing. Traditional nursing knowledge has become subordinate, and is perceived to be less valuable than the 'dominant forces of knowledge that have developed in fields such as science' (Danaher, Schirato and Webb 2000 p103). The superiority of scientific knowledge over experience-derived learning denies enrolled nurses credit and fails to acknowledge the experience required for skilled professional judgement. Furthermore it undermines the status of caring. Participants' accounts of discrimination and stigmatisation (section 5.6.6.) perceived to be related to lack of academic qualifications illustrate a shift in cultural values towards the superiority of qualification over experience. Perceived academic inadequacy is explored further in the next section.

Participants' perceptions of themselves as experienced nurses are important because they illustrate how nurses create new knowledge and develop relevant skill through learning from practice. Each develops a unique theory of practice that is continuously being refined. It also demonstrates the situated and dynamic nature of competence and factors influencing its meaning within a community of practice. It signifies that enrolled nurses are experienced and demonstrates the potential for individual control of professional development and the impact of imposed restrictions on practice. Fenwick (2001) argues that situated learning could lead to unquestioned acceptance of practice as competent, which would not be in clients' best interests. A critical perspective is necessary to counteract conformism (Barnett 1997, Crotty 1998). Professional nurse

education if it is to be inclusive needs to consider the learning needs of individuals and groups who do not hold academic qualifications and to acknowledge learning derived from experience of participating in practice.

9.3. Academic Credibility

Findings related to this theme illustrate how attribution influenced self-perception and how it altered as participants progressed through the conversion course. The impact of political and professional influences on the accessibility of conversion is considered and the need for course design to acknowledge social, political and attributional influences on self-belief is examined.

9.3.1. Being non-academic

Participants perceived themselves to be practical rather than academic. For some, leaving school at fifteen without qualifications related to a culture in which post-compulsory education was less valued for females than earning and contributing financially due to economic circumstance and a belief that females would marry within a few years of leaving school. Some participants regretted not having had an opportunity to gain qualifications at the time and believed that they could have achieved more had they been encouraged to do so. Enrolled nurse training provided an opportunity to gain a professional qualification without requiring 'O' levels and some participants demonstrated a preference for the shorter, practical nurse training as opposed to theoretical study. These findings, illustrated in section 6.3., highlight the

influence of culture on the perceived value of academic qualifications and career aspiration.

Prior to commencing the course participants doubted their academic ability, which was mainly expressed as anxiety about an inability to 'write academically' (section 6.4.). Fear of failure and public humiliation was influenced by participants' perceptions of their lack of intellectual ability which was compounded by internalised beliefs that enrolled nurses were not as clever or as able as first level nurses. Anxiety was further heightened by fear of being incapable of achieving the academic standard of university level education and the perception that tutors expected that they would be able to do so when they did not have any 'O' levels. As participants progressed through the course, assignment success and constructive feedback from tutors contributed to growth in self-confidence and influenced efficacy beliefs. Perceptions of self as non-academic derived from early socialisation of cultural beliefs and values that were reinforced by a predominantly deficit approach to education focusing on what individuals do not have or are unable to do rather than acknowledging abilities (Tett 2005). Emphasis on academic qualifications undermines self-worth and professional credibility and the internalisation of negative attitudes influences low self-esteem and lack of self-belief.

The move to one level of professional qualification and the emphasis on academic accreditation (UKCC 1986) meant that for most enrolled nurses conversion was the only option if they wished to retain their standing as a qualified nurse. Findings identified several issues related to the application and access to conversion courses and self-doubt about academic ability. These reflect the notion that participation in education is influenced by class and gender and that inequalities are influenced by

meritocratic processes of exclusion that fail to acknowledge underlying reasons for non-participation including self-perception of academic ability and expectation of achievement influenced by early socialisation (Tett 2006). Factors influencing access or delay in applying for conversion included family commitments and perceptions of a mother's role, fear of role transition to first level and having to be interviewed or make a presentation. Lack of motivation and reluctance to convert occurred where participants felt content as a second level nurse (sections 6.5.4. and 6.5.6).

9.3.2. Family responsibility and finance

The main reason given for not having applied for conversion in the past was family commitment. The roles of mother, wife and carer took priority over education and career, which was perceived as self-indulgent. Working as an enrolled nurse often accommodated family commitments through the organisation of shift patterns, in particular doing night duty when the children were young. This was evident in one participants' suggestion that to take an opportunity for herself would mean ignoring the needs of her young children and therefore could not be contemplated (section 6.5.2.). There was also a fear that domestic and childcare arrangements would be affected by increased responsibilities associated with being a first level nurse. Other reasons for not accessing conversion courses earlier included social and financial difficulties especially in relation to the bridging course that preceded the stand alone courses where enrolled nurses had to give up their employment in order to become full-time students. Participants' quotations (section 6.6) highlight the importance of financial constraints on decisions about undertaking conversion. Participants reported that during the conversion course, study meant having to sacrifice time that would have been spent

doing agency nursing or extra shifts resulting in loss of income. Also lack of resources such as having a computer at home made it difficult for some to meet the tutor's request for work to be word-processed which caused anxiety.

9.3.3. Difficulties accessing conversion courses

Following the decision to move to one level of nurse qualification opportunities for enrolled nurses to convert to first level were provided, however, these were often inaccessible. Individuals were deemed responsible for deciding whether or not they took the opportunities but in reality found it difficult to secure the support required from clinical managers and employers. At the same time there were less opportunities for professional development and career progression beyond D grade available to enrolled nurses. No alternatives were available to those who decided that they did not wish to convert (Webb 2001). Some participants reported that their reason for converting was due to the threat of loss of employment and income (section 6.6). In addition, conversion could be stressful and demotivating particularly where there was little support from employers (McKenzie 1997, Dowsell, Hewison and Millar 1998).

External constraints that acted as barriers to conversion included rules and regulations normally imposed locally by colleges of nursing or employers that could be perceived as a means of controlling application to bridging courses. For example, waiting lists, having to apply to one's original training school even although that was geographically impossible, setting an age limit and questioning the nature of experience gained since qualifying (section 6.5.8.). Politically there was little to gain in conversion courses. Enrolled nurses were included in the total numbers of qualified nurses and their

conversion to first level did not increase the overall number. Conversion courses were provided but were often inaccessible although this improved where enrolled nurses could remain in employment whilst undertaking the course which reduced the financial constraint.

Tensions associated with the cultural shift in values were evident in participants' perceptions of changing attitudes and practices. For example the assertiveness and questioning of younger members of staff (section 6.7.1.) were associated with loss of respect for authority and traditional values (6.7.2. and 6.7.3.). The emphasis on academic qualifications was threatening because it undermined experience and further excluded enrolled nurses from professional development and career progression (section 6.7.6.). However there was evidence that participants welcomed the changes and the ability to challenge practice and this increased as they progressed through the course (section 6.7.7. to 6.7.11.).

9.4. Motivation

Illeris's (2004) concept that motivation is inspired by challenge is relevant to the experiences of the study participants. Processes enabled individuals to discover that they already knew something worthwhile, which stimulated self-awareness and boosted self-confidence. Facilitative approaches provided challenging opportunities that enabled self-discovery, for example the challenge of having to organise a clinic whilst on placement. The in depth study similarly challenged individuals to transcend their perceived capabilities within a familiar workplace. What is significant is the requirement for full participation and opportunities to control learning in practice.

Challenge motivated and increased self-efficacy through achievement and learning through reflection on action. Combined with a scaffolded approach it enabled individual development. Greater emphasis on a facilitative approach to learning and a democratic partnership would enable learners to voice concerns and negotiate realistic expectations.

9.4.1. Motivation to undertake conversion.

Prior perceptions of the conversion course included reasons for doing it and expectations of what it would be like. One of the main reasons for undertaking the course was a desire for self-development and self-confidence (sections 7.2.4. and 7.2.5.). Encouragement from previous conversion students and managers boosted self-esteem because participants perceived that it demonstrated others' belief in one's ability to succeed (section 7.2.1.). Observing others' success (section 7.2.2.) was also encouraging especially where the other person was perceived to be the same intellectually. These findings and experience of successful completion of part of the course positively influenced motivation and self-efficacy (Bandura 1986). Expectations of the course varied (section 7.5) and most were uncertain about what to expect. Others did have expectations and what emerged from the findings was a desire to achieve a balance between the positive benefit to self-confidence of successfully meeting challenges and the stress involved in doing so. A complex mixture of internal and external forces influenced this achievement. Finding time to complete the work to the perceived standard expected was difficult and demotivating (section 7.3 and 7.8.3).

9.4.2. Main motivational influences during the conversion course.

Elements of the experience perceived to be most influential included the in depth study, group tutorials, residential workshops and placements all of which involved participation in practice. Emphasis on a positive contribution to practice was an important element of the influence of the in depth study on self-efficacy belief and judgement. Formative aspects of the process involved initial chaos, followed by information gathering and sense-making and knowledge growth (section 7.4.1.). The challenge of implementation (illustrated in section 7.4.2) and the satisfaction of the results both in practice and in successful completion of written work boosted self-confidence (section 7.4.5.). Constructive feedback from tutor counsellors and peer support were perceived to be important motivators during the process. Group tutorials and the residential workshops provided opportunities for sharing fears and concerns with others experiencing the course at the same time (sections 7.5 and 7.6). Placements provided a stimulating variety of experiences and influenced awareness of self-identity and altered perceptions of self and others. Concerns about student identity on placement were related to age, others' expectations, lack of anonymity, acknowledgement of experience and feeling like a pupil nurse (section 7.7.2.). Age-related concerns arose from participants' assumptions that students were young and inexperienced, which they found to be false (section 7.7.1). Some participants reported initially feeling like pupil nurses. Immature behaviour in adult learners returning to study has been reported elsewhere (Illeris 2003). Three aspects of placements that stood out as being particularly important were the element of control over the choice of placement, learning through participation and freedom from responsibility (section 7.7.3.). Having the freedom to select placement experiences and preparing for them meant having to identify what was

perceived to be important and why. Participants found that adopting the role of student could be challenging and was influenced by positive and negative past experiences from their enrolled nurse training or those encountered during the course. By the end of the course participants were aware that they had changed and had become aware of future possibilities and opportunities that had not been available to them in the past as enrolled nurses.

All of the participants perceived that their self-confidence had grown and that they valued themselves more. This was apparent in the ability to speak out when they disagreed, to question their own and others' practice, to manage information and learning and express a desire to continue to learn. Awareness of having greater empathy with student nurses as a result of personal experience during the course placements and the impact on practice were also perceived to have influenced deeper awareness of self and others.

Negative influences included feelings of helplessness and initial inadequacy especially in relation to experiences that were unfamiliar such as using the library (section 7.8.1.), being unable to meet demands by tutors perceived as unrealistic and not feeling in a position to negotiate. Perceived lack of tutor support and expectations that students would be self-directed especially in the initial stages of the course (section 7.8.2.) was potentially demotivating. Participants' perceived inability to negotiate with tutors suggests the existence of a power differential within the relationship.

9.5. Conscientisation

Participants were aware of being marginalised as enrolled nurses but appeared less conscious of internalising negative self-images and the influence of this on self-esteem and the resultant self-depreciation (as demonstrated in section 8.2.). Growth in self-confidence and efficacy was related to processes influencing self-affirmation including critical reflection and opportunities to compare one's own situation with others whilst on placements and at tutorials and residential workshops. Lack of consciousness of self-depreciation can influence learning where a passive and subordinate role is assumed that prevents full participation in learning. Awareness of internal influences on learning and processes that can facilitate transformation enables educators to design experiences that promote self-discovery.

9.5.1. Role of critical reflection in self-esteem and efficacy.

Achievement of something previously believed impossible boosted self-esteem and confidence, and was enhanced by critical self-reflection and self-appraisal. Awareness of self-depreciation and self-exclusion from practice influenced by the belief that one is not able or worthy of participation, emerged through self-reflection (demonstrated in section 8.2.). Besides demonstrating internalisation of negative perceptions of the status and lack of importance of enrolled nurses, referring to self as 'only an enrolled nurse' was perceived by participants to be used at times to avoid first level responsibility. The futility of an 'enrolled nurse mentality' was also perceived to derive from internalisation of others' negative perceptions of enrolled nurse status and credibility and involved being deliberately unhelpful and obstructive. Self-doubt regarding decision-making was

linked to general uncertainty concerning what enrolled nurses should be allowed to do (section 8.2 provides examples). As participants progressed through the course they became aware of attuning to and spontaneously participating in others' conversations which they had not done in the past (demonstrated in section 8.3.). Recognition of language and confidence derived from knowledge of what was being discussed were perceived to enable participation in practice in ways that they had not felt able to previously. Feelings of equality with others and being on a par with first level nurses also influenced participation, attributed to assessment success and positive feedback by a participant in section 8.3. Participants became aware of the effect of their own behaviour on the way that others responded to them particularly where they lacked confidence and or assertiveness (section 8.3). For some the transition to first level involved becoming unsettled with the familiarity of their everyday routine and a growing desire to move on emerged from the realisation that they now had the option to do so (section 8.5.).

Findings demonstrate the importance of critical self-reflection in the development of self-consciousness and the recognition that inequality was influenced by perceptions of self and others. This is illustrated in perceptions of enrolled nurse identity in section 8.2. and 8.3. Processes promoting self-acknowledgement and validation also encouraged positive self-perception and the self-confidence to speak out and to recognise that doing so can make a difference as the example in section 8.4. demonstrates.

9.6 Further discussion of issues

9.6.1. Altered perceptions

The findings support the assumption that enrolled nurses' perceptions of self and others do alter as they progress through the conversion course. Examples in sections 8.2. and 8.6. demonstrate that there was a change from self-depreciation to self-confidence and positive self-esteem in relation to professional knowledge, practice and academic ability. Subordination is less evident in participants' perceptions of being able to speak out, voice opinions and challenge practices. Undoubtedly progression and the successful achievement of goals that in the past were perceived as impossible influenced belief in personal ability and credibility as a legitimate professional according to current values and standards (section 8.3.). There is also a suggestion in the findings that the process of conversion can contribute positively to a change in self-perception through acknowledgement of experience and promotion of academic skill supported by a scaffolded approach to learning (for example the in depth study section 7.4.3.). However, findings also highlight less enhancing influences and enable further critical examination of the educational processes involved in conversion (for example superficial learning section 7.8.5.).

9.6.2. Professional nurse education

What is demonstrated is that there is a different way of learning about professional practice than through those currently valued and formally validated by professional education in nursing. Differences could be attributed to those between positivistic and

constructionist epistemologies. Academisation and the scientism accompanying professionalisation support the ideal of objective truth, which is reinforced by a desire for evidence-based practice and competence-based outcomes that fragment the realities of professional practice and perpetuate theory-practice separation (Eraut 1994). Whilst research evidence and propositional knowledge are essential components of professional judgement in clinical practice, they should not be regarded as superior to learning from experience. It is important to recognise the value of experiential learning, intuition and tacit knowing in professional competence.

Barnett (1994) suggests that in order to understand concepts it is necessary to get inside them and live them from one's own perspective. Changes in understanding are individual and learning cannot be predicted. Tacit knowing is personal knowledge derived from experience and is so deeply layered that it is not normally expressed. However, it shapes what is learned and influences how phenomena are interpreted and understood. Barnett believes that one of the main aims of educators should be to 'help students become aware of the understanding that they possess but of which they are unaware.' (Barnett 1994 p.108). This can be achieved through facilitating reflection on and validation of understanding through dialogue with others that promotes the discovery that one already has knowledge that is worthwhile. Furthermore this can influence the development of a sense of self-control and recognition of self-agency. By contrast, competence outcomes atomise experience and separate subject from object and therefore cannot support learning for understanding.

Current values within professional nurse education marginalise learning that derives from experience of the realities of caring. The focus on developing nursing as an

academic profession has promoted the development of degree qualifications and technical aspects of medical diagnosis at the expense of the professional development of those actually caring for patients. The current drive of professionalisation is not possible without those who provide care to clients and there is a need to address the validity of learning from experience within nursing and the contribution that it makes to client care. Furthermore, new nursing is in danger of accepting academic conventions that could be equally conformist and could exclude those who are experienced from acting in the best interests of clients. Whilst the conversion course does appear to meet the needs of the profession and enrolled nurses to some extent, accessibility could be improved by focusing on educators' intentions and critical examination of the extent to which knowledge construction from experience is actively facilitated without commodification. This would include assessing the extent to which prescriptive and pre-determined outcome approaches to learning detract from self-discovery and agency.

Enrolled nurses are being stigmatised because academic accreditation and qualifications are valued over experience of practice (section 5.6.6.). Academic values demonstrate achievement of the standing of nursing as a profession but distance it from what is perceived to be non-academic learning, which could be interpreted as devaluing practice by regarding it as undeserving of professional qualification. If, as claimed (Salvage 1992), professional education is an instrument of change it has a responsibility to meet the needs of all professionals and the clients whose interests they serve. Opportunities for education and professional development must be realistically accessible and therefore need to take into account physical, psychological, social and economic factors influencing individual ability to participate. Greater emphasis on processes that best accommodate learning needs is necessary to ensure that participants in education have a

choice based on realistic opportunities. Many enrolled nurses still wish to convert and opportunities that address their specific access needs should be available. Employers and educators must be made aware of what influences learning in order that they can understand the reasons why some choose not to participate and the fears associated with unrealistic expectations. Opportunities for professional development must also be provided for those who do not wish to convert with greater emphasis upon the value of the role of the enrolled nurse as advocated by Webb (2001). It is important to prevent feelings of failure and stigmatisation through non-participation.

9.7. Learning through social participation

Emphasis on principles of participation in social practice would be relevant to curriculum development in professional nurse education. Wenger (1998) assumes that learning derives from the experience of engaging in practice and is affected by internal and external forces influencing interpretation of actions and their meaning. Participating in practice 'shapes not only what we do but also who we are and how we interpret what we do' (Wenger 1998, p4). Social competence requires knowledge of what is valued within a given community and one comes to know this through socialisation. A community can positively or negatively influence meanings and cultural transition. Influencing factors include institutional norms and values and issues of gender and hierarchy. Learning through participation in practice acknowledges what individuals know and the skills that they demonstrate and facilitates learning through reflection.

The conversion course claims to focus on individual strengths rather than deficiencies. For example assignments should be driven by the motivation of the learner to contribute

to practice rather than governed by external prescription and academic convention. However, the extent to which this occurs is dependent on the ability of the learner to negotiate experiences and influence and control participation. Greater awareness of the existence of a potential power differential between learner and tutor and the promotion of equality within a learning partnership would enhance learners' control and ability to negotiate. A clearer focus on the value of learning through participation and the importance of contextual influences on practice could be promoted through critical reflection. For example, the in depth study is pivotal in its influence on developing critical thinking and the transition from intuitive practice to the process of deliberation that is important in professional judgement (Eraut 1994) (sections 7.4.1.-7.4.3.). Placements provide opportunities for the discovery of future possibilities and create a potential for moving on (sections 7.7.1.-7.7.6.). The promotion of critical self-reflection encourages challenging unquestioned assumptions and facilitates awareness of self-depreciation and self-worth (sections 7.9.-7.12.). Design of a conversion curriculum must take into account the personal and professional commitments that influence learning including perceptions of self as non-academic and lacking ability. Lack of previous experience of higher education and the influence on self-perception in terms of the level of academic work expected must also be considered. Family and work commitments and the financial pressures associated with undertaking the course must be taken into account (section 6.5.). There is a need to confront internal constraints and challenge external ones.

Minimising barriers to participation involves tutors attuning to learners' motivations and the nature of internal and external influences and constraints. At the same time tutors should be aware of the need to challenge their own assumptions and to adopt a

facilitative approach that promotes involvement in a democratic learning partnership and acknowledges and respects learners' experience. Facilitating learning through participation involves enabling individuals to engage in their own personal development process by taking initiatives and actions that are stimulated by their own thinking and deliberation and over which they can exert effective control (Keregro 1989). Awareness of learners' self-perceptions of inferiority and processes that have influenced internalisation of negative self-image and enabling them to voice concerns and negotiate realistic expectations will deter passive conformity. Critical awareness of one's own assumptions of power and control and a deficit perspective and the need to acknowledge ability and enable participation is essential (Tett and Crowther 1998).

9.8. Recommendations

There are two main recommendations arising from the findings of the study:

1. The provision of a conversion course that is accessible to enrolled nurses and that acknowledges their experience and promotes self-validation.
2. The development of a facilitative approach to learning for professional development.

9.8.1. Provision of an accessible conversion course that acknowledges experience and promotes self-validation

The study findings demonstrate the relevance of experiential learning for enrolled nurses that focuses on making explicit tacit knowing and the assumptions that influence professional judgement. Participants' accounts illustrated that they continuously learn

from exposure to situations, create new knowledge and develop personal theories of practice. It is recommended that the professional development of this group of nurses focus on acknowledgement of the validity of their experience and approach to learning and enables conscious control of the learning process. The assumptions underlying this recommendation need to be made explicit and the implications at each level of political, professional, higher education institution and educator must be considered.

The recommended approach rests on the assumptions that the emergent nature of situated learning is relevant to the uncertainty of professional practice (Schon 1983) and that there is a need to promote consciousness of layered perspectives and the development of agency through critical reflection (Barnett 1997, Crotty 1998). This approach is not consistent with the outcomes-based, competency principle to develop critical thinking and practical skill recommended by the Peach Committee (UKCC 1999) to address perceived deficiencies in the practical skills of newly qualified nurses. The approach to learning recommended in this study focuses specifically on the professional development of experienced enrolled nurses. However, it is consistent with the Peach recommendation that programmes leading to professional registration in nursing need to acknowledge and accredit prior experience and be sufficiently flexible in order to recognise the diverse needs of 'students entering nursing and midwifery' (UKCC 1999, p. 3). The recommendation of this study is that acknowledgement of experience should not be deficit in nature but should promote self-validation and the unity of theory and practice.

The recommendation for the development of critical consciousness is based on the assumption that self-agency is a requirement of professional practice if clients' best

interests are to be met. I would contend that this differs from the professional autonomy proposed within the strategy for nursing (SOHD 2001) which is ambiguous and could relate to a freedom of clinical judgement more relevant to the role of specialist practitioners practising at the increasingly blurred professional boundary between nursing and medicine. Agency enables experienced nurses to speak out and to participate fully within the community of practice by contributing to the negotiation of the meaning of competence (Wenger 1998). Learning through participation in practice at a level that acknowledges individual experience challenges the assumption that enrolled nurses undertaking conversion courses require continuous supervision by a first level nurse (NMC 2004). There is a need to demonstrate the competences overtaken by experienced nurses compared to newly qualified staff nurses. The AEDL process used within the current conversion course was originally designed for this purpose (Stillie and McQueeney 1990) however, those involved must question their assumptions regarding the focus of the process if unnecessary commodification is to be avoided.

Within the higher education institution there is a need to negotiate flexibility of regulatory systems particularly in relation to modularisation and its influence on assessment schedules and progression. This should enable learners to develop at their own pace and to manage the competing demands of work and family without being penalised.

9.8.2. Development of a facilitative approach to learning for professional development.

The value of reflection in the development of critical consciousness and an agentic perspective (Bandura 2001) is demonstrated by the study findings. It is incumbent upon professional educators to facilitate this development through curriculum design and also within their individual educational perspective. There is a need to develop a balance between providing structured support and promoting self-control of learning based on individual needs and to recognise the ease with which learners will adopt a familiar passive role. Development of a democratic partnership that defines the role of each participant and acknowledges equality within the relationship is recommended. However, it can be difficult for educators to relinquish the control implicit within a pedagogy that is dominated by reduction of the complexity of practice to discrete elements and pre-determined outcomes. Commitment to learning as an emergent process requires an understanding of the processes involved and factors influencing facilitation and a willingness to engage in constant questioning of pedagogical intention. A team approach would provide support for the continual development of a facilitative approach to learning.

To promote facilitation it is necessary to raise the awareness of educators to the study findings and, in particular, to the importance of the influence of critical reflection on the development of self-agency. There is also a need to acknowledge the value of learning through participation in practice. Facilitation can enable learning and the building of experience through critical reflection and assists learners to learn for themselves (Criticos 1989). This requires an understanding of a learner's 'personal stance' (Salmon

1989, p. 231) and it is important that educators consider this aspect of experiential learning. Study participants highlighted the importance of the constructive feedback received from tutors who are currently involved in the course. However, some participants were anxious that they were unable to meet perceived expectations of tutors, for example that they should teach themselves (section 7.8.3.). There is a danger that educators believe that they are facilitating learning but assume a dominant position of expert within the partnership. There is a need for a commitment to a democratic partnership and for educators to challenge the potential power that they can have over learners. There is also a need for facilitators to 'deconstruct the teacher as expert' (Weil and McGill 1989, p. 243), to attune to learners' perspectives and to learn from the learners.

> Facilitators can play a key role in enabling learners to reflect critically on their experience, to explore different perspectives in serving as an important source of and guide towards knowledge and information and to consider how knowledge is rooted in personal and social circumstances. (McGill and Weil 1989, p. 248).

Educators should participate in experiential learning through critical reflection on their interactions with learners, the nature of the dialogue and the extent to which a learning partnership is democratic. A secure environment for educators to engage in critical reflection and peer-group debate on issues surrounding facilitation is important for the development of professional practice. A commitment to a continual critique of the constraints of one's own perspective should influence consciousness of learners' perceptions (Barnett 1994).

9.9. Final remarks

Acknowledgement of experience and equality of status for enrolled nurses with first level nurses employed at the same grade would improve working relations and safe practice. However, questioning practice within a hierarchical structure requires self-confidence and agency. Participants' perceptions of themselves and others altered as they progressed through the conversion course. They developed self-confidence, enhanced self-esteem and an agentic perspective that enabled them to challenge their own and others assumptions about practice. Prior to commencing the course participants had perceived themselves to be non-academic, but experienced practical nurses. During the course their experience was acknowledged as valid and valued and learning through critical reflection on participation in practice was promoted. This process enabled participants to perceive possible opportunities for future progression and stimulated consciousness of self-depreciation. The study has demonstrated the potential for professional education to act as an agent of change and to promote cultural transition and the validity of experiential learning in the development of deliberative thinking and critical awareness.

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APPENDIX 1

Sample Interview Schedule

Enrolled Nurses' Perceptions of the Experience of Conversion to First Level Registration

Participant: A1/ __ __ __ __ __ __ / __

Pre-amble

Thank you for agreeing to participate in the study. This is the first of three interviews that we will have over the next year and, as we discussed, I'm interested in how you see yourself as a nurse and the way you feel about what you do. During this interview I'd like to examine four main areas:

- *Your past experiences*

- *Your current nursing job*

- *How you feel about the course*

- *And how you see yourself as a practitioner.*

Let's start with the past…

Past Experiences
Why did you decide to become a nurse?

What influenced your decision to do pupil nurse training?

How do you feel now about what happened? Why is that?

Checklist

What is the individual's perception of their decision to become a nurse and to undertake enrolled nurse training?

How much control did they feel that they had over the decision and why?

For example: To what extent were they aware of the differences between the two types of training?

Have their perceptions of what happened altered in any way?

If so how have they changed and why?

How do you feel about being an enrolled nurse?

Why is that?

How has the role of the enrolled nurse changed since you qualified?

Why is that? How do you feel about that?

What experiences of change have you had?

Checklist

How does the individual feel about being an enrolled nurse and why do they feel that way?

How do they feel about the position of enrolled nurses now?

How have their experiences contributed to their views?

Current Experience
Now I'd like to focus on your current nursing job.
Where do you work?

What's it like working there?

What do you do?

What are the staff like to work with?

Checklist

What is the individual's perception of their workplace?

How do they define their workplace and the work that they do?

How do they perceive relations with others: nurses, doctors, healthcare assistants, other

disciplines, patients?

How do they perceive others relate?

As an enrolled nurse how well do you feel that you fit in as a member of staff?

Why is that?

Checklist

To what extent does the individual feel that they belong to their own workplace and

how is this conveyed?

If they don't feel that they belong why is this and how do they feel about it?

Experience of the Course
Now let's consider how you feel about the course.
Why do you want to do the course?

Checklist

What is the individual's perception of the course?

What do you think it will be like?

Checklist

What are their expectations of the course?

Reflective Practice
Now I'd like you to tell me about your practice.
What do you think about when you're actually doing your work?

How do you know what to do in each situation?

How do you feel about your practice?

Why is that?

How much influence do you feel you have over decisions that affect your practice?

Why is that?

In your clinical area how skilled do you feel as a practitioner?

Why is that?

Are there ever any times when you don't feel confident?

Why is that?

How much do you think you have benefited from experience?

Why is that?

Have you ever challenged someone about his or her practice? What happened?

Have you heard of the term "reflective practice"?

What does the term mean to you?

Checklist

To what extent is the individual aware of changes in their thinking and actions?

Is there anything else that you would like to ask me?

Thank you very much for your time. That was most interesting and very useful.