An Examination of Children's Nurse Mentor Experiences of Undertaking Assessments at Sign-off Stage

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Thesis submitted in partial fulfilment of the requirements of the Degree of Professional Doctorate (Health and Social Care)

November 2014

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ACKNOWLEDGEMENTS

GLOSSARY
TERMS AND ABBREVIATIONS

AEI: Approved Educational Institutions (AEIs) must meet the NMC standards and requirements for nursing and midwifery programmes

DH UK: Department of Health (England)

ENB: English National Board for Nursing, Midwifery and Health Visiting

HEI: Higher Education Institution

MDT: Multi-Disciplinary Team

NHS: National Health Service

NMC: Nursing and Midwifery Council

PLSS   Practice Learning Support System. A regional data base used for maintaining a local mentor database and support student learning and placement allocation.

SOM(s):   Sign-off Mentor(s)

UKCC: United Kingdom Central Council for Nursing, Midwifery and Health

Explanation of NMC Terms used:

The following are adapted from NMC Glossary of Terms www.nmc.ac.uk/glossary accessed 30/11/13)

Annotated: This refers to a person who is registered as a sign-off mentor on a local mentor's register. This gives them the authority to approve (sign-off) a student's proficiency at the end of a programme.

Competence: This considers the nurse's levels of competence as a whole. It combines the skills, knowledge and attitudes, values and technical abilities that underpin safe and effective nursing practice and interventions.

Competencies: The various competencies are achieved in stages throughout periods of practice experience during a programme. At the end of the final period of practice experience, or supervised practice, sign-off mentors or practice teachers will use the evidence of achievement of all competencies to decide whether the student is competent to practise as a nurse.

Competency: The knowledge, skills and attitudes required by a nurse at the point of registration. A competency describes the nurse's skills and abilities to practise safely and effectively without the need for direct supervision.

Due regard: This term relates to student assessment in pre-registration nursing programmes. If 'due regard' is required (at sign-off assessment points) the mentor must be registered and working in the same field of practice as the student intends to enter (for example Children's nursing).

ENB: English National Board was established in 1983 the main functions were to monitor the quality of nursing and midwifery education courses, and to maintain the training records of students on these courses. Abolished in 2002 with establishment of the Nursing and Midwifery Council (NMC)

Field competency: This relates to the knowledge, skills and attitudes required for a specific field of nursing. These support the development of learning outcomes that will allow the student to demonstrate basic and more complex skills within each field of nursing.

Field of nursing practice: This relates to adult, mental health, learning disabilities and children's nursing.

Fitness for practice: This shows that the student is able to practise safely and effectively without supervision. It also shows that they have met the standards for competence and all other requirements for registration.

Fitness to practise: Relates to an individual who has the health and character, as well as the necessary skills and knowledge to do their job safely and effectively. The NMC

(2010a) Standards for pre-registration nursing education, London: Nursing and Midwifery Council.

Generic competency: Relates to the knowledge, skills and attitudes required for all nurses regardless of which field they are studying. Generic competencies together with the field specific competencies support the development of learning outcomes that will enable the nurse to demonstrate the basic and more complex skills for each field of nursing.

Mentor: a registrant who, following successful completion of an NMC approved mentor preparation programme (or comparable preparation that has been accredited as meeting the NMC mentor requirements), has achieved the knowledge, skills and competence required to meet the defined outcomes. The NMC (2008b) Standards to support learning and assessment in practice, London: Nursing and Midwifery Council.

NMC: The UK Nursing and Midwifery Council (NMC) established in 2002 is the professional regulator for nurses and midwives and their role is to safeguard the health and wellbeing of the public. Their remit is set out in the Nursing and Midwifery Order 2001 (NMC, 2011).

Pre-registration: This term is used to describe the education programme that students take in order to become a registered nurse or midwife. Students can apply for registration with the NMC after they have completed a pre-registration programme successfully.

Pre-registration nursing student: The term 'pre-registration nursing education' describes the programme that a nursing student in the United Kingdom undertakes in order to acquire the competencies needed to meet the criteria for registration with the NMC.

Proficiencies: These relate to the criteria that nursing students must meet in order to successfully complete their programme and apply for registration with the NMC (NMC, 2004). In the new standards for nurse education, the term competency is used instead of proficiency.

Requirements: The NMC sets the standards and requirements for UK nursing and midwifery programmes. Programmes provided by Approved Educational Institutions (AEIs) must meet the NMC standards and requirements for nursing and midwifery programmes.

Sign-off Mentor: This refers to a person who is registered as a sign-off mentor on a local mentor register. This gives them the authority to approve (sign-off) a student's competence/competency/proficiency at the end of a programme.

UKCC: Established in 1983 the United Kingdom Central Council for Nurses Midwives and Health Visitors (UKCC) with core functions to maintain a register of UK nurses, midwives and health visitors, provide guidance to registrants, and manage professional misconduct complaints. The UKCC was replaced in April 2002, by the NMC.

Abstract

The thesis presents an examination of children's nurse mentor experience of undertaking assessments at sign-off stage. There is a need to determine student nurse competence and competencies throughout preparatory training and pre-registration nursing students are supported by mentors or other suitably prepared supervisors (NMC, 2006; 2008a). Sign-off mentors (SOMs) were introduced by the Nursing and Midwifery Council (NMC) in order to strengthen mentorship. In the nursing profession, SOMs support and assess students who are undertaking their final practice learning experience to confirm the student nurse as either having achieved, or not, the practice requirements necessary in order to enter the professional register (NMC, 2008a, 2010a; 2010b).

The area of nurse SOM experiences in the assessment of pre-registration students at the end of the nurse training programme has received little attention. Using an interpretivist, qualitative, case study research approach the experiences of twelve children's nurse sign-off mentors in the North West of England have been explored and analysed. Data was collected from individual and focus group interviews and analysed using thematic analysis.

The study identified six key themes which were: professional responsibility and development; expectations of students undertaking their final practice learning experience; previous mentor decisions; the need for sign-off mentor support following difficult decisions; experiences of passing and failing students and the physical impact of undertaking the sign-off mentor role. Findings from this study provide new insight and understanding of children's nurse SOM experiences. There was no evidence children's nurse sign-off mentors were failing to fail students.

This study is important to those interested in the assessment of student competency including: mentors and sign-off mentors, employers, educators, patients, policy makers and researchers.

Keywords: Children's nursing, sign-off mentor(s) experiences, pre-registration nursing, competency, student nurse assessment.

CHAPTER 1: INDRODUCTION

Introduction

The thesis presents an examination of children's nurse sign-off mentor experiences undertaking assessment of student nurses at sign-off stage. This chapter will focus on the introduction and background relating to the research topic and is divided into four parts: Research focus and background; Research question and study objectives; Situating the researcher and professional journey and layout and structure of the thesis. A summary draws together the content of this first chapter.

Part 1: Research focus and background

Sign-off mentors

The focus of this study is the interpretation of the experiences of the children's nurse sign-off mentor (SOM). There is a need to determine student nurse competence and competencies throughout their training in health and social care settings. It is a requirement that students on Nursing and Midwifery Council (NMC) approved pre-registration nursing education programmes, which leads to a student gaining registration on the nurses' part of the register, must be supported and assessed by mentors throughout their nurse training (NMC, 2006, 2008a). An NMC mentor is

> 'a *registrant who, following successful completion of an NMC approved mentor preparation programme – or comparable preparation that has been accredited by an Approved Educational Institution (AEI) as meeting the NMC mentor requirements – has achieved the knowledge, skills and competence to meet the defined outcomes'* (NMC, 2006, p.16).

Context of sign-off mentor role and background

From September 2007, SOM assessments have been a requirement for students commencing NMC approved programmes (NMC, 2006). The SOM role was introduced by the NMC in order to strengthen mentorship and requires experienced nurse mentors to have undergone additional training and supervision (NMC, 2006, 2008a, 2010b). The

NMC framework for learning and assessment in practice consolidates the additional role of SOM who confirms a candidate's fitness to practise in their final placement (NMC, 2008a; 2010b). Thus, at the end of pre-registration nurse training a SOM has the responsibility to '*sign-off*' a student nurse as either having achieved, or not, the practice requirements necessary in order to enter the nursing register (NMC, 2008a, 2010a; 2010b). At the sign-off point '*due regard*' is also required, which means the SOM must be registered and '*working in the same field of practice*' as that which the student intends to enter (NMC, 2008a, 2010b).

There is a need of the Department of Health (DH) and a requirement of the NMC professional body that pre-registration student nurses meet the standards required to be entered onto the NMC register and practice as a registered nurse (DH, 2007, 2009, 2010: NMC, 2004a, 2008b, 2010a). Additionally, the general public also assume and expect a nurse at the point of registration to have the skills and knowledge required to be able to fully undertake the role expected of the professional nurse, a view which appears to have remained unchanged over the past decades (Eraut, 1994; Lauder, 2004; Calman, 2006; International Council Nursing - ICN, 2006; Shanley, 2011; Garside & Nhemachena, 2013). However, there remain on-going concerns and debates within the literature regarding health professionals who should not have been able to enter onto a professional register (The Allitt Inquiry, 1991; DH & Home Office, 2003; Shipman Inquiry, 2005; BBC, 2009; Care Quality Commission, 2009; Gainsbury, 2010a, 2010b; The Francis Report, 2013). Thus, provision of good effective decisions by SOMs are paramount in order to ensure that a student nurse is knowledgeable, safe and fit for practice and award on successful completion of their training so at the point of registration so that protection of the public is assured (DH, 2007; 2009, 2010; NMC 2008b).

The study does not involve midwifery mentors as they have differences in the requirements for the assessment of student midwives' practice (NMC, 2008a, 2010b; Fisher, 2009; Barker et al., 2011; Rooke, 2013). Similarly, other health and social care professions have different mentor requirements (Okere & Naim, 2001; MacDonald, 2004; Lewis, Stiller & Hardy, 2008; Finch, 2009). Whilst it is acknowledged that a number of pre-registration student nurse support roles exist globally they are different (O' Connor, et al. 1995; Bourbonnais & Kerr, 2007; Carlson et. al 2007; Lauder et al. 2008; Thorkilden & Raholm, 2010; Tateishi et al. 2013; Kajander-Unkuri, et al. 2013).

This study concentrates specifically on children's nurse SOM experiences in England (UK) as this is the author's own field of practice and area of interest.

Assessment is routinely used to assess a student's performance within professional programmes. In pre-registration nurse education, a student nurse must fulfil theoretical, clinical and professional criteria set by the NMC. Nursing students spend approximately 50% of their time (2,300 hours) out in clinical practice learning settings undertaking a series of practice placements to facilitate their achievement of competencies and range of nursing skills required to be achieved over three years (NMC 2004a, 2010a). During this time in practice learning settings, a student nurse has supernumerary status, but they do nevertheless contribute to the care of patients/clients, under the supervision of qualified nurses or other suitably qualified professionals, in particular those prepared as mentors (NMC, 2006, 2008a). The outcome of both theory and practice based assessments inform the decision about a student's suitability to continue and/or complete the programme.

The NHS in England commissions over 20,000 student nurse and midwifery places each year. Over a three year period approximately 50,000 students are undertaking their pre-registration nursing education (Prime Minister's Commission, 2010). Student nurses encounter approximately two to three mentors a year and are supported by a SOM on their final practice placement (NMC, 2008a, 2010b). Whilst mentors and SOM names are listed on locally held registers (NMC, 2008a, Walsh, 2011), overall national numbers of mentors are unavailable. However, it is estimated that the total cost of the pre-registration education is almost £1 billion (Prime Minister's Commission, 2010) and thus exploring the experiences of sign-off mentors in terms of mentoring student nurses has potentially significant financial implications.

There is an abundance of research which has explored many aspects of mentorship and mentors. However, the area of nurse mentor experiences in the assessment of pre-registration students towards the end of the pre-registration nurse training programme has received little attention (Carlson, Kotze & Van Rooyen, 2005; Bourbonnais & Kerr, 2007; Middleton & Duffy, 2009; Black, 2011). There remain many unanswered questions, gaps, and inconsistencies in the evidence base and importantly, there was no literature relating to children's nurse SOM experiences during the undertaking of this study. This thesis therefore builds on and contributes to work in the field of mentor

assessment, especially children's nurse SOM experiences of undertaking the assessment of pre-registration student nurses in clinical practice learning settings.

Part 2: Research study aim and questions

The idea for the research study arose out of wonder as to the experiences of children's nurse SOMs in relation to their role when undertaking assessment to determine if a student nurse is ready or not, to enter the professional nurse register and implications relating to that. Unable to find insights in personal practice led to the relevant literature being reviewed, yet still no conclusions could be drawn and hence this study was conceived. Research is undertaken in order to generate new knowledge about a little understood phenomenon (Creswell, 2003). According to Thomas (2011, p.29) '*It is the research question that leads you in the direction you need to go*' and so the lack of evidence from the literature informed both the research aim and questions.

Research aim:
To examine children's nurse mentor experiences of undertaking assessment at sign-off stage, in order to gain an in-depth understanding of the experience from the perspective of the SOMs who undertake the assessment.

Research questions:
1. What are children's nurse SOM experiences of assessing student nurse competency at sign-off stage?
2. How do they interpret and describe their experience?
3. What are the factors that influence children's nurse SOMs in their final sign-off assessment of children's nursing students?
4. What are children's nurse SOM views as to how they decide if a student nurse is ready and indeed decisions to pass/fail students?

NB: From here on, the terms 'SOM' and 'SOMs' refer specifically to children's nurse SOM unless otherwise stated.

To answer the research questions a qualitative case study research approach was considered the most appropriate way forward (see Chapter 4 Methodology). A case study approach (Yin, 2003, Yin, 2009) allowed immersion in the SOM experience in order to gain an understanding of their perspective. The approach enabled the gathering of rich data (Yin, 2009, Thomas, 2011) so that an understanding of the SOM experiences emerged in order to identify what can be learnt from these experiences.

The case study research was conducted within the context of children's nursing practice learning settings, in the North West of England. The practice learning circuit focused on in the study provides placements for up to 1,100 student nurses with up to 220 of these students undertaking children's nursing or children's nursing and social work. All SOMs are registered onto the local mentor(s) register (NMC, 2008a, 2010b) and within the region this research study was undertaken this local register is held within the practice learning support system (PLSS) database.

Part 3: Situating the researcher and professional journey

As is commensurate with qualitative methodologies, the remainder of the thesis is written in the first person. The research was undertaken in the Faculty of Health and Social Care (FoHSC) within a University in the North West of England and is my employing organisation. Therefore, it is necessary to reflect on the starting point for this study, and the influence of my own professional experience. Although challenges of insider research have been discussed in the literature (Mercer, 2007), crucially in case study research, a researcher's insider knowledge and understanding is viewed as important and necessary to gain an in-depth understanding (Thomas, 2011). Additionally, in professional doctorate studies, reflection is viewed as fundamental (Smith, 2012) and was seen as essential in order to provide context to the study.

Interest in the research topic arises from my experience both as a nurse and nurse educator. I am a Registered Nurse for Sick Children (RSCN), Registered General Nurse (RGN) and an Enrolled Nurse (EN). In 2001 after many years in clinical practice I moved into nurse education. Thus I have been involved with nurse education, standards, mentors and student nurses almost on a daily basis for over thirteen years. During my own professional journey there are markers which have influenced values and beliefs and

which may impact on the way that research is conducted , however, when undertaking research a researchers personal experience should not be viewed as negative (Hellawell, 2006; Humphrey, 2012).

Professional journey

In 1979 a place was offered to undergo pre-registration training for State Enrolled Nursing – a popular, practical based two year nursing course. At this time an *'apprenticeship model of nursing education'* existed where student nurses were employed to undertake a two or three year course by National Health Service (NHS) hospitals and nurse training/education delivered mainly through schools of nursing located within each hospital (UKCC, 1986). The state enrolled nurse training course required no formal academic entry qualifications and thus was considered to be a less academic course. Nonetheless, students had to demonstrate all the other essential qualities necessary to become a nurse such as competence, compassion, kindness, caring and practical skills.

At this time nursing students were regularly supported and assessed by clinical nurse tutors (essentially experienced registered nurses) based in schools of nursing and also registered and enrolled nurses in practice learning settings. The emphasis was on developing the breadth of knowledge and clinical skills required to undertake the role of a nurse under the guidance and support of an experienced nurse. Nurses 'intuition' or 'just knowing' something was right or wrong with a patient were viewed as key qualities that nurses developed through experience (Carper, 1978; Benner & Tanner, 1987). Whilst mentor and mentorship relationships were not formally used at that time, similar relationships did occur as a student nurse would be assigned to work under the direction of an experienced nurse. As Carroll (2004) concludes, mentorship occurs where a *'respected and seasoned person engages with a more novice person to ensure success of the novice' (*Carroll, 2004, p.318*),* this vision seems to have been upheld by the NMC, especially when support of the mentor role has been further reinforced with the introduction of SOMs.

Towards the end of my second year of training whilst undertaking a paediatric clinical placement experience, a young child who had been involved in a road traffic accident

was admitted with a life threatening head injury. Assigned to care for this little boy each day for the rest of an eight week placement was a positive nursing and emotional experience. On the final day of placement a handwritten report was handed over to me to read and sign which stated '...The pupil nurse has progressed well and has passed both her total patient care assessment and drug round. However, she has found it difficult not to become emotionally involved with the children and thus found working on the children's ward upsetting at times. It may be better that she not seek to work on a children's ward when she qualifies'. This assessment was important as it influenced my professional career pathway and choices for a significant number of years.

Post qualification a position within adult medicine was secured. A year later, an impulsive decision was made to apply to join the Queen Alexandra's Royal Army Nursing Corps (QARANC). Returning to the UK five years later, a short time was spent working as a nurse in an adult hospital ward before seeking new opportunities and accepting a post in a busy military hospital in the Middle East. This allowed for a range of new professional and cultural experiences. One day, all of the registered nurses suddenly resigned from their positions on the busy children's unit, due to on-going poor staffing levels, resulting in a number of staff being immediately redeployed to this area, including myself. However, the placement assessment I had received nine years previously caused me initial hesitation. What if the assessment undertaken all those years ago was accurate and working on a children's unit would prove to be too emotional? Following an assessment of key situational skills and responses this was thankfully not the case.

A year later, I returned to the North West of England which provided an opportunity to reflect on my previous ten years nursing experiences and consider professional options. An opportunity to undertake further nurse training in order to upgrade my Enrolled Nurse professional qualification to that of Registered Nurse was accepted and this was successfully completed in August 1993. As a newly registered nurse in practice, I had direct involvement with observing the mentoring and assessment of student nurses and first observed that they may or may not pass their assessment according to a whole range of factors. Staff and employers from practice learning settings had begun to question the preparation of nurses under the project 2000 competence principles (UKCC, 1986) suggesting the provision of the new, largely theory based, nurse education under this new

system did not prepare students adequately to perform as a registered nurse (Marriott, 1991; While, 1994; Twinn & Davies, 1996; Paley, 1996).

The criminal acts of the nurse Beverley Allitt, also an enrolled nurse, who murdered and injured a large number of children whilst working as a nurse on a children's ward (The Allitt Inquiry, 1994), permanently changed my professional career pathway. Findings from the inquiry suggested that if appropriate assessment and actions had been taken during and following registration, then it was possible opportunities to harm children may have been prevented. Recommendations that followed impacted on the selection, preparation and recruitment of registered nurses for children's health care environments (The Allitt Inquiry, 1994). I therefore undertook a course leading to Registered Sick Children's Nurse and Diploma in Higher Education, following successful completion in 1995, a period of consolidation and promotion to a higher grade followed. It was during this time I became the student link for practice which involved aligning students to mentors on the department and facilitating student learning through the development and implementation of a student induction programme and a range of student teaching and learning resources (Löfmark & Wikbald, 2001). In 1997, an opportunity arose to undertake an MSc advanced nurse practitioner course (Calman Report, 1993; Gibbon & Luker, 1995). On return to the Trust a paediatric adaptation of the advanced nursing role was introduced into existing inpatient children's services, later the service and impact were evaluated (Peter & Flynn, 2002) which identified the introduction of these roles had been perceived by parents and staff as having had a positive impact on service delivery.

In 2001, an opportunity arose for a lecturer in the children's pre-registration nursing team in the Faculty of Health and Social Care in a UK university. Later progression to Acting Programme Lead, Programme Lead, Academic Lead and more recently the Associate Head of Department followed. During this time a Post Graduate Certificate for Teaching and Learning Support (PGCT & LS) was completed as an approved teaching qualification and requirement of the NMC (NMC, 2004a, 2006, 2008a) which provided a good insight into what was required from both a professional and educational viewpoint. Observing how students learn, engaging in curriculum planning and delivery, assessment processes both in theory and practice based learning has allowed opportunities for discussion and personal reflection in relation to the robustness of assessment.

The assessment process of pre-registration nursing students undertaken by mentors in clinical practice learning settings began to raise questions for me personally. In 2004 whilst working as a senior lecturer, a telephone call, from a mentor who was supporting a pre-registration children's nursing student, was received as they were concerned about a student who was failing practice. The mentor sounded angry and upset. At first I felt it was a mistake because as far I was aware this was a third year student nurse who had excellent reports in their file and the student had not failed anything previously and until now there had been no problems with the student's performance, or any indication that the student could fail on this current placement. Following the gathering of information about the placement and locating the student's file, some time was spent quietly reflecting on the how and why in relation to the situation.

As part of my reflective process it was imperative to consider questions around how this had occurred in such a process-driven culture. I asked myself how this student had got to this stage, had something been missed, why was the student failing now, what had the mentor put in place, and what being ready to enter the nursing register actually meant to the mentor? I considered how the student nurse would be feeling and about the impact of the situation and how the mentor may be feeling as the mentor had seemed angry and upset about the situation and/or the possibility of having to fail the student. Whilst at the time I provided the mentor with support in terms of correct processes to follow, it was not possible to gain a sense of understanding what this was like for the mentor because we were both focused on procedures, processes and supporting the student nurse. This pattern continued from time to time. An urgent telephone call would be received from one of the mentors from one of the local practice learning settings requesting contact in relation to a student nurse they had concerns about, especially if the mentor was considering failing a third year student nurse undergoing their final practice learning experience. Often, until the telephone call, the student's personal teacher was not aware that the mentor had concerns or failure for the student was likely. Following the introduction of the SOM role it seemed, anecdotally, little had changed despite the introduction of the role.

The personal experiences detailed above occurred at a time when there seemed to be an increasing negativity in the nursing press and media surrounding nursing and mentoring practices. Duffy (2003) had published her findings indicating mentors were, at times,

reluctant to fail student nurses even though knowledge, ability and attitude maybe questionable. Other debates in the media had emerged and revolved around the issue of competence and the consequences of a lack of competence (The Allitt Inquiry, 1994; Watson et al. 2002; DH & Home Office, 2003; Scholes & Albarran, 2005) and continued to emerge once I commenced the Professional Doctorate journey (BBC, 2009; Care Quality Commission, 2009; Staniland & Murray, 2010; Stone et al. 2011; Francis Report, 2013).

A career in nursing and nurse education, along with several critical incidents and continued issues and debates in the media have had a clear bearing on why I chose this study topic. I wanted to know more about children's nurse SOM experiences of undertaking assessments. I was already in the '*everyday flow of life*' (Gill & Johnson, 2002, p.10) of pre-registration nurse education and a lot had been learnt from my experiences, but there was more to learn and others could benefit from this study. A decision made earlier to undertake further study (a Professional Doctorate in Health and Social Care), provided a valuable opportunity to undertake research in a little researched area. Previous experience and a review of the literature provided strong evidence that this was a research topic in need of investigation and my professional background would strengthen my ability to research it well.

Part 4: Thesis layout and structure

The thesis is presented in eight chapters which address the study aims (see Table 1):

Table 1: Thesis structure

Chapter 1: Introduction			
Chapter 2: Background			
Chapter 3: Literature Review			
Chapter 4: Methodology			
Chapter 5: Methods			
Chapter 6: Findings			
Chapter 7: Discussion of Findings			
Chapter 9: Conclusion			
Implications	Recommendations	Dissemination	Further Research

Chapter 1 introduces and explores the background relating to the research topic. It sets out the research aim and questions and illustrates how these were arrived at through an account of my professional journey to date. An overview of the thesis layout is given.

Chapter 2 sets the scene to the research study. It provides review and discussion of the literature associated with related concepts and issues in which the sign-off mentor (SOM) operates, in order to provide the context in which the assessment of practice learning takes place in pre-registration nursing, identifying where the gaps in knowledge and the evidence base are, and making clear the scope for contribution of this study. In order to support the reader, a definition of current terms used in the research is presented (see Glossary of terms).

Chapter 3 examines critically the relevant literature associated with the research focus and provides a summary of the literature review strategy. The literature included reference to scholarly opinion papers, discussion papers, policy documents and primary research. Key themes include mentors, mentor role and responsibilities, mentor preparation and support, the student-mentor relationship, assessment of students, SOM literature, and decision making (see Appendix 10).

Chapter 4 examines the methodological considerations. The overall methodological approach is presented along with justification for the selection of an interpretivist, qualitative case study methodology.

Chapter 5 presents the research methods used within the study and justifies selection. Issues around participant characteristics, sampling, recruitment and ethics are explored. An account is given of data collection processes and data management including management of confidentiality and anonymity. Data analysis, template development, and details of the thematic comparison of data are also presented.

Chapter 6 presents findings from the individual and focus group interviews. It presents in-depth insights into children's nurse SOM experiences of being a mentor charged with making final decisions whether to pass or fail pre-registration nursing students at the end of their training. It illuminates the six themes arising from the analyses with verbatim quotes from participants. The chapter concludes with a summary of findings.

Chapter 7 presents the discussion of the study findings and comparison of these to existing literature, policy and commentary. The chapter concludes by providing a summary in relation to the findings and discussion.

The final chapter (Chapter 8) draws together the entire thesis and articulates how the study has contributed significantly to the body of knowledge relating to mentors and in particular, children's nurse SOM experiences. The potential impact of the research findings on policy and practice is considered. Next recommendations for policy and practice are given, the dissemination of findings and the recommendations for future research.

Chapter summary

A preliminary review of the literature suggested there remained many unanswered questions in terms of the children's nurse SOM experience, the factors which influence assessment decisions, how a children's nurse SOM decides if a student nurse is ready or not, and why SOMs felt able to pass or fail students. This research study addresses these gaps.

This chapter has presented an introduction to the thesis focus, set out the research aim and research questions. Professional values and beliefs may affect the way that an individual conducts research in order to generate new knowledge, therefore professional values and beliefs have been articulated through a summary of my own professional journey and significant career events. The thesis structure was presented in order to guide the reader.

The next chapter, Chapter 2, sets the scene and provides a review and discussion of the relevant literature associated with pre-registration nursing education, related concepts and issues as a background to underpin the study. This provides the reader a context in which the SOM operates.

CHAPTER 2: BACKGROUND

Introduction

The previous chapter introduced and explored the research focus and background, research question, journey to the research focus and the intended layout of the thesis. This chapter sets out the scene of the research study. Definitions and terms commonly used in nursing in relation to pre-registration nursing, mentors and assessment are provided to support the reader. A review and discussion of the relevant literature associated with pre-registration nurse education, related concepts and issues in which the sign-off mentor (SOM) operates are provided in order to provide the context in which the assessment of practice learning takes place. This includes developments in nursing education in England (UK), practice learning, mentorship, mentors and assessment, competency and fitness for practice and the NMC requirements of students at sign-off stage in order to be entered onto the professional register. The research motivation, context and the potential contribution the research study makes is provided. A summary draws together the discussion of this second chapter.

Part 1: Definitions and terminology used within the thesis

A range of definitions and terms are commonly used in relation to pre-registration nursing. These include; field of practice, generic, mentors, sign-off mentor, assessment, competence and/or competency, which can be confusing. At the study outset it was necessary to consider current terms/definitions and their meaning (see Glossary of Terms p.6) as this would influence the terms used and how they were interpreted within the study.

Defining competencies, competence and competency

In the context of pre-registration nursing, the terms 'proficiencies', 'competencies', 'competence' and 'competency' are used to identify a student nurse's ability to meet the required standards during training and immediately prior to entry onto the nursing register (NMC, 2004a, 2010a), however these terms are often used interchangeably by nurses in practice and within the nursing literature.

The NMC has defined the terms and these are considered in turn. Competencies are defined as the '*various competencies achieved in stages throughout periods of practice experience during a pre-registration nursing programme*' whilst competence is defined as '*a combination of the skills, knowledge, attitudes, values and technical abilities that underpin safe and effective nursing practice and interventions*' (NMC, 2004a, 2010a). The term '*competence*' is used to determine the requirement for entry to the NMC register (NMC, 2010b, p.11) and it is this entry process that is used by the NMC to help manage public safety. Within an earlier standard framework for pre-registration nursing education, the term '*proficiencies*' is a term also used to mean the standard that students must meet in order to demonstrate that they have the knowledge, skills and attitudes required by a nurse at the point of registration and remains in use for those students completing their programme under these earlier education standards (NMC, 2004a). The NMC (2004b) provides a clearer definition of 'incompetence' which refers to '*a lack of knowledge, skill or judgement of such a nature that a registrant is unfit to practice safely and effectively in any field in which they claim to be qualified to practice or seek to practice*' (NMC, 2004b, p.3). Following registration, the NMC reinforces the requirements for competence in '*The Code*' which sets out the *standards of conduct, performance and ethics for nurses and midwives*' (NMC, 2008b).

Part 2: Developments in nurse education

Historical developments in nurse education

A significant number of changes have occurred in nursing education in the last twenty-eight years to address changes in health reform, patient profiles and nursing in general (United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC), 1986, 1999, 2001; DH, 1999; NMC, 2004a, 2010a). As indicated earlier, prior to 1989 an apprenticeship model of nursing education existed where student and pupil nurses were employed by National Health Service (NHS) hospitals and training/education was mainly provided through NHS schools of nursing (UKCC, 1986). In 1989, *Project 2000* was introduced and was termed '*A New Preparation for Practice*' (UKCC, 1986), a key change was the movement of nurse education from schools of nursing into the higher education domain and the introduction of an academic award of a Diploma in Higher

Education for each of the four branches of nursing: adult, mental health, children's and learning disabilities. However, a report (UKCC, 1999) found that the fundamental principles of this new model had been lost, and found that this was due principally to the belief that nurses had moved too far away from the patients' bedside.

In 1999, the DH also published a report '*Making a Difference: Strengthening the Nursing, Midwifery and Health Visiting Contribution to Health and Healthcare*' (DH, 1999), the report also criticised the new model of nurse training by commenting that students had completed their nurse training without having opportunities to gain the whole breadth of clinical skills required and expected to undertake the role of a registered nurse. The lack of clinical nursing skills was reported to have undermined the needs of the health service at that time (Duffy & Scott, 1998). The DH report called for a new model of nurse education, one that was theory-practice balanced, training which would '*reinforce the importance of opportunities for practice based learning and which advocated a competency based approach*' (DH, 1999). In 2001, the UKCC published the report '*Fitness for Practice and Purpose*' (UKCC, 2001), which also supported a move for nurse education towards outcomes based competency principles. The proposed changes were welcomed as it was thought they would lessen the gap between theory and practice (Herbig et al. 2001; Gallagher, 2004). Later, the publication *'Standards of Proficiency for Pre-registration Nursing Education'* (NMC, 2004a) and the more recent '*Standards for Pre-registration Nursing Education*' (NMC, 2010a) again presented further changes and new challenges in delivery structures for pre-registration nursing education.

The new standards for pre-registration nursing education (NMC, 2010a) reflect the needs of the newly registered nurse who will work within an increasingly modernised health service (DH, 2010). Under these new standards, implemented from September 2011, a student nurse will have to meet generic competence and field-specific competence in each of the four domain specific areas:

- Professional values
- Communication and interpersonal skills
- Nursing practice and decision making

- Leadership, management and team working

    (NMC, 2010a, p.7)

The NMC competencies were intended to provide a new framework to further strengthen nursing education pre-registration nursing programmes (NMC, 2010a). However, the four domains offer nothing new as they are each fundamental to nursing care and it would be concerning if student nurses prepared under the earlier nurse education standards (NMC, 2004a) were not achieving in each of these domains of practice. Whilst Ousey and Johnson (2007), reported many students in their study commented that most of the physical and emotional care in contemporary nursing is commonly undertaken by health care support workers, supervised by registered nurses, they argue these changing cultural norms in health care delivery are not currently met within the pre-registration nursing curriculum, which is delivered in Approved Education Institutions (AEIs). What the study does not address is whilst nursing care delivered by an individual registered nurse may at times be delegated to health care support workers this would be dependent both on the field of nursing and the practice environment. Therefore student nurses still require opportunities to gain and achieve competencies in each of the four domains in order for them to supervise nursing care they may delegate to health care support workers appropriately.

Internationally the public and governments expect newly qualified nurses to demonstrate they are fit for practice (International Council of Nurses - ICN, 2006). There have been concerns and debates evident within the literature in relation to the issue of poor care and some criminal acts (The Allitt report, 1994; BBC, 2009; Francis report, 2011; Gainsbury, 2010c) which refer to cases of nurses that have shown a lack of care, compassion and ability. As these nurses were registered, this implies mentors may have passed students who should not have passed. When things go wrong in nursing, professionals, the public and UK governments are said to '*yearn to return to the good old days'* when nurse training and nurses were seen as perfect, regardless of the reality (McKenna et al. 2006, p.135). Nonetheless, for those nurses who challenge poor standards of nursing care they can be seen as unpopular. In a BBC undercover report (BBC, 2009) a concerned registered nurse agreed to film poor and unacceptable standards of nursing care covertly. What was revealed caused concern and outrage among the general public at the time and the NMC responded by suspending and then 'striking off' the nurse involved in

undertaking the filming, a decision which was later reversed following the reaction of the general public. It was considered that the NMC did not respond quickly to address behaviours of the registered nurses and care assistants who had been implicated in the filming.

Developments in practice learning

In 2005, the NMC undertook a consultation on the standards to support learning and assessment in practice and the role of the practice mentor in assuring fitness for practice remained (NMC, 2006). The NMC asserts that a '*mentor is a mandatory requirement for all UK pre-registration nursing students'* whilst they are in practice learning environments (NMC, 2008b). The NMC defines a mentor as: 'A *registrant who has met the outcomes of stage 2* (Establishing effective working relationships; Facilitation of learning; Assessment and accountability; Evaluation of learning; Creating an environment for learning; Context of practice; Evidence-based practice and Leadership) and who *facilitates learning, and supervises and assesses students in a practice setting'* (NMC, 2008a, p.45). It was possibly in an attempt to respond to perceived ongoing public concerns about safety and protection of the public that the NMC have continued to strengthen the role of mentors (2008a, 2010b). While the NMC has defined the four domains of competence (NMC, 2010a) it has arguably struggled to deal fully with the issue of competency, especially around mentorship within the practice learning environments.

A study by O'Luanaigh (2007) explored influence in relation to how nursing students learn in the clinical environment. The author found that students nursing knowledge was gained from registered nurses who were best able to describe and demonstrate 'good' nursing. This appears to be in opposition to the model of practice learning advocated by the NMC (NMC, 2006, 2008a). However, more recent changes require student nurses undertaking their final practice learning opportunity to be supervised by an experienced mentor (SOM) who has undertaken additional training to assess the student's clinical competency and determine if the student is suitable to enter the NMC register (NMC, 2008a, 2010b). The SOM is also required to be on the same part of the register (due regard) as the intended student (see Glossary of Terms).

Notably, a key change within the recent standards (NMC, 2010a) requires that all nursing students achieve an academic award of a degree demonstrating a further shift in the expectations of the NMC in terms of new registrants and mentors who undertake practice based assessments. Assessment is routinely used to assess a student's performance within pre-registration nurse education, with students required to fulfil theoretical, clinical and professional criteria set by the NMC (NMC 2004a, 2010a). Assessment of pre-registration student nurses is split between AEIs and mentors in practice learning environments. The outcome of both theory and practice based assessments, inform the decision about a student's suitability to continue and complete their training programme. The final practice learning assessment undertaken by SOMs determines if the student meets the NMC requirements of a nurse at the point of registration (NMC, 2004a, 2010a), crucially unlike theory assessment, a student nurse can only attempt to pass a practice assessment on two occasions (NMC 2004a, 2010a).

Mentorship and mentors in nursing

Current models of mentor support mean that the NMC requires registered nurses to organise and coordinate student learning in practice. This includes supervision, planning opportunities for learning, monitoring progress and undertaking the required assessment (NMC, 2006, 2008a). In relation to assessment of learning the NMC advises that mentors have a '*breadth of understanding of assessment strategies, provide feedback*' and '*manage students who are failing*' (NMC, 2008b, p.20). In this model consideration such as the quality (reliability, validity, objectivity) of the assessment is not addressed by the NMC. The call for moderation in relation to practice learning may help towards addressing this aspect (Smith, 2012). It seems that the role of the mentor in supporting a student's learning and undertaking the assessment of learning in practice settings is challenging. Supporting and guiding students in order to facilitate their learning in the real world of practice amidst the vast number and type of learning environments is problematic for a number of reasons. Challenges include the risk of exposing the public to potentially unsafe care from a student nurse, the unpredictable nature of the practice learning environment, and the risk of not providing adequate, equitable and fair opportunities for all student nurses to learn in order for them to be assessed.

The nursing profession began its relationship with mentorship in the 1970s when Vance first introduced the concept into the literature (Vance & Olson, 1991). Later, nurse mentors are envisioned as role models, facilitators, supervisors, guides, teachers, coaches, or confidants (Burnard, 1989; Cooper, 1990; Armitage & Burnard, 1991; Vance & Olson, 1991; Anforth, 1992; Butterworth & Faugier, 1992). At this time mentorship was also seen as an opportunity for the development and transmission of professional knowledge across a number of professional groups such as teaching and medicine (Clutterbuck, 1991; Husain, 1998; Dean, 2003; MacDonald, 2004). However, not everyone believed the introduction of the mentor role was helpful in relation to supporting student learning (Darling, 1985; Alavi & Cattoni, 1995; Castledine, 2000). The North American study by Darling (1985, p.42) who interviewed nurses, physicians, and senior managers, about their views of mentors in nursing. Findings from this study first report the concept of '*toxic nurse mentors*' who Darling reports are those mentors who are the '*avoiders, dumpers, blockers and destroyers/criticizers*'. However, the lack of information in terms of sample selection, interview data and analysis makes the author unable to justify her findings.

Following the changes to the pre-registration nursing education programmes (UKCC, 1986, 1999, 2001; DH, 1999; NMC, 2004a, 2008a), mentors and mentoring were increasingly identified as key elements, within nursing education (English National Board -ENB, 2001; NMC, 2005, 2006, 2008a). This resulted in a renewed interest and debate about the concept of mentors and mentorship and there was a demand to redefine both the meaning and approach within nursing. The mid to late 1990s saw a shift in the way the mentoring relationship was viewed to emphasise its teaching-learning dynamic (Clifford, 1994; Bradshaw, 1997, 1998; Andrews & Wallis, 1999; Duffy & Watson, 2001; Dorsey & Baker, 2004; Mallik & McGowan, 2007; Myall et al. 2008). The study by Andrews and Wallis (1999) uncovered confusion regarding both in the understanding and the role of the mentor. They also commented on the inconsistency in preparatory courses for mentors. At the time there was still no agreed minimum standard, no common preparation or level for the preparation of mentors. Earlier, Phillips et al. (1996a, 1996b) argued that the lack of an unclear role specification for mentors had been complicated even further by the use of the range of terms: '*mentor, preceptor and supervisor*' which were all being used as meaning one and the same in the UK.

The NMC Code does not refer directly to mentors (NMC, 2008b), but there is an expectation that '*all nurses facilitate students and others to develop their competence*' (NMC, 2008b, p.3) and it seems places additional emphasis on the role of assessing students '*.... will assess competence in practice and confirm that students are capable of safe and effective practice*' (NMC, 2008b, p.13). Whilst currently mandatory, the role of mentor in supporting, teaching and assessing may be viewed as an additional burden to nurses, especially when they may have found it difficult to develop a relationship with a particular student for a number of reasons (Lloyd Jones et al. 2001; Barker, 2006; Levett-Jones & Lathlean, 2009). Furthermore, a mentor's decision can lead to disruption and potential termination for the student (Parker, 2010). Providing mentors with a choice to undertake the role, was believed to foster a positive mentor attitude, which would promote student learning in practice (Pearcey & Elliott, 2004) and would also allow mentors to have control over their workload (Atkins & Williams, 1995; Cahill, 1996; O'Callaghan & Slevin, 2003; Wilkes, 2006). Despite this, the mentor role in nursing has continued to be developed (NMC, 2008, 2010b; Casey & Clark, 2011) and the choice for a registered nurse to become a mentor, or not, has so far not been addressed, and so for this study, there is an opportunity to further inform and progress the discussion.

Assessment of practice learning

During the mid to late 1990s the move towards continuous assessment placed increasing emphasis on the importance of registered nurses in their role in both the support and assessment of students. The introduction of Project 2000 significantly changed the nature of training for student nurses, particularly because of the change from NHS employee to that of student nurse who had 'supernumerary status' (UKCC, 2001). As indicated earlier the UKCC also published the report '*Fitness for Practice and Purpose*' (UKCC, 2001), which supported changes for competency based principles. At that time competence was defined simply as '*the skills and ability to practice safely and effectively without the need for direct supervision*' (UKCC, 1999, p.35), since that time the NMC has continued to redefine the term (NMC, 2004a, 2010a).

The terms competency and competence are often used interchangeably by nurses and mentors and have been a source of concern and confusion (While, 1994; Bradshaw, 1997, 1998; Feron, 1998; Flanagan & Baldwin, 2000; Watson, et al. 2002; Dolan, 2003;

Cowan et al. 2005). It was Benner (2001, p. 27) who suggested that the competent nurse should have a '*feeling of mastery*' to allow management the many situations in practice. A study by Bradshaw and Merriman (2008) questioned whether the term 'nursing competence' meant fit for practice or purpose as it seemed confusion remained. A later study by Cassidy (2009a) supported these views but went further suggesting competence relates to a nurse also having a range of key personal abilities. Despite ongoing confusion in relation to the terms it would seem competence and competency in nursing relate to '*protecting the public and ensuring patient safety*' (NMC, 2004a, 2010a).

Fitness for practice is another term used to suggest that student nurses have met the necessary criteria of knowledge, skills and behaviour expected by the NMC (UKCC, 1999, 2001; Duffy, 2003; Hughes, 2004; NMC, 2006). This deems that if a student has met the pre-determined assessment criteria set by the NMC then they should be fit for practice at the point of registration. Some studies found that it was possible for poor performers, including those who are just good enough to pass, but not bad enough to fail, to pass their practice assessment (Brown, 2001; Boley & Whitney, 2003; Duffy, 2003, Skingley et al. 2007), which is an issue not confined to pre-registration nursing students (Hawe, 2003; Dudek et al. 2005; Cleland et al, 2008; Finch, 2009). A qualitative study by Finch (2009) added support to this view as she found some social work students had been deemed just good enough to pass when she explored practice assessor's experiences of assessing social work students.

In a review of nursing competence undertaken by Kings College National Nursing Research Unit (2009) they found partnership working between education providers and NHS Trusts is essential to develop competency assessment. The study findings emphasise the '*need for more research on developing and testing methods on the assessment of competence*' (Kings College National Nursing Research Unit, 2009, p.2) which provides further evidence that this current study is necessary.

Research motivation and context

In nursing practice, learning experiences are regarded as fundamental in developing competencies and eventual competency of student nurses into those required as a registered nurse (Holland, 1999; Clarke, et al, 2003; Anderson & Kiger, 2008; NMC,

2008a), with the final placement being recognised as the key point at which the student nurse prepares for registration. A study by Bourbonnais and Kerr (2007) suggest that the final placement is where transition into the nursing profession is fostered as it is the time where students are expected to consolidate the knowledge and practice all that they have learnt and developed during their nurse training.

It is crucial to have practitioners who are deemed competent for the safe delivery of health care in the National Health Service (NHS), independent and private sector (DH, 2004, 2007). As referred to previously the SOM role was introduced by the NMC to help strengthen the assessment process, as the role requires experienced nurse mentors who have undergone additional training and supervision (NMC, 2008a, 2010b). The provision of accurate decisions by SOMs in nursing are essential in order to ensure that student nurses are fit for practice and purpose as they enter the professional nursing register. It is evident from the literature that some student nurses and newly qualified nurses continue to have deficits which questions their competence and the assessment of their competence. This, combined with the personal anecdotal evidence drawn from my field of practice, has provided the impetus to undertake research in this area. The area of SOM experience has received little attention and children's nurse mentors' experience of undertaking assessment at sign-off stage has received no attention. Therefore, the potential contribution this research study makes to the current body of knowledge is important.

Chapter summary

This chapter has presented the background information and developments relating to pre-registration nursing education in England. Key issues relating to the practice learning environment, mentor and mentoring in nursing has been explored and provides the reader with the context in which the nurse SOM assessment of practice learning takes place.

The provision of accurate decisions by SOMs is seen as paramount in order to ensure that student nurses are fit for practice and purpose at the point of registration. However, the discussion has confirmed there is a need to review the literature around the nurse mentor experience. It supports the potential for this study being a valuable addition to the

field. The next chapter, Chapter 3, critically examines the relevant literature associated with the study that has informed its design.

CHAPTER 3: LITERATURE REVIEW

Introduction

The previous chapter presented the background and developments in pre-registration nursing education in England. Developments in practice learning and key concepts were introduced in relation to mentorship and mentors, exploring how these all impact on the nurse sign-off mentor (SOM). This chapter sets out the reviewed literature, providing a rationale for the need to conduct research into the SOM experience of undertaking assessment at sign-off stage. In order to structure the review and provide clarity for the reader the chapter is divided into two parts. Part 1 considers the focus of the literature search and sets out the search for relevant literature. Part 2 considers the key themes which emerged from the search for literature and provides literature reviewed involving the mentor experiences. A summary of this third chapter draws together the review of the literature highlighting areas of the SOM experience to which this study will add to, concludes the discussion.

Part 1: The search for literature

Literature review focus

At the study outset, an initial literature review focused on the experience of the SOM. The scarcity lack of SOM literature in the area of the SOM experiences, and absence of papers relating to children's nurse SOM experiences, directed me expand the literature review focus to include the wider mentor experience of their mentor role including preparation for their role in the practice learning setting and on the mentor relationship within pre-registration nursing education in the UK. The current mentor/mentorship system was introduced in 1986 (UKCC, 1986) and therefore it is anticipated that the majority of pertinent literature dates from the 1990s. In order to set this study within a research context and to establish a research framework within which the study would be located, a search of the literature was conducted (Cronin et al. 2008).

Literature search

A literature search protocol was devised (Cronin et al. 2008) determining keywords and inclusion and exclusion criteria for the collection of papers. I searched literature published in English. Search dates were from 1990, which was around the introduction date for nurse mentors into the UK, to the present day. Whilst a limit on the date of publication was 1990, to coincide with the introduction of mentors in line with Project 2000 (UKCC, 1986), where papers referred to work published prior to 1990, the original sources were sought and included as necessary. The search of the literature began in 2011. This has since been repeated and updated with a formal cut-off date of September 2013. As is permitted with case study research (Yin, 2009) the search for literature continued throughout this study to ensure that all, relevant, literature was included.

Search terms were used which included keywords and combinations of keywords focusing on the aims of the study and included: Children's nurse sign-off mentor (SOM), SOM experiences, SOM assessment and final practice placement assessment. As referred to previously, the initial search yielded modest SOM literature (see Appendix 11), in light of the scarcity of literature in the area of the SOM role and experiences, and absence of papers relating to children's nurse SOM experiences, papers relating to the mentor experience in undertaking any aspect of their mentor responsibilities and preparation for their role provided the closest comparative literature and therefore were sought. The following terms: preceptor, mentor, sign-off mentor(s), mentoring, mentoring practice, assessment, assessment of proficiency / competency / competence, pre-registration nursing assessment. These terms were also combined with others including mentor preparation, mentor support, emotional labour; student-mentor relationship, student feedback, failing to fail and unsafe students, in response to issues raised in the extant literature. Some terms made the search process more complex, for example, 'preceptor' which is a term more commonly used for mentoring students in Ireland and USA. However, in the UK the term preceptor was once used, often interchangeably, with the term mentor, therefore it was anticipated that it would be used in the early literature especially.

A search of discursive literature was also undertaken following a similar approach, although papers were not appraised formally. Posters, conference abstracts and letters to

journal editors were also excluded as their full context was unclear. Some papers, which on further scrutiny did not directly relate to the study focus, were put to one side to aid the discussion within other chapters.

The structured search used electronic bibliographic databases (CINAHL, PubMed, EMBASE & PsychInfo). Cumulative Index to Nursing and Allied Health Literature (CINAHL) was the primary database used to access this literature as it provides the majority of English nursing journals published since the early 1980s. The British Nursing Index (BNI) and education specific journals (NET) were also accessed. The search was complemented with hand searching of volumes of key journals (for example, Nurse Educator, Nurse Education Today, Journal of Clinical Nursing, Nurse Education in Practice) as they provide the majority of English nursing journals which relate to nurse education and practice and which further enhanced the search for literature. Nursing Times.net website and the National Nursing Research Unit website were examined. The BBC news website was also searched due to the public interest in relation to health and social care issues, particularly nursing. The Royal College of Nursing (RCN) and professional nursing bodies such as the NMC and DH databases provided further literature for consideration but these were accessed as supportive, contextual literature and not formally appraised.

Primary research involving SOMs and which looked at the SOM experience was limited. The search terms and limits presented a range of literature and these included reports, policies and guidelines published by the government, DH and NMC, literature reviews and discussion papers, and a limited number of research studies which focussed on the SOM and mentor experience. Where the sample included mentors from different professional groups, those from a nursing background were focused on. Studies looking specifically at the pre-registration mentor experience were therefore sought as these were relevant to the aim of this study. In light of the scarcity of literature in the area of the SOM role/experiences, and absence of papers relating to children's nurse SOM experiences, papers relating to the mentor experience in carrying out any aspect of their mentor role, perception of their mentor role and preparation for their role provided the closest comparative literature and therefore were reviewed and included in the initial review. Other discursive and policy literature was deemed useful in providing background and contextual information in relation to mentors and SOMs.

Research studies undertaken from an international perspective such as North America, Canada, Australia, Asia and Europe were identified; however there are marked differences in relation to mentor assessment and mentoring used for students for pre-registration nursing adopted in those countries, compared with the UK. Therefore, whilst studies from an international perspective were sought the marked differences in relation to the mentor role, assessment of students for pre-registration nursing and terminology compared with the UK meant that following further scrutiny many of these studies were not included.

Quality appraisal of identified studies

Research papers were appraised to see if they fitted with inclusion and exclusion criteria and a judgement of their quality made. A total of 460 potential papers were initially identified, all abstracts were read and if deemed to match the study focus they were included for further reading and critique using an evaluative tool. The literature search identified studies which had adopted a variety of different designs and approaches including qualitative, quantitative, mixed methods and a systematic review of the literature and therefore different approaches to data analysis and interpretation, thus specific quality appraisal tools were required. The Critical Appraisal Skills Programme (CASP) tool were selected to appraise the 61 strengths and weaknesses of all existing published research identified by the literature review (CASP, 2006) allowing for a systematic review of the selected studies.

Using the CASP tool identified (CASP, 2006) research papers were appraised and a judgement was made of their quality. Studies appraised and included in this review are listed (see Appendix 10). Whilst international perspective studies were sought, there were marked differences in relation to mentor assessment and mentoring used for students for pre-registration nursing adopted in those countries, compared with the UK meant that following further scrutiny many of these studies were not included.

Literature themes

Despite changes to pre-registration nursing education (UKCC, 1986; UKCC, 2001; NMC, 2004a; NMC, 2006; NMC 2008; NMC, 2010a) as the literature was identified,

retrieved and reviewed it became clear that the primary body of research reflected common subject themes in relation to the SOM and mentor experience. Subject themes emerged during the literature review and were broadly identified as mentors and mentoring practice; mentor role and responsibilities; mentor preparation and support; student-mentor relationship; assessment, including failure to fail and sign-off mentors. These themes (see Table 2) will be discussed in part 2 of this chapter.

Table 2: Literature subject themes identified in relation to the literature review

Literature Review Themes
1. Mentors and mentoring practice
2. Mentor role and mentor responsibilities
3. Mentor preparation and support
4. The student-mentor relationship
5. Assessment of students.
6. Failing to fail
7. Sign-off mentors

Part 2: Review of included studies

1. Mentors and mentoring practice

A number of research studies were identified in mentoring practice, possibly due to the importance of the mentoring role in health, although in some papers there is a lack of discussion in relation to methods and the rationale for undertaking the research (Morle, 1990; Morton-Cooper & Palmer, 1990; Gray & Smith, 2000; Pellatt, 2006). A review of the studies which explored mentor provision was undertaken by Jinks (2007). Jinks, concluded that despite mentorship being crucial in relation to nurse education at that time, therefore the relatively modest number of studies was disproportionate to the importance of mentorship and mentors in nursing. Jinks (2007) further highlighted that the quality of the studies that had been undertaken into the mentor experience were often weak from a methodological perspective.

Seven studies used a qualitative research approach (Atkins & Williams, 1995; Twinn & Davies, 1996; Watson, 1999; Duffy, 2003; Hutchings, Williamson & Humphreys, 2005; Kneafsey, 2007; Webb & Shakespeare, 2008). Some studies have used the term qualitative to describe the methods they had selected for data collection rather than an overall methodology (Atkins & Williams, 1995; Hutchings et al. 2005; Webb & Shakespeare, 2008). One paper did not provide any discussion on their methodology (Twinn & Davies, 1996). Other studies provided confusing information. For example, Watson (1999) describes her study as being a qualitative, phenomenological study. However, she fails to discuss which phenomenological perspective. Watson (1999) goes on to describe her study as a qualitative, ethnographic study, then reports she had adopted a case study approach for the study. On reading the study it does appear that a case study approach was used and so from a methodological perspective the findings inn this study are questionable.

Seven quantitative studies (Cameron-Jones & O' Hara, 1996; Andrews & Chilton, 2000; Duffy, Docherty, Cardnuff, et al. 2000; Haroon-Iqbal & Jinks, 2002; Pulsford, Boit & Owen, 2002; Devis & Butler, 2004; Watson, 2004) were identified. Two studies, Cameron-Jones and O' Hara (1996) and the study by Andrews and Chilton (2000) used a pre-validated questionnaire based on an American model of mentorship in nursing and Haroon-Iqbal and Jinks (2002) used a mentor survey. In contrast, Watson (2000) used unstructured interviews to help develop her later questionnaires, and in her later study (Watson, 2004), refers to and explains the use of questionnaires that had been previously piloted.

A number of studies identified they had used mixed methods (Wilson-Barnett et al. 1995; Jinks & Williams, 1994; Brown, 2001; Watson, 2000; Lloyd-Jones, Dolan, 2003; Bray & Nettleton, 2007) again, some lacked clarity for their chosen methodology and methods. A study by Bray and Nettleton (2007) suffers from a poor response (13%) and lacks a methodological discussion; though possible reasons for this are explored by the authors in a later publication (Nettleton & Bray, 2008). These authors commented that at that time there was confusion around mentoring in the UK which had been caused by overlapping with the terms of assessor and supervisor and this lead to role confusion.

It is acknowledged that word limits set by journals could impact on the detail of the methodological discussion, methods and findings. However, reflecting on research undertaken which has explored mentor role and experiences, it is at times difficult to make judgements on the findings of the research if there are perceived weaknesses in the research study designs which is often due to a lack of discussion by the author. Nonetheless, if not addressed by the authors this makes the studies difficult to replicate, progress the debate and evidence base.

2. Mentor role and mentor responsibilities

As discussed previously in chapter 2, pre-registration nursing education and therefore mentor support for practice learning has had a significant number of changes and developments in the UK (UKCC, 1986; 1999, 2001; DH, 1999; NMC, 2004a; NMC, 2006; NMC, 2008a; NMC, 2010a). Prior to 2006, the availability of (written) guidance and support for mentors was limited. Although the UKCC (1986) provided the initial idea for the introduction of a mentorship role there remained confusion and misunderstanding about the mentor role and responsibilities (Nettleton & Bray, 2008). The English National Board (ENB, 2001) and later the NMC (NMC, 2005, 2006; 2008a, 2010b) set standards for practice learning. Later the Royal College of Nursing (RCN, 2007) also produced guidance for mentors so there is comprehensive standards and guidance outlining what the role of the mentor should comprise and undertake.

A number of studies have discussed issues surrounding the mentor role and mentor responsibilities in terms of what is required (Donovan, 1990; Morle, 1990; Wright, 1990; Armitage & Burnard, 1991; Clutterbuck, 1991; Marriott, 1991; Atkins & Williams, 1995; Cahill, 1996; Phillips et al. 1996a, 1996b; Spouse, 1996; Andrews & Wallis, 1999; Gray & Smith, 1999; Andrews & Chilton, 2000; Northcott, 2000; Chow & Suen, 2001; Lloyd Jones et al. 2001; Spouse, 2001; Ehrich, Tennent & Hansford, 2002; Pulsford, Boit & Owen, 2002; Andrews & Roberts, 2003; Watson, 2004; Hall, 2006; Pellatt, 2006; Tracey & Nicholl, 2006; Bray & Nettleton, 2007; Carnwell et al. 2007; Jinks, 2007; Ali & Panther, 2008). However, uncertainty as to what is expected of mentors is highlighted in the study by Bray and Nettleton (2007). It seems despite the significant number of studies the authors are representative of those who have not progressed, the narrative, of the mentor role and responsibilities.

In her investigative case study, Watson (1999) explored students' experiences and perceptions of mentoring in a first year theory/practice module which was part of a *Project 2000* course. Interviews were conducted with 35 first year students and 15 mentors. Whilst this study is fourteen years old and relates to the student nurses' first year of pre-registration nursing, it offers insights into the student nurse and mentor experience of mentoring at this time. Students and mentors reported little benefit which may be linked to a distortion between their expectations in terms of the role and purpose of the mentor perceived at the time. A later interpretive study by Duffy and Watson (2001) involved 18 nurse teachers in Scotland which explored their experiences regarding their role in clinical settings. They found nurse teachers had a multifaceted role which included providing advice and support to trained staff and students, interpreting assessment documentation and networking with clinical staff (Duffy & Watson 2001). Thus the role of the nurse teacher may have added to the confusion that both students and mentors seemingly felt at the time, and led to different expectations of both the mentor and student nurse and importantly impacted on the assessment outcomes for the student. Interestingly, participants in Duffy's (2003) study reported mentor difficulties in completing assessment documentation.

A particularly insightful study focused on midwifery mentors was undertaken by Fisher and Webb (2009) who identified that there is also role confusion for midwifery mentors. They found in midwifery that a mentor may perform only a supporting role and others may undertake the assessment of practice competence. Their study aimed to prioritise the needs of midwifery mentors by investigating the role of the midwifery mentor, relationship and conflicts between support and assessment, duration of experience and level of midwife educational qualification. They undertook a cross-sectional correlation study of 82 mentors in the south west of England and identified 15 'needs of mentors' which also became the basis of their later questionnaire. Findings suggest that 'guidance' and continuous changes of role expectations' impacted on individuals. They report that in midwifery a mentor's academic level, background of the midwifery mentor, mentor experience and place of work, impacts on the perceived mentor role. Conclusions included that recognition of their role was required, breaks between students, due consideration of their workplace and the type of student allocated to mentors. Recommendations from the study included the need for a 'mentor pyramid of needs for

midwifery' (see Table 3) which identifies specific training, preparation and support needs, date and level of last midwifery student and if they had assessed the student etcetera, which they suggest '*could be used by educators and managers to audit and prioritise mentor support*' (Fisher and Webb, 2009, p.1).

Table 3 Midwifery mentor pyramid of need (Fisher & Webb, 2009)

Optimal:	Choice in allocation
	Involvement in selection
Preferable:	Academic level/opportunities and access to support group
Fundamental:	Library, preparation, break (between students)
	Student Booking, encouragement, theoretical preparation
	Tutor support, experiences, peer feedback
	Adequate staffing, time, tutor feedback
Crucial:	Shifts with student, guidance

Whilst aspects of the midwifery mentor role is different to that of mentors and SOMs in nursing where both latter roles are consistently responsible for undertaking the assessment of practice learning. What is significant is that the study has led to the development of a pyramid of needs for midwifery mentors, yet a similar version is not available for nurse mentors despite the much larger number of previous mentor studies which have been undertaken in nursing. However, the midwifery mentor pyramid of needs (see Table 3) involves the identification of key midwifery mentor needs and thus the focus is on the objective needs of the midwifery mentor. Further, since its development the use of the tool in practice has not yet been evaluated, nor has the tool been adapted for use by nurse mentors, this may demonstrate potential limitations for implementation across different professional groups such as nursing.

3. Mentor preparation and support

A number of studies demonstrate concern as to the way mentors are prepared and supported (Andrews & Chilton, 2000; Watson, 2000; Ehrich, Tennent & Hansford, 2002; Duffy et al. 2000; Hutchings, Williamson & Humphreys, 2005; Moore, 2005; Pellatt,

2006; Nettleton & Bray, 2008; Pearcey & Draper, 2008). Whilst significant resources are provided by both practice learning partners and AEIs in the preparation and support offered to mentors (Mallik & Aylott, 2005), costs continue to increase following recent changes to requirements (NMC, 2006, 2008a, 2010a, 2010b). However, the level and amount support continues to be questioned and challenged by mentors. In her study Wilkes (2006) questions the form of support provided by the AEI and how it should be focused. Additional tutorial support is suggested as a way to help mentors develop their mentor skills in practice. However, Aston (2013) comments that whilst in the past clinical teachers provided a link between the theory and practice by regularly worked alongside students and staff to assess student's competence as well as address any issues with student attitudes and/or behaviours. The increasing demands and pressures of university nurse lecturers often mean they have little time to visit, let alone work alongside students and mentors in practice learning settings.

A number of papers focused on preparation and support for mentors (Jinks & Williams, 1994; Wilson-Barnett et al. 1995; Andrews & Chilton, 2000; Duffy et al. 2000; Watson, 2000; Pulsford et al. 2002; Sibson & Machen 2003; Watson, 2004; Hutchings, Williamson & Humphreys, 2005; Clemow, 2007), highlighting questions about who should everyone mentor and whether there should be incentives for doing the role and concerns about who will support the mentors in their role. Whilst mentor preparation can make mentors feel more able to carry out their role (Jinks & Williams, 1994), it seems access to mentor preparation and support for some mentors continues to be raised as an issue.

Appropriate preparation and support of mentors can improve mentoring practices (Andrews & Wallis, 1999; Watson, 2000; Pulsford, Boit & Owen, 2002; Hutchings, Williamson & Humphreys, 2005). The study by Andrews and Chilton (2000) was a pilot conducted in a district general hospital in North Wales and undertaken over a three month period. The study explored mentoring effectiveness, findings support the view that adequate preparation has a good impact on a mentor's performance. In addition, students rated these mentors more highly. Mentors also reported the mentor qualification also equipped them in terms of the necessary mentoring and teaching skills. Students rated mentors low in terms of the mentor's ability to challenge them, supporting the earlier findings in the study by Cameron-Jones and O'Hara (1996) which had explored

the mentor role with 87 nurse mentors and 39 student nurses. They found that whilst the supportive aspects of the mentor role was emphasised, students identified there was a need for mentors to challenge students more. The study by Andrews and Chilton (2000) support the view that many mentors feel unable to challenge students due to lack of confidence and having the skills necessary to undertake this aspect of the mentor role. This may suggest that the preparation available for mentors at that time would have benefited from developing those aspects.

The study by Kneafsey, (2007) explored mentor preparation for assessment, reporting that mentors would value further support to develop their approaches and identified that mentors required more guidance about what theory and skills student nurses are taught in HEI's. She also reported mentors require an opportunity to practice the skills required to assess clinical competence and give feedback and so for this study SOMs will be offered an opportunity to be part of the research study and included in dissemination of study findings.

The mixed method study by Watson (2000) within a hospital trust, examined the causes of stress for mentors, support in place and additional support they would like. Findings indicated that mentors had different experiences in terms of the support they received from lecturers (Watson, 2000). Mentors request closer links HEIs could provide the necessary support and allocated time was needed to prepare for students and complete documentation. Mentors believed students could also be better prepared for placements (Watson, 2000). Watson (2000) concluded both Trusts and the AEI were not providing the necessary support to mentors. Watson's study was however undertaken prior to the issuing of the Standards for Practice Learning (NMC, 2005, 2006, 2008a, 2010b) and therefore it could be that the paper does not reflect pre-registration mentorship currently in place.

In a recent qualitative study, Veeramah (2012b) explored the barriers to good mentoring. A postal questionnaire was sent to those who had completed the NMC mentor preparation course between September 2007 and January 2010 (n=346), 199 questionnaires were returned (58%). Findings indicated that mentors have two key barriers to successful mentoring which included a lack of allocated time and conflicting work pressures. Mentors further felt that preparation had been inadequate and this may

mean they could pass students they should fail. They confirmed that they need further support to complete documentation. These study findings suggest that following the introduction of the Standards for Practice Learning (NMC, 2005, 2006, 2008a) mentors perceive little has changed to support them in their roles. This is interesting given that AEI and Trusts have been working together to provide accessible preparation and support for mentors and SOMs. Locally these initiatives have included securing allocated mentor time and the development of an online mentor support tool.

4. The student-mentor relationship

An effective student-mentor relationship which supports student learning and achievement is based on a range of factors: the development of a relationship, partnership, respect and trust (Cahill, 1996; Andrews & Wallis, 1999; Spouse, 2001; Ehrich, Tennent & Hansford, 2002; Pulsford, Boit & Owen, 2002; Burns & Patterson, 2005; Collis & Pellatt, 2006; Tracey & Nicholl, 2006; Wilkes, 2006; Ali & Panther, 2008; Webb & Shakespeare, 2008; Beskine, 2009; Cassidy, 2009b). The study by Beecroft et al. (2006) was a six year survey undertaken from 1999 to 2005 and aimed to examine the perceptions of new graduate nurses about mentoring. Findings indicate the need for provision of a range of opportunities were important: 'guidance, support, socialisation into nursing, and time for regular meetings'. Nonetheless, these elements suggest potentially that this requires effort and a need for the mentor and student to invest 'emotional labour' for the student- mentor relationship to allow it to be successful (Webb & Shakespeare, 2008).

Studies which explored the student perspective highlight a range of positive and sometimes less positive experiences. These studies identify empowerment, disempowerment, supportive and unsupportive practice mentors and practice learning settings, mentors who identify and guide learning opportunities and how different mentors can be, in in terms of consistency (Cahill, 1996; Gray & Smith, 1999; Andrews & Chilton, 2000; Chow & Suen, 2001; Gray & Smith, 2000; Neary, 2000b; Hayes, 2001; Spouse, 2001; Chesser-Smyth, 2005; Henderson et al. 2006; Barker, 2006; Bradbury-Jones et al. 2007; Anderson & Kiger, 2008; Webb & Shakespeare, 2008).

A number of studies explored student and mentor views in terms of quality (Cahill, 1996; Spouse, 1996; Neary, 1997; Gray & Smith 2000; Pulsford, Boit & Owen, 2002; Duffy, 2003; Watson, 2004; Wilkes, 2006). They found disparities in the student mentor expectations in terms of the mentor relationship, responsibilities, and behaviours, understanding of roles, poor expertise, inappropriate delegation, motivation, morale and role modelling. It seems, uncertainty remains for some as to what is expected of each of them.

Assessment of students

Assessment is routinely used to assess a student's performance within pre-registration nurse education, with students required to fulfil the range of educational and professional criteria. In practice settings this is undertaken under the supervision and guidance of qualified nurses, in particular, mentors (NMC, 2004a; 2005, 2006, 2008a, 2010a, 2010b). Throughout their three years' preparation, student nurses are assigned to a range of practice learning settings: NHS, private and independent sector organisations which aim to facilitate and support practice learning and the successful achievement of competencies and skills required (NMC, 2004a; 2010a).

The responsibility for undertaking the assessment of nursing students in the practice learning environment is with the mentor or other suitably qualified supervisor (Gosby, 2004; NMC, 2006; 2008a; 2010b). The assessment of a student nurse's clinical practice has received much attention and been widely debated. Studies discuss the notions of competence and how the approach to competence assessment of student nurses has become increasingly problematic (Alavi & Cattoni, 1995; Hill, 1998; Buckingham & Adams, 2000; Girot, 2000; Brown, 2001; Calman, Watson, Norman, et al. 2002; Boley & Whitney, 2003; Dolan, 2003; Clinton, Murrells & Robinson, 2005; Clynes & Raftery, 2008; Cassidy, 2009c; Black, 2011; Gallagher, Smith & Ousey, 2012). While mentors recognise their professional responsibility to assess students and fail students who are unsafe, mentors can nonetheless find it difficult when their actions will have consequences for the mentor and for the student which may result in discontinuation from the course (Lankshear, 1990; Duffy, 2003; Clynes, 2008; Duffy & Hardacre, 2007; Luhanga, Yonge & Myrick, 2008a; Cassidy, 2009b; Finch, 2009; Killam, Montgomery, Luhanga et. al. 2010; Black, 2011). Lankshear's (1990) first reported some nurses who

should not have passed their assessment, had been passed. They reported sometimes mentors found they struggled to fail a student who seemed to have an attitude problem. Especially, when they had the necessary knowledge and skills. This finding was to be termed 'fail to fail' in later studies.

Others discuss the difficulties of assessing 'borderline' students particularly if a student was not performing as well in one or two areas (Weeks, Lyne & Torrance, 2000; Lankshear, 1990; Jukes & Gilchrist, 2006; Cleland, Knight, Rees et al. 2008; Heaslip & Scammell, 2012) and thus refer to mentors giving students the benefit of the doubt even when students may have had poor knowledge or had poor technical skills as long as they are not 'too bad' or considered 'unsafe'. Mentors found these decisions more difficult particularly when there had been some improvement and effort by the student leading up to assessment. Crucially, the examples are concerning due to potential implications for patients/clients, in terms of their safety. If students are given the benefit of the doubt and not failed in their programme, then they may expose the general public to the risk of harm as potentially an incompetent student may be allowed to continue with their nurse training and enter the professional register; consequences which have been discussed in the literature (Scholes & Albarran, 2005). However, AEIs have been accused of ignoring mentors over their concerns about failing students (Luhanga, Yonge & Myrick, 2008b; Kendall-Raynor, 2009). Despite concerns being raised, it seems there remains a lack of clarity between AEIs and mentors as to what is to be expected and required of each other.

In health and social care a professional and/or clinical judgement is made by the mentor. Carr (1997, p.71) argues one of the most important things about professional judgement is what she calls 'practical reasoning' in which '*the outcomes of practice cannot be pre-specified, there will always be needed a form of reasoning in which choice, deliberation and practical judgement play a crucial role*'. Practical wisdom, appears to require good understanding of what is required in any particular situation and both the ability and the capacity to act appropriately upon this knowledge.

When considering decisions taken by mentors they need to combine practical knowledge with sound judgement about what a student should have done in a particular situation, which would appear to constitute 'good decision making'. However, in nursing when a

judgement has been made and action taken to achieve that success it is often invisible, it is only when a perceived bad judgement (failure) has been made that there is evidence available. This can be clearly seen in those judgements made every day by mentors in clinical practice, only later when a student nurse (or registered nurses) actions are subsequently called into question that their judgement is known and evidence is available for scrutiny (The Allitt report, 1994; Department for Health and Home Office, 2003; Shipman Inquiry, 2005; Care Quality Commission, 2009; The Francis report, 2012).

A number of studies considered the criteria and validity of judgements about clinical performance (Brown, 2001; Cassidy, 2009c, 2009a; Fotheringham, 2011; Gallagher, Smith & Ousey, 2012). Others, in an effort to strengthen assessment decisions, have considered and introduced grading systems. In one study Heaslip and Scammell (2012), using the findings of an evaluation to explore grading of practice. Their study used convenience sampling and a survey questionnaire and was completed by 107 nursing students (51% response) and 112 mentors (practice-based assessors) (86% response). The authors' report the grading tool was valued by mentors, who welcomed the opportunity, reporting it had allowed for an opportunity to be more accurate and confident when undertaking assessments. However, whilst 59.8% (n=67) indicted they had the confidence to fail students, other mentors reported they did not have the 'confidence' to fail students. This reflects findings from a much earlier study by Andrews and Chilton (2000) who also found mentors felt less able to challenge students due to lack of confidence. This may indicate that failure to challenge reflects lack of confidence in failing the student. Later Duffy (2004) indicted a need for more education on managing failing students. It seems the assessment of 'borderline' students continues to be a difficult issue for mentors, grading of practice offers an aide to allow mentors to be more discriminatory. Such findings are important as it is possible that the general public may be exposed to risk if failing students continue to be given the benefit of the doubt and later an incompetent student is allowed to register.

5. Failing to fail

A recurring theme in the literature relates to the idea that mentors 'fail to fail' students (Lankshear, 1990; Duffy & Scott, 1998; Watson, 1999; Watson, 2000; Duffy, 2003; Scholes & Albarran, 2005; Dudek, Marks & Regehr, 2005; Rutkowski, 2007; Finch,

2009; Gainsbury, 2010a, 2010c; Jervis & Tilk, 2011). At times, to safeguard professional standards and the public, students do not pass if they do not meet the required professional standard (NMC 2008b), but it seems at times mentors may be reluctant to do this. What is significant is that this theme has recurred over several decades. The study by Lankshear (1990), appears to have first raised the issue that mentors were 'failing to fail students' in the UK more than twenty three years ago, suggesting that mentors were at times 'concerned and worried' about ultimately failing a student in practice, therefore the students passed their assessment. The study by Lankshear (1990, p. 37) reports that mentors felt '... *failing a student opens up a hornet's nest'.* This suggests mentors were maybe reluctant to fail a student due to the consequences for them as mentors and/or the student.

Two later mentor studies suggested that nurse mentors saw failing a student as a personal slight (Duffy & Scott, 1998; Watson, 1999). Watson (1999 in her investigative case study explored nursing student's and mentors experiences and perceptions of mentoring. The study reported claims that mentors admitted that they sometimes passed students at assessment who should not pass and also found mentors reluctant to refer students who did not perform well. Participants commented that they (mentors) believed the educational institution/university would and could overrule their decision anyway. Whilst the study is based on only one module in the first year of a 'Project 2000' course it is nonetheless important as mentors continue to mentor students in their first year of nurse training. In another study a year later, Watson (2000) reports at times mentors sometimes felt under pressure to agree a student was a pass even though in their opinion they were not, or the student nurse was not 'bad enough to fail'. In my own experience this remains a belief held by some mentors in practice, especially when a student nurse is in their first or second year of training.

The literature suggests that the issues in terms of 'failure to fail' has shown little improvement in more recent years (Scholes & Albarran, 2005; Dudek, Marks & Regehr, 2005; Finch, 2009; Gainsbury, 2010a, 2010c; Jervis & Tilk, 2011). In their study within an NHS Trust, Jervis and Tilk, (2011, p.384) reported they had found evidence that mentors were 'failing to fail' bringing the issue into focus once again. They reported that mentors were '*reluctant to refer students who did not perform',* with mentors commenting that it reflected their own and peers common experiences. In my own

experience mentors do fail students for a variety of reasons. Nonetheless, studies have explored why this occurs and have found the reasons are varied: difficulties completing and understanding documentation, work pressures, unprotected time, poor support and feelings of personal failure (Duffy, 2003, 2004; Rutkowski, 2007; Nettleton & Bray, 2008; Kendall-Raynor, 2009; Middleton & Duffy, 2012).

There is scarce literature which relate to the management of students failing in practice, a view supported by Scanlan, Care and Gessler, (2001). The study by Duffy (2003) is still viewed as the most important piece of research in the UK focusing on the issue of failing students. The detailed grounded research theory study, focused on the accounts of fourteen lecturers and twenty-six mentors, shared their experiences and perceptions regarding the issue of failing to fail students whose clinical competence was perceived to be weak and reasons they each thought this. Duffy indicates that the distinction between unsafe practice (in relation to students) and the assessment of a student who was safe but deemed a fail by the mentor needs further exploration, particularly those students assessed by their mentor as 'borderline'. Duffy's (2003) report remains the most highly regarded mentorship research, and her findings remain largely unchallenged. However, it is unclear why Duffy did not use the opportunity whilst undertaking her study to explore mentors' understanding between unsafe practice (in relation to students) and other students who whilst not unsafe were also failed, in more depth.

At the time Duffy's (2003) findings were disconcerting to the profession, in part because it was confirmed some mentors were passing students in practice who were not competent, due in part to the additional time that was needed to do so. This was explored and mentors reported 'failing a student' placed further pressures on their time and workload and so this led to them passing the student. In addition, Duffy (2003) highlighted mentors were not always addressing concerns they had with students, in time for them to be addressed, because they worried about the possible consequences for the student which could impact negatively on a student's career, threat that the student may appeal their decision and concern about own previous experience which had resulted in feelings of sadness, fear and isolation. Failing a student was described as '*horrendous, traumatic and draining'* (Duffy, 2003, p.38). Thus, if participants were faced with any doubt about their decision, mentors would usually give the student the benefit of the doubt. If the student was deemed to be not bad enough to fail, mentors would usually

decide to pass a student. It seems a student would fail only if they were deemed unsafe or identified as having poor understanding, knowledge, skills or demonstrated inappropriate professional behaviour. Duffy (2003) concludes that failing a student requires confidence, experience and adequate mentor preparation.

However, participants had more difficulties in failing students because of attitudinal problems, an issue highlighted in an earlier study by Lankshear (1990) who also found mentors were less likely to fail students who were perceived to have an attitude problem towards patients if they demonstrated they had all the other necessary skills and qualities. The study was undertaken prior to the Standards of Proficiency for Pre-registration Nursing Education (NMC, 2004a), Standards for Practice Learning (NMC, 2005, 2006, 2008, 2010) and Standards for Pre-registration Nurse Education (2010a) therefore it could be that the report does not fully reflect present pre-registration education and mentorship systems currently used.

In 2010, a large anonymised survey of over two thousand nurses was undertaken by the Nursing Times (Gainsbury, 2010a). Whilst it has not been possible to accurately determine the quality of the research (including through personal communication with the journal), this study has been included in this review as it was deemed significant for a number of reasons. The publication is widely read by registered nurses, mentors and students in practice. The survey results reported 37% of mentors who responded said they had 'passed students they thought should actually fail'. Mentors reported they believed 'universities routinely overturn student fails' and this rendered their 'assessments pointless'. Some mentors (17%) admitted to have 'fudged paperwork so students pass' (Gainsbury, 2010a). What is not clear from the survey is when this has occurred, where the students were in their programme, the preparation and experience of the mentor(s) and the wider experience of the mentor role in practice. These alarming findings clearly suggest rigorous research is needed on this topic to verify these practices and experiences.

In contrast to the papers claiming mentors were failing to fail, others suggest this is not occurring (Fitzgerald, Gibson & Gunn, 2010; Black, 2011). The study by Fitzgerald, Gibson and Gunn (2010) found 'little evidence' to support concerns relating to the issue that mentors were 'failing to fail students' as had been reported in earlier studies. They

did however find a mismatch between mentor (written) feedback in student's assessment documentation and verbal feedback to universities about student abilities. This appears to support the findings in the earlier study by Duffy (2003) in which mentors confirmed difficulties completing student assessment documentation. The authors also report inconsistencies and lack of ability of mentors to give accurate feedback to students on the issues of professional values and behaviours (Fitzgerald, Gibson & Gunn, 2010). Despite their claim that they found little evidence mentors were failing to fail students, these findings may be suggestive that mentors in their study are 'inadvertently or intentionally helping students to pass' or 'simply failing to fail' by not addressing issues and therefore giving students the benefit of the doubt about their abilities during assessment.

Another specific area in relation to assessment which has received attention is drug calculations and drug administration, both in the UK and abroad (Blais & Bath, 1992; Weeks, Lyne & Torrance, 2000; Grandell-Neiemi, Hupli, Leino-Kilpi, et al. 2003; Tzeng, 2003; Jukes & Gilchrist, 2006; Wright, 2009). These studies explored a specific perceived lack of competency in relation to drug calculation and drug administration in practice settings and include both pre-registration student nurses and newly registered nurses. Findings identify a lack of competency of both students and newly registered nurses. These findings seem particularly contradictory as the newly registered nurses would have been assessed and deemed to have the competency requirements for successful completion of nurse training prior to entering the nurse register. Interestingly all the authors focused on this one aspect and not on the overall set of competencies required to become a nurse. Despite this, they do support the need to investigate the important area of assessment, in particular the experiences of mentors undertaking sign-off assessments.

6. Sign-off mentors

Modest literature was identified relating to the SOM role and experience. As discussed previously – Chapter 2, in 2008 the NMC introduced the SOM role (NMC, 2006; 2008a). At the end of the student's final placement, the SOM makes a judgement on a student's performance throughout their three years of training as well as their final placement (NMC, 2008a). Potentially poor SOM preparation, lack of supervision, a lack of detailed

written feedback from previous mentors or even concerns that a student's career could be jeopardised by the mentor's actions could result in a SOM feeling unable to address a student's weakness or shortcomings at such a late stage in the student's training. The need for SOMs to undertake additional preparation and have access to support was advocated and is discussed in the literature (Fisher, 2009; Fisher & Webb, 2009; Glasper, 2010; Casey & Clark, 2012).

The literature search identified thirteen papers and reports (Bourbonnais & Kerr, 2007; Sharples, 2007; Fisher, 2009; Fisher & Webb, 2009; Middleton & Duffy, 2009; Glasper, 2010; NMC, 2008a, 2010b, Black, 2011; Barker, Durham, Kingston & Sykes, 2012; Casey & Clark, 2012; Wimbleton, 2012; Rooke, 2013). These pertained to final placements towards the end of a student's training, not necessarily SOMs and two papers relate to NMC guidance. The majority of the papers were simple commentaries related to the proposed implementation of the SOM role, NMC requirements and preparation. Nonetheless, these papers are important as they aim to address mentor understanding of the background, difference and necessary preparation required for undertaking a SOM role which will affect the assessment of students.

Three papers were identified relating to studies about aspects of nurse mentor experiences towards completion of a student's three year pre-registration nursing programme (Middleton & Duffy, 2009; Black, 2011; Rooke, 2013). In their qualitative study, Middleton and Duffy (2009) explored the views of community nurses in Scotland, mentoring adult branch student nurses immediately prior to registration. The study included 12 community mentors supporting adult field nursing students undertaking a diploma programme. Mentor participants comment that students should not be given the 'benefit of the doubt' when on their final placement, which does suggest that there may have been students who the mentors have previously failed to fail. Some mentors revealed that they did feel pressured to pass students on their final placement, which supports the findings in Duffy's earlier study (Duffy, 2004a). The study also focuses on the length of the practice placement, allocation of mini caseloads to final placement students and the support and development needs of the mentor. Nevertheless, the study misses the opportunity to explore other fundamental issues in greater depth such as the determination of pass and failure.

In her phenomenological study, Black (2011) interviewed nineteen mentors who had previously failed nursing students (adult) at the end of their nurse training. Mentors were interviewed and during the interview process guided through a process of structured reflection. Mentors justified decisions in terms of their duty of care and findings from her study found mentors did fail students if needed, but courage was required to make difficult decisions, despite the mentors' own beliefs and feelings. However, if Black's (2011) findings found mentors required courage to fail a student this may suggest that mentors may not always have the required courage to fail students.

One Canadian study (Bourbonnais & Kerr, 2007) focused on the preceptorship of students in their final clinical practice placements. The study was based on nurses in a Canadian hospital where SOMs are not utilised for students in their final practice learning settings, and therefore it was difficult to draw any correlations with SOM experiences here in the UK. In another paper, Rooke (2013) evaluation, included: nurse and midwifery mentors, new mentor' and lecturers' undertaken to elicit views and understanding of the final sign-off mentor role. Findings suggest that there remains some confusion and concern relating to the sign-off mentor role, understanding and preparation, although it is necessary to consider that in midwifery, sign-off mentors undertake sign-off assessments of midwifery students at additional progression points to that in nursing and concerns raised may therefore have related to midwifery students first progression point. However, limited clarity and uncertainty remains as to the pre-registration nursing SOM experience.

Chapter summary and conclusions

This chapter has offered insights into the literature reviewed and provided justification for the need to undertake research into the SOM experiences of undertaking assessment at sign-off stage. Provision of sufficient contextual information is an important aspect of case study methodology (Yin, 2003) and has therefore been employed in this chapter.

It is quite clear from the critical review of the literature is that it has confirmed a gap in the literature, especially pertaining to children's nurse SOM experiences. Research into the element of sign-off assessment is needed and crucial in relation to ensuring future practitioners are deemed able to deliver safe and effective health care and enter the NMC

nursing register. Whilst definitions of mentorship exist, there is inconsistency in mentors' understanding of their role, preparation, support available and knowledge about what is expected of them, which can impact on the ability of the mentor and SOM to undertake their role which includes undertaking assessments.

Overall, the literature review found that there were studies of variable quality in relation to unclear methodology and methods, poor reporting in the field of mentors, mentor assessment and mentor experiences of undertaking assessment of student nurses. Some areas relating to mentor assessment have been studied and debated over a long period of time, especially the issue of failing to fail students. The NMC introduced the sign-off mentor role, however, research in relation to this important aspect of pre-registration nurse education remains scarce. No literature was identified relating to the children's nurse SOM experience of undertaking assessment at sign-off stage. The literature search confirmed that although there appears to be an abundance of research regarding the issue of the nurse mentor role and experience, there are many unanswered questions, gaps, and inconsistencies.

Following a review of the literature, the children's nurse SOM experiences has not previously been addressed and the closest previous study by Duffy (2003) is now outdated. Therefore this research study focus was timely and needed to address the identified gaps in the literature. This study which explores children's nurse SOM experiences would provide a greater understanding of an important element of the SOM role and therefore strengthen the evidence base.

The following chapter, Chapter 4, explores the methodological considerations and philosophical perspective that have underpinned this study. It sets out the conceptual framework, revisits the research questions, and considers relevant theory considered in selecting an overall methodological approach. Case study research, methodological limitations and insider researcher/role issues are also discussed.

CHAPTER 4: METHODOLOGY

Introduction

The previous chapter offered insights into the literature critically reviewed and confirmed a need to conduct research into the children's nurse sign-off mentor (SOM) experience of undertaking assessment at sign-off stage. This chapter explores the methodological and philosophical considerations made in planning to answer the research questions. It presents the research focus, research design, relevant theory, epistemological stance, theoretical perspective and methodological approaches selected. Methodological limitations and insider researcher/role issues are also discussed.

Research focus

The literature examined in the literature review (Chapter 3) has illuminated the complexity associated with the role of the SOM in the practice learning environment. To consider how this complexity may have affected SOMs, I attended a regional mentor support group. An initial contact was made with an individual from the North West Mentor Forum, a regional support group that meets three to four times a year to provide peer support. It was here I initially introduced my early research ideas and provided some context as to why I was interested in this area. Following confirmation from mentors that the area of research was worthy of further exploration, the research aim was developed. The review of the literature has led to four research questions being developed to meet this aim.

Research aim:

To examine children's nurse mentor experiences of undertaking assessment at sign-off stage, in order to gain an in-depth understanding of the experience from the perspective of SOMs who undertakes the final assessment.

Research questions:

1. What are children's nurse SOM experiences of assessing student nurse competency at sign-off stage?

2. How do they interpret and describe their experience?

3. What are the factors that influence children's nurse SOMs in their final sign-off assessment of children's nursing students?

4. What are children's nurse SOM views as to how they decide if a student nurse is ready and indeed decisions to pass/fail students?

Research design

Consideration for the research design is important as it is '*the researcher's overall tool for answering the research question*' (Polit, Beck & Hungler, 2001, p.167). Crotty (1998) refers to four key elements of research design; epistemological stance, theoretical perspective, methodology and methods. Three of these elements will be discussed in this section whilst the fourth element - methods, will be discussed in the next chapter, Chapter 5.

Epistemology

It is generally accepted that each of us has a point of view that frames our approach to the world. Social reality can be approached in different ways and researchers undertake research based on their individual thoughts and ideas and beliefs about the world and the nature of knowledge (Crotty, 1998). It is suggested that the epistemological viewpoint of the researcher informs the theoretical perspective of a study and supports the methodology (Crotty, 1998). Epistemology is defined as the basis of a philosophy, it is a theory or set of beliefs that is concerned with what counts as valid knowledge or social reality and considers the nature of the natural world (Crotty, 1998; Bryman, 2008).

Three epistemological positions are identified in the literature: objectivism, subjectivism and constructivism (Crotty, 1988). Objectivism suggests the social phenomena and their meanings exist whether society is conscious of it or not. The position involves consideration of cause, effect and explanation. Constructivism supports the participant's interpretation of meaning through their engagement with the world. Subjectivism is the belief that everyone has a different understanding of what is known. Research using this assumption would involve the understanding of a person's meaning of what they do, essentially to understand an individual on their own terms and the ability to make sense of the world based on their own experience and background.

Theoretical perspective

An interpretive or interpretivist approach provides the theoretical framework for this study. Its approach centres on the way that individuals make sense of their subjective reality and attach meaning (Morse, 1991; Bryman, 2008). Researchers with this view believe that understanding is as important as explanation, prediction and control (Morse & Field, 1996; Yin, 2003; Bryman, 2008).

Interpretivism is linked to Weber's *verstehen* approach (1947) or notion of understanding (Bryman, 2008). Weber believed researchers should try to gain access to people's experiences and perceptions by listening to or observing (Platt, 1985). Weber thought the interpretive understanding of human beings meant that meanings could be found which requires the researcher to explore the subjective meaning of social action and human behaviour (Hughes, 1990).

An interpretivist approach was considered appropriate for this study as it '... *seeks to understand human behaviour and the social processes that we engage* (Gerrish & Lacey, 2006, p.158). Thus, the approach recognises that difference exists at an individual, social and cultural level and as such there can be no single interpretation, truth or meaning applied to an experience (Gerrish & Lacey, 2006). Interpretivists also have regard for subjectivity, values, beliefs and the opinions of the 'knower' about that which is considered to be known. Gaining understanding, as opposed to explanation, is the goal and is appropriate when using a case study research approach (Thomas, 2011) and therefore was deemed appropriate to meet the aim of this study.

Methodological approaches and considerations

In my day-to-day experience, I was aware of the children's nurse SOM role but I did not understand what the experience was like for the children's nurse SOM. I did not fully appreciate what it was like to be faced with the responsibility to support, guide, pass or fail a student undertaking their final practice learning experience. A methodology was required for this current study that would enable an understanding of the SOM experience to be explored.

Research is undertaken in order to generate new knowledge about a phenomenon (Creswell, 2003). A number of approaches are available which include quantitative, qualitative and mixed methods (Creswell, 2003; Johnson & Onwuegbuzie, 2004). Quantitative research places importance on rationality, objectivity, prediction and control (Creswell, 2003). In contrast, qualitative enquiry collates and interprets non-numeric, narrative data (Polit & Hungler, 1993). Qualitative researchers seek to develop rich descriptions and generate theory. The intention is to develop theoretical, rather than statistical, generalisations (Creswell, 2003: Bryman, 2008). Subjectivity is intrinsic to the qualitative research process. Rather than striving for detachment, the researcher forms part of the instrument of data collection, data interpretation and analysis (Crotty, 1998).

The philosophical implications of a research question directly influence the methodology chosen for a study (Crotty, 1998). Qualitative methodological design focuses on the way people interpret and make sense of experiences (Creswell, 2003; Bryman, 2008). It is considered appropriate when the phenomenon being studied is some form of social experience that needs greater understanding or further explanation (Crotty, 1998; Creswell, 2003) as was the case in this study. A qualitative methodological approach would also allow children's nurse SOM a voice and allow their experiences to be heard (Jack, 2010). What is not being suggested is that quantitative research approaches are less valid than quantitative ones. It is rather that they are appropriate for certain kinds of inquiry.

In the UK, qualitative health-related research is largely focused within grounded theory, phenomenology, ethnography and case study methodologies (Creswell, 1998). Grounded theory is a primarily inductive approach to theory development whereby emergent hypotheses are tested and theory and data collection modified until the optimal fit is achieved (Morse & Field, 1996). Whilst the emphasis is on developing theory of social processes and appreciating individuals' experiences it did not offer as good a fit as case study research which supports developing an in-depth understanding.

Ethnography was also considered as it is concerned with cultural beliefs and values explored by participating in people's daily lives (Hammersley & Atkinson, 1995). It seeks to gain an insider's view in order to understand human behaviours (Morse & Field, 1996). Ethnography was at first an attractive approach in view of SOMs' experiences

being underpinned by the development of a mentorship culture in nursing. Like grounded theory, it is also suited to the use of a variety of research methods but again it lacked an emphasis on gaining an in-depth understanding.

Case study was considered as it is concerned with the how and why and identification of its meaning and what can be learnt from experiences. Yin (2009, p.18) confirmed a case study research approach was appropriate when a researcher wanted to '*understand a real-life phenomenon in depth, to capture the detail of specific experiences under investigation'.* Case study research is an approach that supports the use of multiple research methods most suited to answering the research questions and enabling discoveries within, and interpretation of, the social world (Coffey & Atkinson, 1996).

Rationale for selecting case study

A case study research approach was selected as the preferred methodology and was chosen to undertake this research. The definition by Yin (2003, p.13) appealed since it reflected my current understanding of the area of enquiry I was interested in because of the emphasis on '*real life context'.* I considered that case study offered me the flexible approach needed to research in an area where boundaries were not clearly identified when examining the experiences of SOMs (Gerrish & Lacey, 2010). I anticipated that by gaining a detailed description of SOMs' experiences I would be able to gain insight to the complex nature of the experience of being a SOM in the practice learning environment.

Case study research is not without a theoretical basis and Yin (2003, p.14) purports that case study research, '*benefits from the prior development of theoretical propositions to guide data collection and analysis'.* Therefore this confirmed this approach would also support the theoretical perspective of the study. Although case study research can be conducted by adopting a positivist approach, it is often associated with interpretivism as it allows for   '*an in-depth understanding and deep immersion in the environment of the subject'* (Thomas, 2011, p.124).

Methodology strengths and limitations

There is continued debate around the value of quantitative versus qualitative approaches. Having considered the principles of each approach, a qualitative methodology was chosen as it provided the best fit in order to answer the research questions. Qualitative research can present a number of practical issues. Examples include, ease of access to the setting and ethical concerns (Parahoo, 1997). Qualitative methods also have a tendency to be quite time-consuming (Morse & Field, 1996).

Critics of qualitative approaches would suggest that objectivity has been lost in qualitative research (Mulhall, Alexander & le May, 1998; Sibbald & Roland, 1998). However, objectivity is not the goal of qualitative enquiry; in relation to this current study the aim is to seek understanding of the children's nurse SOM experience of undertaking assessment at sign-off stage, these experiences are unique, context-related and not replicable (Yin, 2003; Parahoo, 1997). Again, it is possible to argue that achievement of complete objectivity is not possible even within quantitative approaches.

Allen and Cloyes (2005) identify a potential limitation when undertaking qualitative research which raises potential ethical issues and challenges for the researcher. Whilst interpersonal relationships are critical to qualitative research, the researcher and participant, the approach can cause previously forgotten stories and memories to be remembered by the participant that otherwise would not have occurred and therefore could cause distress. Therefore, it is necessary for the researcher to consider and be aware of this and ensure support is available, if necessary, for participants.

The case

The overall case, or target group, are the SOMs based in the Mersey, Cheshire and West Lancashire practice learning settings in the North West of England. The subdivisions within that case include the children's nurse SOM experience practice learning settings. The focus of interest was an examination of children's nurse mentor experiences of undertaking assessment at sign-off stage (Yin, 2009). Thomas purports '*case study is not a method, nor is it a set of procedures. Rather it is a focus*' (Thomas, 2011, p. 37). Thus, once the case was decided, choices about the approach were determined

The case study research was undertaken in the North West of England, with participants from the practice learning setting and so generalizability beyond this single setting was a consideration. Whilst a criticism of case study research concerns the lack of potential for the generalisation of findings. Creswell (2003) suggests that the intention of qualitative research is to develop theoretical, rather than statistical, generalisations of what is being sought. Children's nurse SOMs may not experience events in the same way and these may be significantly different across other fields of nursing. Thomas, (2011, p.216) supports the view that '*generalisation from all inquiry are tentative as they all produce knowledge that is provisional until future researchers find out something new',* thus findings from this research study may also change if a different group of children's nurse SOMs were interviewed at a different time, however, the aim is gaining new explanations and insight into the SOM experience, not generalisations.

As detailed in Chapter 2 - Background, the climate in the NMC, AEI's, changes in pre-registration nurse education and the introduction of SOM in practice learning settings at the time of the study was suited to a case study approach to investigate it. Use of a single case study design proved appropriate in gaining an understanding of the children's nurse SOM experience of undertaking assessment, especially as this was a phenomenon about which little is known (Yin, 2003, 2009). Another advantage of the case study method has been to maintain a clear focus on the design and direction of the research (Yin, 2003, 2009) and in this case has permitted investigation of the children's nurse SOM experience rather than become blurred around related issues such as other aspects of mentorship.

Yin (2009) suggests that all case study research starts from '*the desire to derive a (n) (up) close or otherwise in-depth understanding'* (Yin, 2009, p.4). In order to gain an in-depth understanding it is necessary to look at the whole rather than a sum of parts or a set of interrelating variables (Thomas, 2011, p.46). In this study the approach has allowed a new understanding of the children's nurse experience in terms of preparatory needs for undertaking the SOM role and responsibilities, influences that impact on their assessment of student nurses, including their own expectations of students as a SOM, previous mentor decisions, access to support and the emotional impact of the SOM role.

Insider researcher

There are a number of issues and considerations around the role undertaken by researchers, dependent on whether they are viewed as external, internal, or practitioner-researchers. Case study research roles have their own issues and are considered in this section.

Insider researcher issues

An 'insider researcher' is a term usually associated with someone who undertakes systematic enquiry in relation to his/her employed work. The topic of insider/outsider research has received considerable attention within the literature. A study by La Gallias (2008) discusses the issue of insider/outsider research. Her work builds upon the work of Hellawell (2006) which provided an analysis of the insider-outsider concept as a heuristic device to develop reflexivity in students undertaking qualitative research. La Gallias (2008) also stresses the value of enhanced self-awareness commenting it is reciprocal in nature, which is, the researcher becomes more aware of the nature of research in terms of how their own values and beliefs may influence the research being undertaken.

Insider qualitative researchers could be criticised for failing to achieve sufficient objectivity due to being too close to the data (Asselin, 2003). However, objectivity is not the goal of qualitative enquiry (Creswell, 2003). Whilst Yin (2009) agrees that researchers cannot avoid affecting those they study, he offers reassurance that interpretations are a part of the scientific knowledge being pursued. It is however, recognised that the maintenance of pre-existing work relationships is difficult and consideration is needed to prevent the researcher being seen as patronising. Asselin (2003), argues that this can be offset by the fact that the internal researcher generally shares the same occupation as the participants.

The dilemmas of an insider researcher who, similar to the researcher, was employed as a lecturer were explored by Humphrey (2012). Humphrey, a lecturer and registered social worker, comments on a series of dilemmas which materialised from her four-year study with students. These included a range of ethical dilemmas which arose in terms of gaining informed consent from participants and confidentiality which occurred whilst

undertaking her data collection (surveys), the study also highlighted a range of professional dilemmas which arose from a new position of researcher, her current role of lecturer, from her professional responsibilities as a registered social worker and also from her former role of practice educator which she recalls '*converged and collided*'. Humphrey confirms all these elements required consideration as they all had the potential for the study to cause conflict among participants, her university, amongst peers and practice partners (Humphrey, 2012).

Insider researcher status

Children's nurse SOMs undertake assessments of students and some of these are undertaking the pre-registration nursing course at the university where I am also employed. It is important to note that I had a vested interest in the success of SOM assessment as a senior member of the pre-registration nursing programme team where I held student nurse progression and practice learning responsibilities and thus I am very much an 'insider'. Rather than adopt a research approach that determined whether or not children's nurse SOM role had been successfully implemented or not, I preferred an approach that meant I could understand their experiences and identify positive and issues related to the children's nurse SOM experience. The researcher role and how it is conducted is clearly an important issue with a number of ethical considerations. Within case study research, much attention is paid to the critical examination of the researcher role to ensure transparency in the way it is managed (Yin, 2009; Thomas, 2011).

Chapter summary

This chapter has explored the methodological and philosophical considerations made in planning to answer the research questions. It has highlighted the research design choice of an interpretivist, qualitative approach to frame a case study research inquiry. These choices gave the best fit for meeting the study's aims regarding examining the children's nurse SOM experiences of undertaking assessment at sign-off stage. A case study approach is appropriate for use when investigating a complex issue such as children's nurse SOM experiences.

All research designs have their merits and weaknesses. Decisions need to be made as to which approach is preferable and support the method/s most suited to achieving the goals of the enquiry. A case study research approach was chosen because it would allow an in-depth understanding of the subject to emerge. Advantages and disadvantages of insider research roles have also been explored. There is acknowledgement in case study research that researchers cannot avoid affecting those they study (Thomas, 2011, Yin, 2009). Interpretations are in themselves a part of the scientific knowledge being investigated (Thomas, 2011), thus providing reassurance for the chosen methodology for this research study.

The next chapter, Chapter 5, considers the methods considered and utilised to collect and analyse the data that will answer the research questions.

CHAPTER 5: METHODS

Introduction

The previous chapter explored the methodological considerations and philosophical perspectives underpinning this study and set out the research aim and questions. This chapter provides the methods, analysis and limitations experienced within this study. Each aspect selected for use in this study is considered here including the processes of data collection, data management, data preparation procedures and analysis in the study. Sampling and recruitment issues are also considered. A summary is provided which draws together the discussion of this chapter.

Part 1: Methods

This section sets out the methods considered for use within the study and the final selection. The methods critiqued for use to explore SOM experiences are one-to-one interviews, focus group interviews and survey.

Consideration of methods

The intention of this study was to gain a deeper understanding of children's nurse mentor experiences at sign-off stage and therefore crucial to approach the study in a way that would allow deep exploration of this issue. When looking at the available methods it was necessary to select those that support the overall design and help to elicit SOM's essential experiences (Crotty, 1998; Creswell, 2003). It was also necessary to select appropriate methods which support a case study approach, which was the chosen research study approach. Case study research encourages multiple sources of evidence (Yin, 2003, p.13) and permits the use of mixed methods. The methods will be set out and considered in order to illuminate what decisions were made and why.

Interviews

The main method to be considered was interviews. Interviews are a well-established approach within a qualitative research design (Creswell, 2003; Silverman, 2007; Bryman, 2008; Olson, 2011) and their use also aligns well with case study research (Yin,

2009; Thomas, 2011). A range of interview types exist including the structured, unstructured or semi-structured interview which are the main types used in qualitative research (Creswell, 2003; Bryman, 2008). Focus group and group interviews are another form of interview (Liamputtong, 2011). Telephone interviewing and online interviewing in which the interview is undertaken by email and self-administered questionnaires are other forms of interview (Bryman, 2008).

The primary function of an interview is to generate information in order to gain insight into an individual's experience (Silverman, 2007). Interviews can provide a method of discovery about things that cannot be directly observed, and are commonly used in the collection of data (Silverman, 2007). Case study interviews have been described as distinct from other forms of in-depth interviewing as the approach values the experiences of individuals as unique to them and thus the aim should be to gain an understanding from the individual's perspective (Yin, 2009; Thomas, 2011).

Interviews may be structured, unstructured or semi-structured. Structured interviews can be administered relatively easily and quickly, however this approach has little advantage over the use of a questionnaire (Kvale, 2007; Thomas, 2011). In contrast, an unstructured interview has no fixed format and like a conversation, means that the participants can raise the issues that are important to them and so divulge their own terms of reference which would enable participants to express their views with less influence from the researcher (Chirban, 1996). The use of a semi-structured method provides a sense of a general structure and guide to allow the interviewee the opportunity to express their views, talk about experiences and focus on the research topic to be explored (Bryman, 2008).

Other methods were considered such as observation and questionnaires, but they were discounted. Whilst observation is a method which is often used within case study research (Yin, 2009), it can be intrusive and/or inconvenient for those being observed for what can be long periods of time or when asked to select from given alternative responses, as is the case with administered questionnaires (Bryman, 2008; Chirban, 1996). Therefore it was considered that these methods may not elicit the SOM experiences, especially if they were left feeling they had to act or respond in a certain or artificial way because they were being observed undertaking sign-off mentorship.

Individual interviews

Individual interviews were considered as they avoid the steering of the conversation by group dynamics and would allow interviewees to feel more comfortable and provide opportunities to divulge sensitive issues in a one-to-one situation (Smith, 1995). Interviews would allow the SOM perspective of the interviewee to be heard. As a registered children's nurse and nurse lecturer myself, I identified with being able to relate to children's nurse SOM interviewees within the context of their role in order to understand and explore their experience.

Individual, semi-structured interviews were preferred to unstructured interviews. Semi-structured interviews would provide some structure to encourage focus on the research topic whilst permitting participants to raise the issues that are important to them. A semi-structured interview guide would aid the interview process by providing a framework and allowing questions to be asked in no specific order, encouraging participants to converse (Polit & Hungler, 1993). Prompting and probing during the actual interview to check meaning and encourage elaboration of participants' views is also permitted (Bryman, 2008).

An interview guide was developed based on insights from the literature and my own professional practice experience. This was designed is such a way as to permit prompting and probing during the actual interview to check meaning and encourage elaboration of participants' views and exploration of new insights. A comprehensive participant information sheet and consent forms were also developed (see ethics section p.61 and Appendices 3- 5) and these were to be sent to potential participants identified through the PLSS database (see Appendix 1).

Focus groups

Focus groups were considered and selected as they are useful in exploring participants views and experiences (Llamputtong, 2011), offering a further way of obtaining insight on a range of views, stories, experiences, beliefs and needs of participants. Therefore, it was anticipated that choosing both individual interviews and focus groups to collect data

would enhance data richness (Lambert & Loiselle, 2008) and their use was also permitted in case study (Yin, 2009; Thomas 2011).

Unlike individual interviews, focus groups would allow participants to converse with and build on previous responses of the other participants within the focus group, allowing for '*joking, arguing, teasing and recapturing past events*' (Llamputtong, 2011, p.5). The emphasis on the participant's interaction and communication would provide opportunities for increased spontaneity in the sharing of participant's experiences and opinions, which would support a means of generating insights from the communication between participants and thus allows exploration of diverse perspectives and group norms (Kitzinger, 2005). Whilst interviewees may find it difficult to discuss issues within a focus group in relation to aspects of their SOM experience, the use of focus groups would be a way of providing a forum in which participants could feel both supported and empowered (Krueger, 1997).

It was important to recognise that a focus group was not a group interview but a group of individuals brought together and facilitated to focus on and discuss a particular issue (Llamputtong, 2011), although sometimes both these terms are used interchangeably. The aim is to facilitate or moderate the discussion between participants and not to control the discussion (Thomas, 2011). Thus, rather than the researcher taking a lead role as in individual interviews, in a focus group the researcher is the facilitator or moderator (Llamputtong, 2011). Kvale (1996) warns problems can occur, especially if certain members of the group are much more vocal than others. Despite this, it was anticipated participants would have something in common (all children's nurses and all SOMs) which would promote interaction, resulting in a more free-flowing discussion of experiences and issues. Participants may be more inclined to share and compare their individual experiences, both positive and negative, of undertaking student's practice assessments at sign-off stage. This method had the potential to be less influenced and directed by the researcher compared with the individual interview situation.

Focus group size was considered as it is crucial for success, but there is variation of ideal size for a focus group. Generally, it is recommended that there be between six and ten participants (Llamputtong, 2011). Larger groups can be more difficult to facilitate and can make it difficult for quieter members to contribute and have their say. Information

generated in groups smaller than four may not be adequate, given there will be fewer people to interact and one or two individuals may try to dominate the discussion (Llamputtong, 2011). Successful, very small focus groups (which consist of two participants) are also reported in the literature (Toner, 2009).

Organising focus group events can be fraught with difficulties which can impact on their success. Consideration of the location and venue was a crucial aspect in the planning, as choosing the right location and timings can influence whether participants are able to turn up, or have difficulty making time to participate during working hours (Llamputtong 2011, p.72), who continues that it is '*essential that the location for the focus group is prepared in advance*'. When the environment is appropriate (not too large or small), comfortable (not too hot or cold) and relaxed this will be conducive to the quality of interaction and discussion as participants will not want to simply '*finish off quickly*' (Hennink, 2007, p.157).

It is considered that focus groups are quick and cheap to undertake, although Krueger and Casey (2009) suggest that this is a myth and argue that payment is necessary for participation in focus groups, especially if the researcher needs to recruit those who are hard to recruit because they have busy schedules. Others warn that payment in research is not appropriate as a payment can also be seen as coercion (Holloway & Jefferson, 2000).

Survey

To complement interview data an anonymous survey was considered. Whilst surveys are often associated with quantitative research, a survey involving the use of a questionnaire can be used in qualitative research (Wellington & Szczerbinski, 2007). An online primarily qualitative survey is useful in order to gain insights from greater numbers of SOMs than is permissible from interviews alone. The advantage of using an online survey tool for the distribution of the survey is it can give easy access to a large sample of SOMs who all have internet access. Furthermore, such a survey could provide rapid response rates (Mann & Stewart, 2000), although response rates may not be as high as paper based surveys and may contain less detail.

The rationale for consideration of an anonymous survey was the issue of registered nurses potentially speaking out or raising concerns (Stone, Traynor & Gould et al. 2011). Nurses have a professional and ethical obligation to report concerns about poor or unethical practice (NMC, 2008b). If practitioners tell the truth or 'blow the whistle' on poor practice it may be costly to the individual (Gallagher, 2010; RCN, 2009). This issue is potentially both challenging and complex for nurses (Stone, Traynor & Gould et al. 2011). It was considered that a survey would complement interview participant's data and provide data from non-interviewed participants. Those already interviewed would not be excluded as they too may reveal insights via this method that they did not do at interview in the company of others. A survey would permit anonymity to be assured in the seeking of views of SOMS on a, potentially, sensitive topic.

Selection of methods

It was considered that individual in-depth interviews and focus group interviews would provide a good fit with the aim of the research and the case study tenet of enabling participants to tell their own stories (Yin, 2009). The use of interviews would provide an opportunity to elicit deep, meaningful and useful data (Yin, 2011) concerning children's nurse SOM experiences and the use of both methods is recognised as a valuable strategy in case study research, as data generated from one method can serve to illuminate data gathered in the other method (Yin, 2009).

The rationale for an anonymous survey to elicit views that participants may be reluctant to reveal in a face to face situation, was also strong. However, the need for such a survey unexpectedly diminished during data collection and so this method was abandoned and is no longer referred to in the chapter.

The sampling method chosen would be purposeful because of the need to select SOMs fitting the inclusion criteria. Participants were to be drawn from across the practice learning circuit which would include a children's hospital trust, four smaller hospital based units across different hospital trusts and a range of community areas from across the practice learning settings which would allow SOMs who have knowledge of the research topic to be included (Thomas, 2011). This strategy would ensure efficient and effective sampling, allowing the potential to obtain optimal quality data. Sampling

adequacy means that sufficient data has been obtained to account for all aspects of the particular issue (Morse, 1991),

Personal reflective diary

The use of a personal reflective diary was recognised as a potential valuable research tool in providing a contextual dimension to the research (Glaze, 2002; Ortlipp, 2008). Although not a method for data collection, a personal diary would allow records of conversations, thoughts, feelings, issues and actions that have occurred during the research. These theoretical memos written immediately after every session of interview could include any actions or remembered conversations that I had in relation to the study. Diary use is supported in case study research (Thomas, 2011; Yin 2011). During data analysis it would provide a way of considering a range of decisions made such as ethical dilemmas relating to recruitment, confidentiality, power and knowledge, that I (the researcher) had with participants and reflections on what had occurred throughout each stage of the study. Thus diaries can support the research process in relation to the recording of a transparent decision trail and ideas of areas in need of further exploration and research. When not in use and following completion of the study the reflective diary would require to be locked up securely on university premises in line with the Data Protection Act (2003).

Recruitment

Having met with potential participants when originally exploring the need for the study, I believed that actual participants would therefore be more receptive when they received an invitation to take part in the study. At interview this prior relationship building would potentially help participants feel more comfortable with expressing their true views. I also believed that SOMs would be more inclined to share views concerning their individual experiences, both positive and negative, of undertaking student's assessment at sign-off stage. As an insider researcher, it was anticipated that a good rapport would have been built with potential interviewees, a view supported by Silverman (2006).

Sampling

Sampling in qualitative research tends to be guided by the principle of purposeful sampling, which ensures potential participants are information-rich and can inform the questions under study (Silverman, 2007, Creswell, 2003). In case study research studies there is a variation in how sampling processes are different. Yin (2009) directs that it is necessary to select participants who are able to '*provide rich data and therefore deep levels of understanding*'. Thomas (2011, p.62) agrees and states that '*sampling is not important in case study research it is the selection that is vitally important*'. Thomas, (2011, p.62) continues '*the point of case study is not to find a portion which shows the quality of the whole*', *i*t would therefore appear that when considering sampling strategies for case study research studies they must not be driven by generalisation of findings but rather by those SOMs who are able to provide rich data.

The sampling method considered was purposeful because of the need to select SOMs who had knowledge about the area under study due to their professional registration and experience. The identified sample group for the research would consist of SOMs from the North West of England (UK) and they would be chosen from across the range of practice learning settings. The SOM roles within the large and smaller hospital practice learning settings were anticipated to be fairly similar, yet potentially different from the SOM roles undertaken in community practice learning settings. The community SOMs most likely faced different challenges; they often undertake lone working and although students may have their own small caseload of children to care for (under supervision) local policy may restrict this in some instances and students may not have the same opportunities to develop and demonstrate the range of ward management skills expected of a student at sign-off stage.

Inclusion and exclusion criteria

The participant inclusion and exclusion criteria set to determine who could be included in the study are summarised in table 4 below:

Table 4: Participant inclusion and exclusion criteria

Inclusion Criteria All must have	Exclusion Criteria Used to exclude
A current children's nursing registration on the NMC professional register.	Does not hold a children's nursing registration on the NMC professional register.
Holds a current mentor qualification	Does not hold a current mentor qualification
Nurse mentors-sign-off (sign-off status or currently undertaking supervised sign-off assessments).	Has not been involved in supporting pre-registration nursing students at sign-off stage.
Have undertaken assessment of nursing students (Past five years to enable sufficient recall and no number limit).	Not registered as an active sign-off mentor on the West Lancashire, Cheshire and Merseyside Practice Learning Support System (PLSS) placement and mentor database.
Registered as an active sign-off mentor on the West Lancashire, Cheshire and Merseyside Practice Learning Support System (PLSS) placement and mentor database.	
Willing to participate and reflect on their experiences	

One hundred and four SOMs expressed an interest in the study and twelve were selected using the selection criteria outlined above (Table 4). The intention was to undertake twelve individual interviews and then invite all participants to take part in one of two focus group (six in each group) interviews. This approach would mean that the participants were selected to include children's nurse SOMs registered on the PLSS mentor data base and who may display varied characteristics, for example, hospital or community based, less experienced and a varied range of previous mentor experience. All twelve participants were female which was not unexpected as it is reflective of the predominately female nursing workforce particularly evident in children's nursing. Despite the number of men entering the nursing profession reported to be on the rise, it seems a significant increase in the percentage of men has not occurred, which is particularly evident in children's nursing (Meadus & Twomey, 2011).

Summary

This section has illuminated the choice of adopting individual and focus group interviews. The complexities of decision-making in relation to assessment also add weight to the preference and choice of the case study components identified above. Whilst not a data collection tool, a personal reflective diary was also recognised as being a valuable research tool to aid transparency and reflection throughout the study.

Sampling would be purposeful and recruitment guided by the principle that there was one practice learning circuit and that SOMs from across a range of hospital and community settings would provide their own individual experiences and could offer potential for comparison and contrast. These are acceptable in line with the research questions and case study research approach.

Part 2: Data collection

Introduction

Having determined the methods of choice, this section sets out details of the data collection strategy including recruitment, procedures followed for undertaking interviews, data management and analysis procedures. Before data collection could begin, a number of steps needed to be taken to ensure ethical approval procedures, including considerations for the gaining of consent from participants were met as well as confidentiality and anonymity. Steps taken to prepare the data in terms of transcribing, coding, verification and storage are summarised.

Ethics

The ethics guidance and best practice standards provided by the Research Governance and Ethics Committee, College of Health and Social Care, University of Salford were used to inform my research planning, structure of information sheets, consent forms and how I was to conduct the research interviews and focus groups. Ethical approval to undertake the study was gained from submission of an application for approval to the Research Governance and Ethics Committee, University of Salford and the Research Ethics Committee at my employing university.

Ethical issues

To ensure I was well equipped to undertake the study research training needs were identified and met prior to undertaking the study and reviewed during regular supervision throughout the study (see Appendix 9).

A range of potential insider research dilemmas were identified and these included: informant bias, conflict of interests, influence (position power) and interview reciprocity. These were explored at research supervision and by the use of a reflective diary to regularly reflect on whether these factors were influencing my approach. I was especially aware of my influence (position power) at all times during the conduct of the research. Insider research is however valid and useful, providing opportunities about what organisations are really like to emerge (Rooney, 2005). This view is supported when undertaking case study research where Yin (2009) states it is necessary the researcher uses '*their own prior, expert knowledge'* in order to demonstrate awareness of current thinking and discourse about the topic (Yin, 2009, p.161).

A key element was to consider how to identify and access children's nurse SOMs and establish if they were currently active as a SOM. As an existing employee of the university where I was collecting data, I had a wide range of access to practice learning settings and staff who support students. I also had access to the PLSS online placement and mentor data base and so there was a need to redefine access in view of my new position of researcher. A formal request to access the PLSS database which holds a range of data, including practice staff mentor and SOM status details, was therefore requested and assured by the PLSS Senior Management Group (see Appendix 1).

Access to SOMs was further secured through informal methods and already established working relationships with the team of Practice Education Facilitators (PEF) whose role it is to support mentors in practice areas across the sector. Additionally, I had spoken with likely participants through a regional mentor forum group to gain their approval of the study in principle in the early stages.

Whilst participants in this study were identified through the PLSS database, in those areas where a Practice Education Facilitator (PEF) was employed, they sometimes

played a role by reminding the SOMs about the study and in identifying staff that had moved to another area or left the organisation. During the recruitment phase an offer of help was put forward 'let me know how many you need and I can find the best sign-offs'. This offer to potentially choose their best SOM in the organisation was declined and at the time considered a naïve comment rather than a deliberate act to prevent any contact with any particular children's nurse SOM. The incident was documented and later discussed during research supervision (see Appendix 7). My insider researcher role helped me appreciate the risk of 'cherry picking' participants and seek more robust means of sampling.

In terms of this study, my own participation as an insider researcher familiar with the pre-registration nurse education context, practice learning ways of working and having a similar professional health care background when interviewing SOMs, has been valuable in understanding the perspectives of participants and their situations. Whilst in a study by Humphrey (2012, p.1) had commented on how their different roles of *'researcher, academic tutor, social worker and former practice educator converged and collided'*, this has not been the case in terms of my own study. Case study research requires deep immersion in the environment of the research topic and a deep understanding of social situations (Thomas (2011) and my own insider researcher role has helped facilitate this.

My insider researcher role also proved to be valuable during the study design, recruitment and the gaining of consent. Nurses have a professional and ethical obligation to report concerns about poor or unethical practice (NMC, 2008b). SOM participants were informed through the process of verbal and written informed consent that if this occurred then I would be required to divulge breaches of the Code of Conduct to the SOM manager following a discussion with them (NMC, 2008b, 2010c). My insider researcher role helped me fully appreciate the potential risk to participants and ensure participants were fully informed.

Consent of participants

With any research study there is a need to ensure that informed consent is gained from participants. Participation in the research study was voluntary, however in order to ensure prospective SOM participants made an informed decision they needed receipt of

sufficient information about the research study and all that was expected to occur. A participant study information sheet was developed in a suitable format to ensure participants were able to make an informed judgement (see Appendix 5).

Individual and focus group interview consent was gained in the following way: individual potential participants were identified and accessed via the PLSS database and once identified, children's nurse SOMs were e-mailed a covering e-mail and a more detailed invitation letter by me which provided details about the study (see Appendix 2). A reply was requested by e-mail or telephone to determine their wish to participate. The email and attached letter were designed to raise awareness of my research, my professional background and what would be expected if they agreed to take part in the study, allowing potential SOM participants to make a decision about requesting further information.

On receipt of a reply e-mail or telephone call a more detailed Participant Study Information Sheet (see Appendix 5) was sent to potential participants about the study outlining the purpose of the study, consent issues, their right to withdraw at any time, contact information for any enquiries or complaints regarding the conduct of the research and an invitation to participate in an initial individual interview with a view to a later focus group interview. Following confirmation to take part in the study, arrangements were made to answer any queries and a date, time and venue set for the interview that was convenient to them.

On the day of the interview; written and verbal information to participants detailed who I was and why the interview was required; what was expected of participants; that the interview would be digitally recorded; that they could withdraw from the study at any time; maintenance of confidentiality; identification of poor practice and what would happen; when findings from the research would be available. Signed consent confirming agreement to be included in the study was obtained (see Appendices 3 - 5).

Confidentiality and anonymity

Every effort and precaution was made to try and protect the participant's anonymity and ensure confidentiality. These issues were considered throughout the design of the study.

Confidentiality was assured to participants at all times and complied with the Data Protection Act (2003), and the Nursing and Midwifery Council regulations (NMC, 2008b).

All information collected about participants during the course of the research study was kept strictly confidential. Any identifiable information was removed from the transcripts and these materials made available only to myself and research supervisors as agreed with SOM participants. All data including paper copies and data memory sticks, including back up data sticks, were kept in a securely locked cabinet within a locked room in my place of work. Consent forms were also kept securely and separate from other data. Research records will be kept securely for five years. Digital recordings were kept separately and securely from interview transcripts and were appropriately destroyed on completion of the research study analysis.

Due to the research study topic it was acknowledged that some occurrences might be of a sensitive nature, such as discussions related to poor practice of themselves or practice they may have witnessed in others. In anticipation of this SOM participants were informed during verbal and written informed consent that if this occurred then I would be required to divulge breaches of the Code of Conduct to the SOM manager following a discussion with them (NMC, 2008b, 2010c).

The aspect of maintaining anonymity within focus groups was considered. During focus group introductions the importance of confidentiality and the need that participants respect the confidentiality of other focus group members in relation to their attendance and contributions was addressed (Smith, 1995). Whilst facilitating focus group(s) only first names were used in order to provide some protection of the participant's privacy whilst still providing a basis for focus group members and myself to build a rapport. Whilst every precaution was taken and focus group SOM participants were encouraged to maintain confidentiality about what had been discussed, it was not possible to guarantee that all discussions in the focus group remained totally confidential once participants had left the focus group(s). This was made clear to participants.

Interviews

Individual interviews

Potential participants were given seven days to consider taking part and were to reply via e-mail, telephone or post before the interview took place. Twelve participants were finally recruited. On the day of interview, participants were invited to attend a meeting room within, or near to, the individual's area of work. The environment was suitably prepared, including careful positioning of seating. The risk of interruptions was anticipated, and minimised by putting a sign on the door informing colleagues that an interview was in progress and to interrupt only if necessary. Copies of the participant information sheet, consent form and pens were set out ready. I was to conduct the interview alone and each was expected to last approximately 50-60 minutes. Two audio recorders would be used to allow for failure of one of them and positioned discreetly. A friendly but professional manner was adopted and smart casual dress worn. Following a welcome, further information detailing the purpose of the interview, expectations of participants, confidentiality and issues of identification of poor practice was provided, discussed and questions were invited. The children's nurse SOM participant was asked to read and if they agreed, sign the written informed consent form (see Appendix 4). All SOM participants were made aware that their individual interview would be digitally recorded, with their permission. I explained that the interview would be informal and offered reassurance that they should take their time and not worry about pausing to think whilst the recorder was running. SOM participants were encouraged to respond and elaborate their responses fully. It was stressed that it was their experience, the reality of their assessment experiences at sign-off stage as well as their own views, opinions, interpretations and comparisons that were being sought.

During the interview reference was made by me to the interview guide placed nearby. Each participant was invited to share their personal experiences, insights, the reality of assessment experiences as well as their own views and opinions. At the end of the interview participants were thanked for their time and participation and assured a copy of the transcript would be sent to them for them to check, amend and keep.

Focus group interviews

Each of the 12 participants who attended an individual interview was invited to attend a focus group with others (two groups of six). This would enable views to be generated by the group composition, which is not always possible by individuals regarding a potentially sensitive topic such as this. It was explained that the focus groups were intended to enable discussion of any shared views amongst participants concerning their experiences of undertaking children's nurse SOM assessments. At the individual interviews, initial verbal agreement to take part in the focus group interviews was obtained from participants prior to scheduling them. Dates were set to suit the participants and the university venue chosen as it was the most central for the participants who were from across the practice learning circuit.

On the day of each focus group interview the environment was suitably prepared to produce a context that was conducive to focus group interviewing, including careful positioning of seating (Llamputtong, 2011). The risk of interruptions was again anticipated, and minimised by putting a sign on the door informing colleagues that an interview was in progress and to interrupt only if necessary. Digital recording equipment was checked and positioned discreetly. Copies of participant information sheets, consent forms and pens had been set out ready. Following the welcome and informal introductions, questions were invited and once satisfied, the participants were invited to read and sign the written informed consent form (see Appendix 3). All participants were made aware of the need to have the focus group interview digitally recorded with their permission and they were reminded the interview was expected to last between 45-60 minutes. Participants were assured that a copy of the transcript would be sent to them for them to check, agree and keep.

A friendly but professional manner was adopted and smart casual dress worn, as had been the norm when undertaking earlier individual interviews. It was explained that the interview would be informal and offered reassurance that participants should take their time and not worry about pausing to think whilst the recorder was running. Participants were encouraged to respond and elaborate their responses fully. It was stressed that it

was their experiences, the reality of assessment experiences as well as their own views and opinions, views, interpretations and comparisons that were being sought.

Reference was made to an interview guide. The guide was developed to encourage participants to elicit information that would address the research questions and had been informed by earlier individual interview data collection and emerging findings that were in need of further exploration. At this point the digital recorder and microphone was rechecked and positioned and the interviewees encouraged to try and relax and to ignore the recording equipment as much as possible.

Again, participants were invited to share and discuss their experiences, insights, the reality of assessment experiences as well as their own views and opinions. In addition, my facilitation skills were used to promote discussion amongst participants around any topic areas raised at individual interviews that required further exploration without losing the focus on SOM experiences. At the end of the interview participants were thanked for their time and participation and assured a copy of the transcript would be sent to them for them to check, amend and keep.

Case study also has flexibility for adaptation as a study progresses, as was deemed necessary in this study when the originally planned anonymous survey was thought to be no longer necessary. During the initial research design, an anonymous online survey was considered and deemed to be necessary in order to elicit views of all children's nurse SOMs in the research site (including those who had taken part in the current study's individual and focus group interviews). Following completion of the interviews a decision was made not to undertake the survey as initially planned. At this time it had become evident that children's nurse SOMs were able to discuss fully their experiences and views. Initially it had been thought that they would not speak openly about sensitive issues and an anonymous means of data collection was needed to complement interviews. With hindsight, it was recognised that the method would not likely yield any further data that had not already been shared by SOM during the interviews, and certainly not in the same depth.

Summary

The use of two types of interviews as methods employed to gain in-depth insights into the children's nurse SOM experience proved appropriate (Yin, 2003; Thomas, 2011). The development and use of semi-structured interview guides proved to be fitting as participants' responses have indicated new areas for enquiry. Techniques aimed at putting interviewees at ease, including allowing them to choose the individual interview venue, adopting a welcoming approach and beginning the interview with small talk (Morse & Field 1996; Liamputtong, 2011) were effective. There was no obvious reluctance to speak in the company of others as was an anticipated risk of focus group interviews (Liamputtong, 2011). The likelihood of participants being at ease in a group interview situation was promoted by their similarities as all participants were registered children's nurses and all SOMs (Liamputtong, 2011; Thomas, 2011).

The size of the focus group, each with six participants, seemed ideal as they allowed all participants to have an opportunity to make active contributions. Focus group size is deemed crucial for the success of the method and there is variation on what is considered the ideal size (Liamputtong, 2011). Large focus group size (over ten) has been recognised as a problem as they may affect responses (Liamputtong, 2011), conversely very small focus groups, containing only two participants, have been reported as successful (Toner, 2009). Whilst it is argued that having six participants or less could result in less contribution and therefore less rich data, especially if one or two participants remained quiet whilst others did the talking (Liamputtong, 2011), this did not occur in the focus group interviews conducted here. However, it was intended both groups would have six participants each, yet in reality one focus group comprised of five participants (the sixth participant unable to attend on the day). No difference was noted between the groups, in terms of contribution, discussion or silences. On reflection the decision to have two focus groups was fitting for this study.

Part 3: Data management

Introduction

A number of decisions were made around data management, including data sources, preparation, transcribing of data, coding and retrieval. Data management in this way organises the data and forces decisions around such things as data for inclusion/exclusion

to be made, and makes working with copious amounts of data (and being able to make sense of it) more manageable.

Data sources

Data drawn from the twelve individual and two focus group interviews were considered. The data sources used have been divided into three sections shown in Table 5.

Table 5 - Data Sources

Individual interviews	12 children's nurse SOM
Focus group interviews	1 group of children's nurse SOM x 6
Focus group interviews	1 group of children's nurse SOM x 5 (1 SOM unable to attend)

Data were collected during interviews between the end of October 2013 and April 2014. All interviews were digitally recorded to ensure I could engage with the participant during the interview without the need to continuously make a written record of the interview. The digital recording also allowed a full transcript of the interview without the risk of losing any detail. No participants refused to have their interview digitally recorded and anticipated personal technical challenges (equipment failure) did not happen.

Data preparation

The purpose of data preparation was to organise the data to facilitate the next stage in their processing.

Individual interviews - Transcribing

Each individual and focus group interview recording was listened to once in its entirety to gain re-familiarisation with the recording I had taken during the interview (Kvale, 2007). It was anticipated that each recording would be transcribed verbatim personally, which again would allow familiarity to be gained with the data and allow recall of moments of laughter, pauses, interruptions, sounds and disagreements as well as who was being interviewed, to be documented accurately. As names arose, they were replaced by that individual's initials and later allocated a pseudonym. It had been anticipated that

total transcription would take between 48 and 60 hours to complete, depending on the length and complexity of each recording. However, transcription of the individual interviews took much longer than this.

Focus groups - Transcribing

For the transcription of the focus groups interviews, Llamputtong, (2011) suggests that the transcribing process should be completed within 24 hours of the interview. Despite the time required for transcribing being provisionally booked into my diary as soon as an interview date and time has been confirmed, this was not always possible. Therefore, a decision was made to access a professional transcribing service following completion of each of the focus group interviews. Following transcription, each focus group interview transcription was then read in its entirety to check its accuracy and gain a familiarisation again with the data I had heard during the focus group interviews.

Data verification

The process of checking, confirming and making sure the data is accurate has been used throughout the research study and has informed: the research focus, researcher training and development needs, research design, sampling, recruitment, use of a personal reflective diary, data collection and analysis. Following transcription, typed copies of transcripts from interviews were sent to the participants for them to read, check, amend any errors and clarify any of the inaudible words highlighted. This served to promote participants' sense of control over the data (McDonnell et al. 2000). One SOM who had participated in individual interviews, but had not participated in the focus group interviews was not allowed access to the transcript from those who did. Following transcription of all interviews one participant requested amendment. Together, all of these strategies contributed to verification of the data (Morse, 1991).

Data storage

All interview transcripts were anonymised by assigning each one with a pseudonym and number known only to me, and by keeping them separate from the consent forms. Participants were informed that these would be kept securely for five years. These together with a hard copy and copies of digital recordings were kept locked securely in my office on university premises in line with the Data Protection Act (2003).

Summary

This section has illuminated the choice of adopting individual and focus group interviews. Whilst not a data collection tool, a personal reflective diary was also recognised as being a valuable research tool to aid transparency and reflection throughout the study. Processes around ethics, access to participants, consent, confidentiality, anonymity and potential disclosure of poor practice are set out. Data collection and data management undertaken in preparation for analyses were also detailed.

Part 4: Data analysis

Introduction

This section provides justification for the choice of analysis method. An analysis framework and strategy consistent with the type of data and aims of the research was required. Preparation of data for analysis, coding, template development, data presentation and verification processes are also presented.

Thematic analysis

The analysis of data is important as it will lead to how findings are interpreted and presented (Llamputtong 2011). The Attride-Stirling (2001) model of thematic analysis was used to analyse the interview data. A further consideration was that this study is an interpretative inquiry which starts with the view that '*an interpretative inquirer study means that people are constructing of the situations in which they find themselves in order to understand the social world*' (Thomas, 2011, p.171). Thematic analysis was therefore a good fit as it would provide an interpretative analyses that goes beyond the initial obvious data analysis (Clarke & Braun, 2013).

Preparation for analysis

Decisions in terms of analysis were important as a potential weakness of case studies is around inadequate analysis of data (Yin 1994) and therefore every effort was made to address this. I undertook all the individual interviews and focus group interviews. Following transcription, they were checked for accuracy including pauses, exclamations

and expression (Morse & Field 1996). Individual and focus group interviews resulted in a large amount of textual information that required a process for analysis and interpretation.

Thus following transcription and in order to study the meanings of the data it was necessary to undertake data preparation and analysis personally for meanings to emerge from the data that were being constructed by the participants and myself. Qualitative research can yield great quantities of data in the form of extended text that can be quite cumbersome to manage. Therefore, a number of computer programmes had been considered for computer analysis of data such as NVivo (Gibbs, 2002). However, this approach is not supported in case study (Thomas, 2011) and therefore due to advice from peers concerning the number of interviews that would be manageable in this way the decision to use manual sorting was made.

The individual stages of analysis within the Attride-Stirling (2001) model of thematic analysis were followed:

1. The first step was to regain familiarity with all the data, reading interview transcripts, notes and listening to audio recordings. This examination process is recognised in case study research as valuable in highlighting the persistent themes or phrases within the data (Thomas, 2011).

2. The next step involved printing a hard copy of the individual and focus group interviews, and examining each line of the transcription, picking out any significant phrases. These phrases were highlighted and distinguished between focus group and individual interview responses.

3. Re-examination of transcripts then took place, even though all transcripts had been previously read in their entirety, certain phrases or sounds formerly seen as insignificant on first reading could appear significant such as minority opinions, those silenced during a focus group, pauses, sounds and emphasis, sensitive or controversial moments (which had briefly occurred when Beverley Allitt discussed during FG interviews) and who it was, all warranted labelling.

4. A manual wall chart system was used to record focus group and individual interview phases/responses and influences.

5. Time to think about the emerging themes and how they were connecting together, what matches with what?

6. Continued examination, reflection and sorting to enable a analysis of condensed data. This led to identification of major themes, sub-themes and labels.

7. Reviewing themes.

8. Defining and naming themes.

9. Comparison of themes from interview data to those drawn from personal reflective diary (used to aid a transparent and reflective process).

10. Writing-up: seen as an integral element of the analytic process in thematic analysis.

A model of thematic analysis was chosen to visually illustrate the process of interpretation. The interpretive approach adopted suited the needs of the study and resulted in many readings of the transcripts and searches of the emerging data to illustrate categories of meaning and make judgements of meanings (Gertz, 1973; Harbison, 2006). This approach guided and supported the transparency of the analytical decision making process. The goal was to reduce the data and make it manageable for interpretation (Braun & Clark, 2006). The manual thematic analysis process was time consuming in terms of the time required to read and re-read transcripts, think about the interviews and what had been said, coding and identifying emerging themes in order to make sense of the data. This approach turned out to work well as interpretative inquiry enabled an in-depth understanding and deep immersion in the environment of the research topic (Hughes, 1990) and therefore its use complemented the use of the case study which also demanded a deep understanding of this social situation (Thomas, 2011).

Reflective diary – preparing for analysis

In qualitative research the researcher is often seen as both researcher and participant. According to Parahoo (1997, p.292), '*reflexivity is a continuous process whereby researchers reflect on their preconceived values and those of the participants'.* Asserting the process allows the researcher to '*reflect on how data collected will be influenced by how the participants perceive the researcher'.*

When preparing for analysis, the reflective diary which had served as a record of events for remembering, thoughts, conversations, ideas, actions and planning was able to aid a transparent and reflective process. The reflective diary had allowed time for reflection and review of decisions made, processes and during data collection and analysis. This noted regular process of review served to strengthen verification as the research process and decisions made along the way were transparent.

Maintaining a personal reflective diary also allowed the '*messiness*' research process to be visible to myself and the reader of the research and avoid producing, reproducing, and circulating the discourse of research as a neat process (Boden, Kenway & Epstein, et al. 2005, p.70), who continue that inexperienced researchers are '*often not made aware of the muddle, confusion, mistakes, obstacles, and errors*' that make up the research process (p.70). Brown (2006) also supports the use of note taking and describes a positive experience in her study where she had interviewed both students and lecturer practitioners about their experiences, in which she made notes directly after each interview, with the intention that they would act as additional prompts during the analysis of the data.

The decision to maintain a personal reflective research diary was considered early on in the research process and was maintained throughout. Whilst the reflective research diary did not contribute to research data, it did provide insight into the research journey and the many decisions, issues, challenges, joy and progress that occurred along the way. My personal reflective diary entries reflect a sense of struggle at times and a range of emotions. For example, there are my initial feelings of alarm and sadness when a student nurse was potentially failing in practice and another occasion when a SOM requested urgent advice or support and I had not been present to deal with these requests (see Appendix 7). Nevertheless, it shows how the children's nurse SOM role was taken for granted in many ways in relation to my own professional role. The diary proved invaluable as a record of my decision-making trail and helped in writing the thesis accurately.

Its use in qualitative research studies is supported in the literature. Ortlipp (2008) confirms a diary allows the researcher to promote research that is both methodologically and ethically valid and its use is permitted in qualitative research. As the researcher I was

able to be part of the experience, a view supported by La- Gallias (2008, p.149), who stated that the maintenance of a research diary '*enables us to become experienced*'. Glaze also explored the use of reflective diaries in her research. Although she found little evidence about its use in relation to Ph.D. study she reports that when students had used a reflective diary it provided an opportunity for students to '*re-evaluate issues that had arisen along the way, such as time constraints, juggling different demands between home, study and work, constant changes in feelings, when they needed to step back, take stock and make changes along the way*' and it also helped students identify learning (Glaze, 2012, p. 165). As the study explored the PhD journey of students, her findings resonate with many aspects of my personal journey and experience. I believe the reflexive process involved aided the integrity and trustworthiness of my qualitative data *(*Finlay, 1998, 2002).

Coding scheme

Qualitative data analysis often uses coding as a mechanism for identifying then drawing together themes. Thematic coding was thought to be a suitable method for examining data pertaining to SOMs' perceptions of their experiences. The form of thematic coding that I adopted follows the work of Braun and Clarke (2013) who comment that the process of '*coding is a common element of many approaches to qualitative analysis*' (Braun & Clarke, 2013, p.122) and '*involves generating labels for important features of the data of relevance to the (broad) research question guiding the analysis*'. The process whilst initially seen as a method for data reduction, forms part of the analytic process. Every data item has to be coded and all the codes and relevant data extracts collated (Braun & Clarke, 2013). During analysis of the SOMs experience codes were identified and numbered within the transcripts. Multiple codes were applied to each aspect of the text and codes identified across the data. Braun and Clarke (2013) report those undertaking research may be tempted to skip the first steps of reading, data familiarisation and coding in order to try and immediately identify themes in the data. They stress it is undertaking these elements which allow for the opportunity to engage deeply and develop a rich, complex account.

Once this process of data familiarisation and coding had been completed, and reading the texts to interpret this experience, a number of themes began to emerge for example; the

expectations of SOMs in terms of a student nurses knowledge and performance and the physical/emotional impact of the SOM role, uniting the children's nurse SOM experience as a whole. Six themes were identified from within the findings (see Chapter 6).

Ongoing analysis processes

The in-depth process of labelling and theme development detailed above was part of the analysis process and guided decisions around data presentation methods. Following labelling and theme development the process of analysis continued and the stages revisited on a number of occasions to confirm the themes and satisfy myself all had been identified. Braun and Clarke (2006) concur suggesting the stages using the Attride-Stirling (2001) model of thematic analysis is not simply a linear model where analysis cannot proceed without completing each of the prior phases (correctly), rather '*analysis is a recursive process' (*Braun and Clarke, 2006)

Follow up verification meetings

Following identification of the six themes a series of informal verification meetings were set up to meet with SOM participants to allow a summary of findings to be presented to participants. These events provided an opportunity for participants to receive feedback and for them to confirm whether or not they agreed I had captured their meanings in my interpretations. A verification feedback form was devised for their feedback (see Appendix 6) which was a helpful tool as it provided participants with a confidential opportunity to indicate if they agreed and make further comments. Queries were checked out in the data and minimal changes made to my interpretations.

The approach of checking out findings with participants is supported by Reason and Rowan (1981) and criticised by Bryman (1988), who disagrees it is necessary. Confirmation was gained from Yin (1993, p13) who points out that '*plans for the analysis of case study evidence are often weak and ill thought out' and sug*gests that analysis and interpretation requires the checking and rechecking of data and findings '*this will make your findings as robust as possible'* (Yin, 2009, p.13).

The verification events proceeded as planned, although the events were difficult to organise, due in part to the work demands of participants, their various employment

locations and short notification of potential dates (which were to be four to six weeks later). They did provide an opportunity to present a summary of the findings to be appraised by the children's nurse SOM participants and for the participants to agree, or not, with the way I had interpreted the data and captured what they said. One participant who had been unable to attend provided their feedback via a telephone conversation. The verification (see Appendix 6) provided a structure for participant's feedback and comments. Overall, there was a consensus that the findings were accurate and there were no gaps or surprises.

Data presentation

In the subsequent presentation of findings, individual participants were not named. It was considered that some individuals may be potentially identifiable by their roles, for example particular specialist nurses, advanced practice staff and staff working in specialist community teams or regional units, and in these cases the particular specialist role or department were not referred to. Wherever maintenance of anonymity was proving difficult, I requested the participant's individual approval to include specific material.

Generalisation of results

A potential weakness of the case study method is acknowledged around generalizability of research study findings (Yin, 2009; Thomas, 2011). Generalisation was not the aim of the study and is not appropriate within a qualitative, case study research design (Yin, 2003). Sometimes similar viewpoints of participants emerged during the process of analysis and at times there was strong agreement. At other times, a unique children's nurse SOM experience emerged from the process and was considered significant.

It is acknowledged that children's nurse SOM may not experience events in the same way and these may be significantly different across other fields of nursing. Findings may also change if a different group of children's nurse SOM were interviewed at a different time, which would result in gaining new explanations and insight into the SOM experience. Thomas (2011, p.216) suggests '*generalization from all inquiry are tentative as they all produce knowledge that is provisional until future researchers find*

out something new'. An obvious gap from this research is the experiences of SOMs from across the four different fields of nursing.

Summary

This section has illuminated the analysis strategy and how the choice of adopting the Attride-Stirling (2001) model of thematic analysis as a tool to analyse the data supported the analytic process. How the analysis of data progressed through each stage to aid further analysis and the steps in the processes and characteristics of each are presented.

Chapter summary

The chapter has been presented in four parts: Part 1 set out and justified the chosen methods which are consistent with the aims of the research, to construct a picture of mentors' experiences which fits with the philosophy of enabling nurse mentors to tell their own stories (Yin, 2009).

Part 2 presented data collection including issues around ethics, access to participants, consent, confidentiality, anonymity and potential disclosure of poor practice. The use of individual in-depth and focus group interviews provided sources of potentially rich data. A personal reflective research diary kept by the researcher enabled records of ideas, reflections, thoughts, conversations and actions that have occurred.

Part 3 presented data management undertaken in preparation for analyses was also detailed. Part 4 set out the analysis strategy. The chapter presented the methods considered for use within the study and their final selection. The methods chosen were well suited to examining perspectives in depth and fully reflect case study philosophy (Yin, 2009).

The strength of any research study lies in its transparency and recognition of those aspects that could have been improved or approached in a different way (Yin, 2003; Bryman, 2008). The methods used within this study fitted well with an interpretive, qualitative case study design and allowed the examination of data from individual interviews and focus group interviews. Thematic analysis supported the interpretation of findings and allowed questions to be raised as to what the children's nurse SOM experience of assessment was

in order for substantive themes to emerge. The case study method chosen has been demonstrated to have embraced the research methods and sampling required to successfully answer the study questions.

The following chapter, Chapter 6, presents the findings from the study.

CHAPTER 6: FINDINGS

Introduction

The previous chapter outlined the methods employed in the study. This chapter will consider the study findings concerning children's nurse SOM's experience of undertaking assessment of practice at sign-off stage. Participants are referred to according to their pseudonyms and verbatim quotes are selected from across participants that best illustrate the point being made.

Findings

Six major themes were identified:

1. SOM preparation and role
2. Children's nurse SOM expectations
3. Mentor decisions
4. Passing and/or failing students
5. Children's nurse SOM support
6. Personal impact

Theme 1: SOM preparation and role

The SOMs discussed the introduction of the role, NMC requirements and the need for additional preparation and annual updates which are required to undertake the role. Generally, all interviewees felt they had a clear understanding of the difference in relation to the mentor and SOM role and responsibilities, the difference in the form of the requirements of the NMC and additional preparation required.

As indicated earlier (Chapter 2) from September 2007, in the UK students commencing a pre-registration nursing programme must be supported by and assessed by a SOM when undertaking their final practice learning experience (NMC, 2006, 2008a, 2010b). Preparation for the SOM role includes: successful completion of an approved programme and then they are required to be supervised, on at least three occasions, signing off the proficiency of a student (at the end of a final placement) and the SOM is required to

attend annual updates (NMC, 2008a), increasingly these updates are available and accessed online.

All SOM participants recognised the difference between supporting and assessing students undertaking an earlier placement and those undertaking their sign-off practice learning experience, especially in terms of their responsibilities and need to make the right sign-off decision. All participants described the potential consequences of making the wrong decision. These consequences were multifaceted but relate to safety of children and their families and the need to ensure that the future workforce was safe and competent. All SOM stated that they had been required to undertake additional preparation to equip them to undertake the role of SOM and described how they had personally found the additional training and access to training. They described how undertaking the additional preparation and training experience had enabled them to understand more clearly the difference between being a mentor and SOM. Thus the additional training to become a SOM was mostly perceived positively in terms of enabling the participants to develop a clear understanding of the SOM role, requirements and responsibilities.

The SOMs described how the preparation had enabled them to appreciate the reasons why the role had been introduced and therefore appreciate the difference in responsibilities between a mentor and SOM. Following attendance at a SOM preparation workshop they articulated how the experience had encouraged them to not just focus on the students' final practice learning experience but also consider the student nurse journey as a whole:

> *'The training helped me understand its different being a sign-off and why the NMC introduced us. We have to look at the whole three years and always be 100 per cent sure.'* (Amy, Individual interview, participant 1)

> *'I thought I understood why but the additional training helped even more. It explained in detail why we need sign-off mentors and that we have the final say at the end of the students' training'* (Fiona, Individual interview, participant 6)

Increased responsibility in relation to the SOM role was discussed by nearly all SOMs who said they understood that responsibility was a fundamental element of the role but thought the NMC have simply delegated the whole responsibility to SOMs. Many SOMs in the focus group nodded in agreement when Helen commented:

> *'I think basically the NMC needed someone to be responsible and it turns out that is us. That said, I think it is a good thing that someone takes responsibility.' (*Helen, Focus Group 2, participant 8*)*

Another participant expressed that children's nurse SOMs have a different kind of responsibility to those from other branches of nursing:

> *'As a sign-off mentor we have the responsibility to ensure ultimately children and their families are safe. Umm, yes I think this is how it is different for us as children's nurses to other branches or fields'.* (Bobby, Focus Group 1, participant 2)

For SOM participants this consideration was a key difference between mentoring students earlier on in the pre-registration nursing programme and being a SOM who has the responsibility to mentor student on their final practice learning experience. Bobby had been a SOM for two years and was employed as a staff nurse in a children's community team. She thought the SOM preparation course had been most helpful and had ensured she had a clear understanding of key differences about whom and what she was required to do when supporting a student nurse at sign-off stage:

> *'At sign-off students need to be ready to enter the register and so be knowledgeable and safe across the whole range of children's needs and skills. The sign-off mentor training helped me think about students' assessment differently, not just now but across the whole three years, It's a big responsibility knowing this'* (Bobby, Individual interview, participant 2)

However, having to attend preparation and update sessions alone is not enough. SOM generally commented that whilst preparation and update sessions had been useful, a few went on to explain that sometimes the delivery of the session raised questions for them. Carol, who was an experienced mentor and sign-off mentor referred to the delivery of SOM updates:

> *'......... So yes we have updates but these don't include opportunities to discuss things that have happened, difficult decisions, it seems more like a tick box...a type of production line to me'.* (Carol, Individual interview, participant 3)

A few children's nurse SOMs commented that following attendance at the preparation and/or update sessions they had no access to advice and support about issues that arose on a day-to-day basis, especially those interviewees who had limited access to other SOM. This left them feeling isolated and concerned that they are unable to discuss things with others:

> *'I know how to do the documentation and sit down to discuss things, but sometimes I have a question or something on my mind, you know just something that would be nice to talk over with someone. Searching* (the trust folder, website and NMC website) *is hopeless so I just wait.....'* (Amy, Individual interview, participant 1)

This perceived isolation was viewed as bad for students as well as SOMs:

> *'I can do the job but you feel alone and that doesn't help me or the student'* (Nina, Individual interview, participant 12)

The need for everyday advice and support is illustrated by Fiona, a children's nurse SOM who as a senior nurse involved with managing a case load of children required access to care across a range of professional services. She explained that when attending SOM update sessions there were minimal opportunities available to discuss issues that have occurred in practice either with the facilitator or other SOMs. She shared the potential negative impact this has on her and other SOMs like her who either were working in the community, private organisations or within other small teams:

> *' ... I feel out of it I suppose, being in the community and not always with nurses so I don't usually have day to day contact with other sign-off mentors. I only touch base when updates are due or some issue occurring, and the update is going on line in the future! I think isolation could potentially be a problem with someone new. I think I would like some sort of support network, even some sort of online resource to keep in contact with others.'* (Fiona, Individual interview, participant 6)

Fiona noted accurately that the SOM yearly update process is scheduled to go online in her area and others will follow which stands to increase the risk of mentors feeling isolated.

In summary of this theme, the NMC promotes a general sense of optimism about the purpose and role of the SOM being able to support a student nurse in their final sign-off practice learning experience. This suggests that being a SOM ought to be a positive experience and this was largely supported by the participants. The recognition of the need for additional preparation and annual updates was strong, although the need for the delivery to be addressed in order to meet individual needs was thought to need additional discussion and debate. The introduction of a resource or mechanism for routine advice and support, possibly through a forum in which SOMs can meet and discuss issues irrespective of their place of work, was strongly supported.

Theme 2: Children's nurse SOM expectations

This theme relates to children's nurse SOM expectations and concerns about nursing students undertaking their final practice learning experience. Commonly discussion focused on the underpinning knowledge and skills of students and the need for consistency. The SOMs were knowledgeable about the NMC requirements for a children's nurse to enter the register and their responsibilities to ensure students they sign-off meet the required standard to enter the professional register. All SOM interviewees shared they had a clear understanding of the difference in relation to the expectations of a student nurse undertaking their final practice placement at sign-off stage and those students who are not undertaking their final sign-off practice learning experience. This clear sense of expectations is seen as the realisation of the difference in the requirements of the NMC to enable a nurse to enter the professional register and the guidance, support, assessment and performance of students undertaking their final practice learning experience require.

Participants discussed how they expect more of the student nurse by the time they undertake their final practice learning experience, but in turn expect that they should have to direct the student nurse less. SOMs discussed that some students may have grasped some key elements of expected performance but not all. For example, a student

nurse may appear to demonstrate a good theoretical knowledge of anatomy and physiology, conditions and other key skills such as communication, organisation and management which underpin practice but were unable to demonstrate how they could apply these in the clinical area. An example of this was given by Debbie:

> '*She knew a lot about A and P* (anatomy and physiology)*, children's conditions and some syndromes that I hadn't even heard of, but she couldn't apply it to situations.....she was receiving good marks in her assignments. She just couldn't do the practical side of things, which was frustrating because I could show her lots of times but she just couldn't remember how to do it.*' (Debbie, Individual interview, participant 4)

A further participant echoed the difficulty of students putting theory into practice:

> '*Her documentation was excellent and her knowledge was there when we sat down to discuss things, but she couldn't put it into practice.*' (Amy, Individual interview, participant 1)

These students seemed be an exception as it would seem that the students' ability to apply theory to practice was acknowledged by the SOM interviewees as generally good. This was especially the case where students demonstrated consistent good or excellent academic success. Thus good academic ability was said to correlate positively with students' ability to put theory into practice in participants' experience. The majority of students mentored by the SOM participants were fortunately able to demonstrate that they had good overall knowledge and they were able to make the links between the theory and their practice. An example of a positive SOM experience was given by Bobby:

> '*I can see most students are making good links between theory and practice, I think maybe because they have to think about what they do more and more. They* (the students) *tell me they use simulation and scenarios to practice when in university which seem to help them make links.*' (Bobby, Individual interview, participant 2)

Another example shows how students use evidence successfully in support of their practice:

> *'... I find all the good ones have a set of key skills. They can discuss lots of common conditions, lots of nursing care and common drugs used* (pause) *they can even back stuff up with this study and that study. I think this helps them with confidence on the ward when they are challenged by others who say "hey why are you doing it that way?"'*
> *(*Amy, Individual interview, participant 1*)*

There is an expectation by children's nurse SOM interviewees that on reaching their final practice learning setting the student nurses meet the expectations of the SOM and be able to demonstrate that they are ready to enter the register. The expected breadth of knowledge and skills specifically relating to children and young people includes; good communication with children, families and the multi-professional team; undertaking assessment, care planning and care delivery for a range of care that children and families may require.

Emphasis was placed by all interviewees on the need of the student to consistently demonstrate professional behaviour in determining their ability to enter the register. The SOMs mentioned concepts such as professionalism, caring, confidentiality and honesty. There were a number of ways in which students could demonstrate these behaviours, for example:

> *'Just always being professional without being reminded like being on time for every shift, aware of things they can and can't talk about, not using mobiles, being smart in uniform, no false nails and just being caring to the kids, yes this says a lot.'* (Greta, Individual interview, participant 7)

Similar views were held by Carol, who added confidentiality into the conversation:

> *'Being professional without being reminded to do things like being on time, mobiles, being kind but honest with parents, yes it's all that sort of thing. Umm* (pause) *they should be confidential that goes without saying ....just being like this tells me if they are ready or not.'* (Carol, Individual interview, participant 3)

On the final practice learning experience, children's nurse SOMs expect that a student nurse should require less guidance and close supervision and have the skills to anticipate care and guide others. This seems to be the expected norm and there is an element of surprise from SOMs when a student nurse differs from this as shown by this example:

> *'One student nurse as far as I was concerned was not ready at all when she arrived. She was eager and willing but had to be told all the time to do this and can you do that, even basic things like observations and routine paperwork. At this stage they should be thinking about what needs to be done and just do it.'* (Amy, Focus Group 1, participant 1)

As well as immediate care tasks, this participant expected longer term planning to be demonstrated:

> *'I agree at this stage it is about them being ready to be a staff nurse, I mean I shouldn't have to remind them about routine things, they should be thinking about it and anticipating what is needed, checking everything is done even before I ask and definitely helping first year students. I think sometimes they have been too protected so I start getting them to think about planning for tomorrow's shift.'* (Debbie, Focus Group 1, participant 4)

Thus an inability to work without constant direction indicated to the SOM that the student was not meeting their expectations and made the student who was not ready to enter the register easier to identify. These elements included being professional, hardworking, having initiative:

> *'When a student nurse is ready it becomes obvious, the student just gets on with it and does not wait to be asked and this includes being professional. They just become part of the ward team (*pause*) yes it's all that sort of thing. This tells me if they are ready and working at the right level or not.'* (Carol, Focus Group 1, participant 3*)*

There was a frequent expectation that the student nurse should be trusted to take responsibility in supporting other students' learning. SOMs identified the need for students at sign-off stage to support the needs of others including junior students through such activities as role modelling professional behaviours. This commonly expressed point was illustrated by Greta:

> *'Even during quieter times when it was less stressful some students sit there and wait for me to ask rather than taking the initiative to do something. Others say to the more junior students shall we go and do this or go and look at how to do this or that and so on.'* (Greta, Individual interview, participant 7)

A further participant acknowledged some students need time to grasp what is expected of them:

> '... As it turned out she was very good and had a lot of skills but for that first week I don't think she could recognise this herself. Later in the practice placement she was flying and took all the other junior students under her wing. .... I think I had nearly forgotten myself what it was like to move around all the time to different places, I also learnt students need a little more space and time sometimes.' (Helen, Focus Group 2, participant 8)

During discussions the SOM explored if they had higher expectations of the student nurse because they will enter the register as children's nurses. Possessing certain qualities to be a children's nurse was stated as being important including being kind, caring, friendly, pleasant and happy. These traits were generally taken to signify that such students were nice people to be caring for children and their families. Many SOMs recalled students who displayed these qualities. They discussed how having these qualities helped students and the SOM as these students are easy to like.

This commonly expressed point was illustrated by Bobby:

> 'She was a very nice student nurse and worked very well with the team, everybody liked them... They were very helpful and willing and got on with everyone. I think this helps a lot in relation to their overall confidence and so they just grew from there.' (Bobby, Focus Group 1, participant 2)

A further participant acknowledged how this quality helped some students:

> 'She was a lovely nurse and genuinely a gentle, kind person. She was always professional, you know on time, smart, approachable manner and polite. She was definitely a good role model for junior students.' (Joanne, Focus Group 2, participant 9)

However, having all these certain qualities in isolation is not enough. The concept of safety was discussed by a SOM who shared this was a fundamental element that all student nurses must be able to consider and maintain on their final practice learning experience. During focus group the other SOMs nodded in agreement when Bobby shared her views:

> *'My stance is that children's nursing students have to ensure children are safe across all age ranges and the whole spectrum of practice areas, I think this is more so than some other branches or fields. At this stage they need to show they are organised, confident, capable and knowledgeable about lots of things for all ages to ensure children are safe.'* (Bobby, Focus Group 1, participant 2)

SOMs were constantly assessing the risk to children and their families in their care in order to maintain their safety. Whilst SOMs recognised student nurses needed to demonstrate they were ready to enter the register it was nonetheless deemed necessary for the SOMs to make accurate judgements about the level of supervision a sign-off student required. The following extract by Amy further illustrates this point:

> *'............ I expect a certain level from them now so I say to them you have to show me you can organise, plan and deliver care, supervise others so that children are always safe. I make the need for safety clear to all students, even right from when the students start in their first year.'* (Amy, Focus Group 1, participant 1*)*

A few SOM interviewees acknowledged it is more difficult when students do not seem to fit into expected norms. They discussed how they had to think differently about the reasons why a student is this way. They indicated support would be beneficial during these times:

> *'It's more stressful when they don't seem to fit in, they may be really good and get along with the parents but just don't seem to fit in and you just can't put your finger on it. The staff will say they are workers but haven't settled in yet or she is not popular with such and such. This gets me thinking if they have had a bad time before or maybe not a team player or happy person.'* (Debbie, Individual interview, participant 4)

Where SOMs felt they were personally very experienced, this helped them feel comfortable in supporting students develop independence and confidence. It emerged that SOMs use a range of strategies to help students develop:

> *'I expect the student nurse to be able to think and organise themselves and others and finding out how to do new things. I tell them I do not expect them to sit around waiting for me to ask them to do this or that. I set them {the students} tasks each day to try and encourage them to do more and more. This usually works for me and them.'* (Bobby, Individual interview, participant 2)

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A further participant shared how they helped students:

> '*I expect them* (the student) *to have a lot of different skills by the time they are here on their sign-off........I just remind them it's time to think about the whole thing for the whole shift without you needing me to remind you what to do all the time. Of course I am there to supervise and guide as needed or more often give them a gentle nudge.*' (Joanne, Individual interview, participant 9)

There is general recognition by SOMs that students function differently in different environments and there is no suggestion that students are expected to be able to function perfectly in every situation. SOMs frequently expressed care and concern for students who need a little more time to settle down. SOMs discussed how they supported a student who initially appeared less able than other students at this stage. Other SOMs nodded in agreement. The following was shared by Lynn during a focus group:

> '*I was really worried once about a student nurse as she required a lot of direction, even to do routine things. A week later she told me her last practice placement had been on community and how everything had been so different. I told her without realising she had developed lots of skills in the community and as we had lots of time decided I could take any pressure off for a little longer so she could settle back into the ward routine, which she did.*' (Lynn, Focus Group 2, participant 11)

A view reinforced by a participant in a different focus group who also acknowledged how a similar approach had helped her students:

> '*You hear the phrase 'they need to hit the ground running' a lot, but although I expect them to have really good knowledge and skills, be more independent, definitely be able to plan and deliver care, have the same qualities of a good staff nurse ..... Students need time to settle in and become part of the team.*' (Debbie, Focus Group 1, participant 4)

It would appear that the final practice learning experience is seen by SOMs as important for the transition from student nurse to registered nurse. After a settling in period SOMs discussed that they expect students to be able to use their initiative, think more widely in terms of what they have got to do and the time they have got to do it and become much more independent in their practice. This includes the student nurse being able to manage a group of children or caseload and organise junior students and other members of the team. The similarity of SOM expectations became apparent within focus groups:

> *'... I just encourage them to plan and organise more each day; look after their allocated kids whilst they start thinking about the whole department needs. I start pushing them a bit more with ward rounds, organising things, being in charge, and lots of other different things. This scares them a bit at first ...... but it's time for them to see the whole thing now and learn how to become a staff nurse.'* (Ellen, Focus Group 1, participant 5)

This shared expectation occurred across focus groups as Helen demonstrated when she shared the following:

> *'When they get to me they are almost staff nurses, I know they are still learning and this is a practice placement and all the rest of it, but they will be staff nurses soon and so I know that they need to start thinking about the whole thing and start thinking about what else is needed.'* (Helen, Focus Group 2, participant 8)

In children's nursing there seems to be an underlying acceptance and understanding of what being at the right stage was without always actually articulating what it is. It is meeting this unspoken expected level for children's nursing that SOMs know will enable the student nurse to progress and enter the professional register after completing a three year professional training programme:

> *'I say to students I know you're not a staff nurse yet but you need to start acting and thinking differently now about what you do and others need to do. I say consider when other things need to be done and think about who needs to know. I'm being real about what it is like and they need to start thinking about this to be ready.'* (Amy 1, Focus Group 1, participant 1)

The sense of just knowing what is required by a student undertaking the final practice experience was not isolated and something that was shared by other SOMs. Carol linked this to her experience when she shared the following views:

> *'As an experienced nurse I know what is required for students undertaking children's nursing, so I tell them you know a whole lot of things by now, so it's time to pull it all together and do it. Still students need time to settle in and settle down.'* (Carol, Individual interview, participant 3)

All SOMs discussed the components considered necessary which include being able to gather their whole range of knowledge and skills gained over the previous two and half

years together in order to be provide sensitive, safe care for children and their families. Again the goal of the SOM is seen as making the right sign-off decision and them having a clear grasp of the consequences of getting it wrong. This commonly expressed point was provided by Bobby:

> *'At this stage they know lots of things and now must put it all together every day without reminders. This means being able to prioritise, provide nursing care to children and make decisions relating to care. They need to learn how to take charge, organise the shift, delegate and plan ahead for tomorrow ....they will have big responsibilities when they qualify and they can't get it wrong, so I must be sure.'*
> (Bobby, Individual interview, participant 2)

Bobby stressed the importance for the need for the SOM to ensure their decision making is accurate.

Sub theme: Medicines management

Knowledge and skills in relation to medicines management was identified as a particular aspect deemed essential for students about to enter the register as children's nurses and it is a key expectation. SOMs discussed how they perceived there to be increasing numbers of students who were unable to manage children's medicines safely due to poor underpinning knowledge and skills. It emerged that mentors and SOMs have many difficulties developing this aspect for children's nursing students as students are often not able to lead the administration of medicines personally, and are often the third checker (according to Trust and/or university policy), which means they have limited hands on opportunities and/or experiences during their training.

All participants acknowledged the students need to grasp what is expected of them in relation to medicines management:

> *'If they* (the student*) calculate wrong they need to recognise the error because if they don't well........'* (Helen, Focus Group 2, participant 8)

Many participants acknowledged the difficulties students have in children's nursing always being third checkers and therefore they need time to grasp what is expected of them as Katy explains:

> *'Yes but we know how hard it is to get this experience in children's nursing as students are always third checkers so the first years sometimes have to miss out as you have to concentrate on the second and third years to get them through. I always make them (*sign-off students*) the priority in the real world.'* (Katy, Focus Group 2, participant 10)

SOMs discussed how often mentors in children's nursing often use lots of simulation and other practice opportunities to develop various skills when nursing students commenced their final practice placement. SOMs discussed how this has increased the demands on them during the final practice learning experience in order for the student nurse to develop essential knowledge and skills, especially in relation to medicines management:

> *'I had one student nurse who was unable to get drips at all; I mean estimate how much IV fluid a child she was helping me look after had over the previous hour. She just froze and stood there just looking.....she had a guess and was way out, unbelievably out and worse had no concept that this would be massive for such a young child. I had to put an immediate action plan in place.'* (Helen, Individual interview, participant, 8)

All SOMs acknowledged safety of the children was paramount at all times and many expressed the fear that Trust policies were becoming so restrictive that in the future they may have an adverse effect on safety as the skills of the future workforce, not just nursing, may not be fully met:

> *'They have to be good at the whole thing but medicines are really important. This is where our students have a harder time (*than other students from different fields of nursing*). I find many students are really good at maths on their calculators but found some struggle when asked to apply. You have to work out if they can do it....I ask them to calculate and practise drawing meds up and practice the administration procedure over and over until they can give out (*under supervision*) some meds and then I can see the gaps in their knowledge and work on this.'* (Amy, Individual interview, participant 1)

Carol, an experienced SOM working in a Hospital Trust recalled a student she had mentored earlier and later was assigned as the student's SOM and could compare the student's progress following her earlier intervention:

> *'It's the practice part that gets the students as most I have seen seem to get the theory. I had a student nurse in second year that completed her work book really well, but to get her to work out a prescription for simple meds and oxygen took quite a while, it was simply impossible for me to pass her first time. I met her again by chance when she ended up on my new ward and I was her sign-off, she had clearly practised, practised and practised since second year. She said she had been worried about returning to me for sign-off but she must have listened as she was great.'* (Carol, Focus Group 1, participant 3)

Despite their obvious restrictions SOMs discussed how they provided opportunities for the student nurse to develop essential knowledge and skills in medicine management and achieve the required level expected. Again the following SOM demonstrated incredible resourcefulness in order to manage their own workload and to safely manage student learning:

> *'It is essential they know this as it is a big part of just being a staff nurse. We have loads of students all the time which makes it hard and you can't invent medications for students to do. Saying that my last student nurse was excellent even though she had little experience of doing them, she knew basic calculations, everyday common medications and usually the dosage for these with children. It was easy to just build on these over the following few months often by practising and practicing in the treatment room.'* (Helen, Focus Group 2, participant 8)

All children's nurse SOMs expect their student nurses to be able to perform consistently and they discussed when a student nurse was unable to achieve an aspect consistently, when this related to medicine management they took immediate action even though it was sometimes difficult to facilitate:

> *'This aspect always defines my best and worst students...My worse student nurse ever seemed so nice and plausible at first. I believed her that no-one had ever taken the time to explain drug administration or let her practise before her final practice placement with me. I was really angry for her but after a phone call to her personal teacher I realised this was not true at all. Her whole approach to drug administration, recognition of potential errors in her calculations, procedures and processes was really bad ....well the worst I have seen. It should have been picked up before me and despite hours of work from me she didn't progress and so didn't pass.'* (Carol, Individual interview, participant 3)

This quote shows how it can be difficult for SOMs to know what has gone before with a student and that their personal accounts or documentation may not give a true or full picture.

In summary of this theme, there was a clear sense of children's nurse SOM expectations in relation to the performance expected of the student nurse on their final practice experience due to the requirements of the NMC. Within this theme participants discussed that they had expectations of the student nurse and expected that they should have to direct the student nurse less than in previous placements. Expectations of students undertaking their final practice learning experience does not relate to them having skills to manage complexity or requiring them to know about everything, it relates to the range of key transferable skills that they should have developed by this stage and carry with them when they become a registered nurse.

Knowledge and skills in relation to medicines management was identified as a particular aspect deemed essential for students about to enter the register as children's nurses. SOMs discussed behaviours such as acting like a staff nurse in relation to a student nurse not waiting for direction and using their initiative, anticipatory and problem solving skills. It was viewed as a time where students should be demonstrating increasing independence, consistently demonstrating professional attitudes and behaviours and routinely guiding and supporting others, including other students. In children's nursing policies are often restrictive in order to protect children, however this can prevent students from developing the range of skills necessary during their training programme and result in SOMs being placed under increased pressure to provide opportunities and often intense levels of support. A resource for students to gain skills and experience, especially in relation to medicines management was therefore strongly identified.

Theme 3: SOM experiences of passing and/or failing students

In relation to the SOMS this theme relates to the most difficult aspect of SOM role. During interviews and discussions mentors commented that although they had always been accountable for decisions about students, there was a difference in decision making about whether the student nurse would pass or fail at sign-off stage. The interviewees focused on the responsibility, the weight of this decision and on the physical,

psychological feelings and emotions that resulted from this experience. The insights of participant's experiences provided meaning to what it was actually like being a mentor who has the responsibility and makes final sign-off decisions at this stage.

Amy discussed her experience as a staff nurse within an area for children admitted with acute conditions. She stated that the department was very busy and patient turnover was often rapid. Amy had been a children's nurse SOM for two years and had supported three students during the sign-off stage. At first Amy, simply described her experience as different to that of being a mentor to other students:

> *'It is different being a sign-off mentor, a big responsibility.' (Amy, Individual interview, participant 1)*

When asked to continue about why it was different she hesitated for a moment and then she went to describe her experiences in more detail:

> *'I worry that the student nurse may be fine when I assess them but may go on to do something later on. Nervous...... yes, I definitely feel nervous about them* (the students) *potentially doing something wrong in the future. I think I would feel responsible and would not forgive myself.' (Amy, Individual interview, participant 1)*

This concern for the ongoing safe practice of the student nurse in the future was not isolated and it was discussed by a number of other participants during interviews. Carol worked in the community setting and had been a mentor for many years and a SOM for four years. She expressed her continued nervousness at undertaking assessments at the sign-off stage and described the constant checking process she goes through from the start of the student's sign-off practice learning experience to its completion. She provided a profound account of what she does and expressed her concern that the potential effect these decisions may have on her future as a SOM:

> *'I approach it by thinking this is about the whole thing, not just this practice placement. I constantly think about the student nurse and push them a lot more to do things ....I also keep little notes to remind me. I talk to the student nurse and find out what they know; I talk to others who have mentored her to find out what I can about them over the last three years. I feel nervous about them doing something in the future. I would be devastated, feel responsible and would definitely give up the*

*role, actually probably give up nursing.' (*Carol, Individual interview, participant 3*)*

At this point Carol behaved very nervously, then continued, she explains because she was an experienced mentor and loved working with students, taking the next step to becoming a SOM was just expected of her. When she was first approached she explained that she had initially said no as she did not want the additional responsibility. Then a few weeks later she was asked again as the community practice setting needed more SOMs and so she felt guilty and somewhat obliged. She therefore agreed to do it, although she still had feelings of doubt as she was assured the preparation process would be rigorous and would be fully supported at all times. She then continued:

> *'I think I worry too much really as I make big decisions all the time about all sorts of things. It is about safety and standards and they will hopefully be one of us in the future won't the*y?' (Carol, Individual interview, participant 3)

The link between children's nurse SOM decision making and the ongoing effect these decisions may have on them as a SOM was shared by a number of participants. Debbie described how she continues to think about her decisions to pass or fail a student:

> *'..... Every time I have made my decision I continue to think about it long after they have gone. I mean what happens if they do something later, after they qualify?'* (Debbie, Individual interview, participant 4)

The theme was explored within the focus groups and at first there was hesitance to discuss the matter. After a few moments a SOM referred to the crimes of the nurse Beverley Allitt in terms of who assessed her and who was subsequently deemed responsible after the events. This aspect of the interview was briefly a very tense part of the discussion between the SOMs. Ellen revealed her personal concerns about what could happen and then commented that she had a sense of relief that now SOMs were in post this would most likely not happen again. A lot of nodding happened around the room. The need for a SOM to undertake this final assessment of practice learning was defended by Ellen:

> *'I'm old enough to remember Beverley Allitt and the damage she did to children's nursing, those poor parents and public confidence? She was somehow let through so yes it scares me that it could happen again. I*

take my role of sign-off mentor very seriously.' (Ellen, Focus Group 1, participant 5)

SOMs in the focus group had been nodding, but had remained looking at the floor during these tense few minutes. They looked up and agreed that they felt the introduction of the SOM role had improved the assessment process through the preparation required for the SOM role and how they felt their previous experience as a nurse and mentor had helped strengthen the assessment process at the end of nurse training. There was a strong sense of SOMs wanting to make the right decision and having a clear sense of the consequences of getting it wrong:

> *'We all do* (referring to Beverley Allitt) *but it was different then so I don't think that will happen again.....* (Carol, Focus Group 1, participant 3)

The perceived enormity of decision making in order to ensure the children and families were safe were shared by other participants, Amy shared the following:

> *'I agree ...... but still when I'm about to sign I take a big breath, think it's the responsibility that flashes in my mind for a moment? But I think the sign-off mentor role has helped make it better and much safer for the kids. Before you just had to be a mentor and that depended on who the student got, we are better prepared and more experienced.'* (Amy, Focus Group 1, participant 1)

There is a perception that students who were pleasant managed to progress further because they were perceived as nice people and therefore liked by children, parents and staff. This alone was considered insufficient to be passed by SOMs if the student nurse was not progressing in all other areas:

> *'I expect them to be professional all the time and that includes being nice. Saying that it's not enough just for them to be nice ... even though some students are really nice to parents and the kids; they also have to come up to the mark and know lots of things, how to do things, be safe. But they must be harder on a sign-off to fail.'* (Helen, Individual interview, participant 8)

Other participants agreed with the view that professionalism was important, they also agreed this aspect alone was not enough to warrant passing, but they acknowledged that a student nurse displaying either of these qualities consistently, would be harder to fail:

> *'Being a staff nurse is so much more than being nice. So unfortunately some really nice students sometimes fail, I think this makes the decision harder still.'* (Katy, Individual interview participant, 10)

Whilst a high standard of practice is clearly expected of those student nurses wanting to be a registered children's nurse, all SOMs agreed that students must reach this standard. One participant in particular expressed her frustration that anything less was just not acceptable:

> *'I think the kids deserve more than just a nice nurse, I mean being nice but just being OK in other areas as a standard to become a registered children's nurse is not enough.'* (Joanne, Focus Group 2, participant 9)

Despite all the support, guidance and encouragement SOMs provide, some students do not pass their assessments. Katy, an experienced SOM explained that sometimes even constant encouragement provided to a student was not always enough to ensure a student would succeed:

> *'It was a bit of a shock as I had to give her quite a lot of direction to even do every day routine stuff like remembering to brush teeth and remember things were due, much more than you would normally expect to give at this stage. I really tried to help her by going through things again and again, even giving her a first year student nurse to look after. By her midway point she was still the same and I knew then she was not going to make it, so I contacted the university. Still it was hard to do at the time.'* (Katy, Individual interview, participant 10)

In summary of this theme, this aspect caused worry and concern for children's nurse SOMs even long after decisions had been made. SOMs had a clear sense of failure at sign-off stage and how it was perceived in terms of the student nurse not being safe or ready to enter the register and therefore not fit for practice. Although there was a sense that SOMs wanted student nurses to succeed and achieve their ultimate aim of becoming a registered nurse, they all agreed that as a SOM they always wanted to make the right decision and that they had a clear understanding of the consequence of getting their sign-off decision wrong. Children and their families must be cared for safely and a student nurse must reach standard expected of a registered nurse. There was no evidence that children's nurse SOMs were failing to fail'.

Theme 4: Mentor decisions

This theme relates to the theme of previous mentor (not SOM) decisions as perceived by the SOMs interviewed. Some SOMs expressed how issues with a student's previous performance or knowledge had not always been addressed and caused doubts about whether it was mentors who were indeed 'failing to fail'. Accurate information about the student's progress and abilities so far were sometimes viewed as inaccurate, which can make the role as SOM much more difficult. SOMs perceive the failure of some previous mentors to address a student's deficits and challenge the student, as the primary reasons for students reaching this final stage and failing, rather than a failure to make decisions at sign-off stage.

Frustration associated with decisions made by some previous mentors was expressed by both new and experienced SOMs. Despite the impact their decisions would have on the individual student nurse and SOMs themselves at sign-off stage, it was clear that they would not support these students to complete and register:

> *'It was my first sign-off student nurse and I thought oh my god! How did this happen? I felt concern but also reassured they could not just get through. But I still worried about them as they had completed nearly three years and so I hoped they would be alright when they left nursing.'*
> (Debbie, Individual interview, participant 4)

When students commenced their practice learning experience the SOM relied upon accurate information from previous practice assessment documentation, the initial interview with the student, observation and feedback from colleagues in order to piece together an impression of the student. The SOM interpretation of the various sources of information and experience and knowledge available subsequently informed their decision making and therefore needs to be accurate. Many participants acknowledged they had mentored students at sign-off who had difficulties in performing as a student nurse and that they had needed time to grasp how it had happened as Ellen explains:

> *'Only happened once and it just didn't seem possible to me that someone could get so far in their training without someone putting in an action plan at least? Now I say to my mentor friends you must help and support students to develop but ultimately make your decision and don't leave it for me to do.'* (Ellen, Focus Group 1, participant 5)

A previous mentor's failure to provide accurate feedback and put in place a robust action plan is seen as having a consequence for SOM. It was suspected that some students had issues during some or all of their previous practice learning experiences, there is a clear sense that previous mentors had failed to act on the students' deficits in practice. During focus group interviews questions were raised as to how this could have happened but there was equally a clear sense of frustration about why this situation was viewed as continuing and not improving:

> *'It was clear that there must have been problems on the previous placement but I don't know why a mentor would not address that.....actually I imagine there had no doubt been some issues from the start.'* (Fiona, Focus Group 2, participant 6)

Another participant within the same focus group expressed her concern as Katy explains:

> *'That happened to me, I thought if he was so bad then I think there must have been issues as professional values and behaviour is the same from the start, it should be second nature by then and no reminders......I agree I think there's definitely been an issue along the way. This is what drives me mad.'* (Katy, Focus Group 2, participant 10)

The SOMs all nodded in agreement but then focused on why a student nurse had been allowed to continue and had not been supported or discontinued earlier. The SOMs discussed their roles as SOMs and stressed they ensure a student nurse who was not meeting the requirements did not pass the assessment:

> *'Same happened to me and although at the time no one admitted it ... They had obviously been like that from the start, professional behaviour gets better not worse and so they failed over something that should have been picked up, addressed and corrected earlier.'* (Lyn, Focus Group 2, participant 11)

For those SOMs who had not yet had this experience they added their support.

> *'It hasn't happened to me yet but I would be shocked like you that someone could get that far in their training and no one had picked it up or said anything...'* (Amy, Focus Group 1, participant 1)

There was agreement that students had often been told what they are good at but not been told about which areas to improve on, and not received sufficient feedback to guide

them as a whole. There is a sense that students needed to be told what they have to focus on, that previous mentors are aware that they need to do this and that this is sometimes problematic for the eventual SOM as Greta explains:

> *'Just think some mentors are maybe scared to say it sometimes as it is so hard, they* (the students) maybe *are OK, they know they are not brilliant but definitely OK and they have the next year to get even better, I think this is how it happens sometimes......'* (Greta, Focus Group 2, participant 7)

Greta tried to understand some of the potential difficulties some mentors may have in providing feedback to students prior to them undertaking their sign-off practice experience and which means they avoid the responsibility in what is expected of them. To summarise this theme relating to mentor decisions, SOMs expressed concern that students who had difficulties during their sign-off practice learning experience had often displayed problems which not been addressed or effectively addressed earlier. There was a strong sense the SOMs perceive this is a result of a failure to act or act effectively by the previous mentor to address a student's lack of underpinning knowledge, skills, progress, or suitability to become a registered nurse. These were the primary reasons given for students reaching the sign-off stage of practice learning experience and subsequently failing.

Theme 5: SOM support

This theme was derived from the need for SOM to have the opportunity to access appropriate advice and support prior to, and following, difficult decisions. Discussing the difficulties and demands of the SOM role and the need for support at key stages SOM described how supervising a student nurse during their final practice learning experience was very different from what they considered to be the 'usual SOM experience'. They felt they did not receive access to the support they required in a timely way, stating that this sometimes left them in difficult situations that could have been avoided.

SOMs considered support for them themselves to be crucial, especially those working in the community setting, as part of small teams or employed in the private sector. Support was especially needed when SOMs were new in role, in order to manage their concerns, stress and to best meet the needs of the individual student. These priority times for

support were identified as being prior to and following students' sign-off assessment meetings with their SOM, especially when the SOM may be giving bad news to a student nurse or following a prolonged period of difficult meetings with a student.

A SOM discussed that she had previously identified the need for support. She had wanted to discuss ways to improve SOM support in her area of work but this had not been followed up. She therefore felt that her needs in terms of accessing support were not considered a priority. This is how she described her experience:

> *'I had to do extra sign-off training, the training was fine, it was a sort of package and we all did the same. I now have to attend yearly updates but we don't have anything in place in-between which would be good. In fact I don t have any opportunity to meet up, discuss things or support other sign-off mentors. I think this is missing. I have told work this but nothing has happened.'* (Carol, Individual interview, participant 3)

This view was not isolated and was shared by many children's nurse SOMs during other interviews. Later another SOM described a similar form of frustration in her interview. She described that she was experienced and aware of the student nurse needs during the sign-off practice learning experience and described how sign-off students' needs are different from other students. She explained how she had sometimes needed to discuss a difficult issue with sign-off stage student nurse, at other times clarify something or sometimes provide a much needed opportunity to help her interpret those more challenging students seen as 'borderline' as Debbie explains:

> *'The really good students are easy, it's the borderline students who are definitely harder.....but I think if I have to think about reasons why I can't fail them then I have doubt and they should not pass. I know everyone is busy but sometimes it would be nice just to have someone available to talk to, yes someone to talk things over with.'* (Debbie, Individual interview, participant 4)

SOMs generally discussed the need for the NMC to revisit the role and process of sign-off for student assessment. They spoke about how they thought the NMC had introduced the SOM role for a good reason but have not taken time to revisit the role and process requirements. Ellen shared that in her opinion, whilst many benefits had resulted from the SOM role, some fundamental issues remained, such as a lack of support for SOMs

and the ongoing perception by the SOMs that the SOMs were responsible for future mistakes by registrants. She expressed the need for the process of assessment to be strengthened:

> *'I still think at such an important point two people should give feedback at sign-off ......maybe it should be the sign-off and the students tutor? I think it needs looking at.'* (Ellen, Individual interview, participant 5)

Even those who viewed themselves as experienced SOMs said they found the role and assessment process very difficult at times. The following interviewee had been a mentor for many years and also a SOM for four years. She recounted how she had felt when she had to fail a student and yet felt she did not have necessary support at the time:

> *'It's hard, really hard sometimes as this is about their future* (the student)*, I haven't had many fails at all.....just two....but I worried a lot the night before as I knew it was going to be bad news. Even afterwards it was hard to stop thinking about it. On both occasions I had a ten minute chat with someone afterwards and no one contacted me from the University to check if I was OK. It's like you have inconvenienced them.'* (Carol, Individual interview, participant 3)

The above quote suggests the university staff may underestimate the strain of failing a student. Conversely, for the SOM, a great amount of relief is experienced when a student passes:

> *'It's such a relief when students pass. I suppose I even put pressure on myself when they are good students, most are, but I think that we* (sign-off mentors) *worry. Still just having someone to talk things through with should be routine.'* (Greta, Individual interview, participant 7)

Greta was nervous as she tried to justify why access to support was important to SOMs but she was able to articulate that access to support should be routine and how this would allow an opportunity to discuss thoughts and ideas in terms of SOM decisions. There was a general appreciation that not all student nurses who display competency at the point of registration would then go on to cause a child harm through an error at a later stage. However, there is the perception that if they made the decision then they would feel that they were ultimately responsible. There is also a perceived ongoing threat of seeing the student involved in a disciplinary hearing in the future.

In summary, children's nurse SOM interviewees were greatly dissatisfied with the current support available prior to and following difficult decisions. Support for SOMs was neither adequate nor consistent and did not meet the needs their needs. SOMs were keen to discuss their need for more accessible and timely support, especially for those SOMs not based within a hospital Trust and at those times when more difficult decisions had to be made and discussed with the student nurse. Children's nurse SOMs wanted support to include access to support from other more experienced SOMs, employers and university staff. There was significant concern that university staff did not routinely contact the SOM when a student nurse had been failed to offer support.

Theme 6: Personal impact of SOM role

The final theme concerns the personal impact of the SOM role. There is the sense that the SOMs expend a substantial personal price in undertaking the assessment of students at the sign-off stage. This personal cost relates to the emotional responses to having to make the final sign-off decision which may involve the need to challenge and fail the student. These emotions were felt both physically and psychologically. An earlier theme (Expectations of SOMs) described how they use a range of strategies which involved building a student's confidence, determination, persistence and assertiveness with both the student nurse and other professionals, yet they did not discuss these strategies in relation to their own personal development needs.

All children's nurse SOM participants shared the impact their experiences of undertaking assessment of student nurses on their final practice learning experience had on them physically. They discussed how despite preparation to become a SOM and their prior underpinning experience as a mentor, they experienced nervousness and worry related to their key role in the process of ensuring students they assess as being ready to become registered. SOMs felt anxious that they assessed correctly so that the students they passed had the skills and knowledge necessary to keep children in their care safe. The experience as a SOM had often led to emotions which were felt by them both physically and psychologically in terms of fatigue, tiredness, headaches, anxiety, relief and tearfulness as Debbie explains:

> '......the pressure on you as a person is intense. Sometimes this means I just don't sleep.' (Debbie, Focus Group 1, participant 4)

Many other participants articulated the difficulties they have Ellen explains:

> 'It was such a relief I cried, maybe it was a release of stress and I suppose pressure when he passed and he was really good, but you still worry don't you.' (Ellen, Individual interview, participant 5)

Ellen was upset following the SOM process as she felt both a sense of release from the length of time and effort she had spent with the student during their sign-off practice experience and also the need to make the right decision. SOMs being upset was not an isolated incident but shared by other participants who expressed they had become upset either prior to and/or following their final SOM decisions. As Amy explains, for her this occurred when she was faced with the student she had failed again and perceived she had a lack of support:

> 'It was so intense the first time it was on my mind for weeks, but when I found out the student nurse had to come back for their second attempt I cried for days. I felt so guilty for their previous failure..........the PEF came to talk to me before just to let me know but that's all.' (Amy, Individual interview, participant 1)

Other participants articulated the difficulties they have within the focus groups as Debbie explains:

> '...sometimes this means I just don't sleep'. (Debbie, Focus Group 1, participant 4)

Even when the SOM had no issues with the student nurse, once they had a clearer understanding of the student's previous difficulty it created a sense of concern for the SOM:

> 'It upset me as I think it should have been dealt with on her previous practice placement...I felt that as nothing had been done about it then it had been left to me to sort out.' (Nina, Individual interview, participant, 12)

For the SOM there was a sense of a constant burden of responsibility which was related to a professional desire to ensure the safety of children and that students meet the

standards required to enter the register for children's nursing. This is seen in the response given by Greta:

> *'..... the PEF* (Practice Education Facilitator*) said the student couldn't go back (*to the previous placement*) and they needed a new sign-off, I thought maybe it been a personality thing? It was difficult for me as I had another sign-off student at the time but didn't want to say no to the poor student. But later when I got home I just cried, then I was fine after that.'* (Greta, Individual interview, participant 7)

The extract above demonstrates a lack of confidence by the children's nurse SOM, to effectively refuse the request to mentor another sign-off student despite her workload. Furthermore, the extract highlights the challenges faced by the SOM who was trying to manage two sign-off students and the significant other demands of being a Registered Nurse.

Other participants discussed their ongoing feelings of responsibilit*y,* after the student had passed and gone on to become a Registered Nurse:

> *'The pressure just doesn't go away when giving good or bad news* (laughs) *in the past I even checked through the names for NMC hearings, I did this from time to time to just reassure myself.' (*Debbie, Focus Group 1, participant 4)

Whilst other participants in the focus group laughed at this comment, many nodded in support as Ellen continued:

> *'I agree with you .... it is easy to give feedback to the good students but it is hard to give feedback to others on what they are not good at especially if it means bad news for the student nurse ...... there is no actual practical support of how to do it is there and so for ages afterwards you feel sad, well I do.'* (Ellen, Focus Group 1, participant 5)

Despite the personal impact of supporting students as a SOM, when a student does pass at sign-off stage it was considered to be worth it. They all expressed that this was the case regardless of how hard the journey with the student had been or how long they had been undertaking the role. Benefits were identified as pride in the student's success and achievement and a sense of happiness in being able to let go in order for the student nurse to continue their journey:

> *'I felt really proud when I saw them in the cafeteria in their staff nurse uniform.' (*Katy, Individual interview, participant 10)

Many participants had described this as the most rewarding element of the role:

> *'It makes all the hard work worthwhile when they pass, I can't express how it makes me feel; I'm happy, the student is usually crying, the whole team is happy.'*(Carol, Individual interview, participant 3)

> *'It is just amazing when they pass and so hard to put into words. You wish them a great future and that they become a really good staff nurse.'*(Helen, Focus Group 2, participant 8)

Maintaining professional standards and having time to look back at their own strengths and abilities were also discussed:

> '*I was actually nominated for a prize by one student; it was very embarrassing as I thought I was just doing my job. But I was really delighted inside.'* (Joanne, Individual interview, participant 9)

Despite the personal impact that being a SOM may have had on Joanne, it seems although difficult and upsetting at times, having the hard work acknowledged and recognised when a student does pass at sign-off stage it was considered to be worth it.

The final theme of personal impact of the SOM role has been discussed. During interviews with children's nurse SOMs they articulated that although they had always been accountable for decisions about students there was a difference from undertaking the SOM role when supporting and assessing a student nurse at the final sign-off stage. The SOM focused on the increased responsibility to ensure the student meets the required standards and requirements to the NMC. Whilst largely a rewarding role the weight of this decision-making responsibility frequently impacted negatively on the SOMs, on their physical state, psychological feelings and their emotions. The insights provided meaning to being a SOM who makes final decisions at this stage.

Chapter summary

This chapter has illuminated the mixed experiences of SOMs. The SOM interviews provided data that reflected their perspectives of the experience of undertaking

assessments of pre-registration student nurses at sign-off stage. Six key themes were identified from the findings:

- SOM preparation and role
- Children's nurse SOM expectations
- Previous mentor decisions
- Passing and/or failing students
- SOM support
- Personal impact of SOM role

There was a general sense of optimism about the purpose and role of the sign-off mentor. The valuing of additional preparation and annual updates was evident, but concerns in relation to the proposed introduction of these becoming on-line updates. During discussions, sign-off mentors expressed the need for general support to be addressed in order to meet individual needs. The introduction of an advice and support forum in which SOMs can meet and discuss issues outside updates was strongly identified as a development need.

There was a clear sense of SOM expectation in relation to the performance expected of the student nurse on their final practice learning experience due to the requirements of the NMC. SOMs discussed what they expected of the student nurse in terms of directing the student nurse less, the need for a range of underpinning knowledge and skills relating to nursing children and their families, consistently demonstrating professional attitudes and behaviours and increasing independence and initiative skills. Supporting and teaching others were also seen as important in demonstrating that the student was ready to enter the register.

Previous mentor decisions were considered along with support for students, including feedback and how these impact on the role of the SOM. The perception existed that a student's performance or knowledge had not always been adequately addressed by earlier mentors and deficits and learning needs had at times been overlooked. Furthermore there was an opinion that there had been a number of instances of failure to challenge the student nurse and their suitability to become a registered nurse by previous mentors, who may have simply given students the benefit of the doubt. These were

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viewed as the primary reasons for students reaching the final stage of their training and then failing, which made their role as a SOM much more challenging and difficult.

The experiences of passing and/or failing students was an aspect that caused worry and concern for sign-off mentors long after decisions had been made. Failure at sign-off stage is perceived in terms of the student nurse not being ready to enter the register or fit for practice. There was a sense of SOMs wanting to support students to succeed and be able to enter the nursing register, yet they always wanted to make the right decision and they had a clear understanding of the consequences of getting their sign-off decision wrong. There was no evidence that SOMs who took part in this study were 'failing to fail'. However there was a strong view that mentors were failing to address issues in earlier placements thus placing an increased pressure on SOMs to address student's deficits late in their training programme, with an increased risk of ultimate failure.

Lack of support following difficult decisions reinforced the need to provide support to SOMs that is accessible and timely including prior to and after difficult meetings and decisions. The type of support advocated for was support that is easy to access regardless of SOM experience or location. Participants believed that support was required in order to develop much needed confidence which would benefit students and limit the impact on sign-off mentors personally and emotionally.

Participants reported a significant burden of the SOM role on their physical and emotional wellbeing. Regardless of final assessment decisions, there is a sense that SOMs pay a physical and emotional price in undertaking the final sign-off decision. These emotions were felt both physically and psychologically by SOMs in terms of fatigue, tiredness, headaches, anxiety, relief and tearfulness.

The following chapter, Chapter 7, is the discussion of findings chapter which appraises the study findings.

CHAPTER 7: DISCUSSION OF FINDINGS

Introduction

The previous chapter set out the findings from the study conducted with children's nurse SOMs. This chapter presents a discussion of the study findings on the children's nurse SOM experiences of undertaking assessment. It considers the meaning of the findings identified in the previous chapter to provide an accurate picture as possible as to the children's nurse SOM perspectives. The research focus was the children's nurse SOM experiences which had not been explored previously and so by the end of this section the reader will have a greater insight into these experiences. A summary of this chapter will then be presented.

Six themes were identified and each will be discussed in turn:

1. SOM preparation and role
2. Children's nurse SOM expectations (including medicines management)
3. Mentor decisions
4. Passing and/or failing students
5. Children's nurse SOM support
6. Personal impact

Theme 1: SOM preparation and role

This first theme relates to SOM preparation and role, in which the SOMs shared their experiences in relation to preparation for the SOM role and the weight of responsibility. Sometimes this responsibility was manifested in tensions that existed, for example, between accessing training and meeting the additional role responsibility. The SOM must meet the additional criteria and maintain their SOM status (NMC, 2008a, 2010b).

When interpreting the data it is clear that children's nurse SOM had a clear grasp of their role, required SOM preparation, responsibilities and the importance of getting the role right. The findings presented are convincing that children's nurse SOMs have

accommodated the requirements for SOM preparation and role. The role of the children's nurse SOM is multifaceted. The SOM role is demanding and requires the need for supervising, guiding and supporting students undertaking their final practice learning experience. They also have the responsibility to sign off these students, or not, on completion of their pre-registration training so that they can enter the professional register. In addition, they have significant competing demands upon their time to meet the requirements of their professional regulatory body (NMC), their employer and the needs of their patient/client group which involves making decisions in order for them to prioritise the delivery of care to patients/clients. Such complexity also requires children's nurse SOMs to appropriately undertake continuous expeditious assessment of student abilities, needs and progress whilst they are undertaking their sign-off practice learning experience. This need is essential to ensure continued patient/client safety.

Watson (1999) discussed that although the mentor role had been accepted in the practice learning environment, it seemed that both staff and nursing students made their own assumptions about the purpose of the mentor. In two later studies it seems that mentors are still not giving the mentor role priority and there remained some confusion in relation to what were seen as conflicting role elements (mentor and assessor) (Gray & Smith, 2000; Neary, 2000). Confusion in relation to the mentor role continued in Bray and Nettleton's (2007) multi-professional study which included nurses, doctors and midwives investigated both mentee and mentor perceptions of the mentorship role. These authors reported that mentors continued to struggle with the idea of having what was considered two distinct elements of mentor and assessor. They also found that the assessment element undertaken by the mentors as part of the mentor role was poor. However, this was not evident when children's nurse SOM shared their experiences in this study. SOM clearly stated that their assessment and decision making (underpinned by their experience, expectations of a student at sign off stage and clearly defined role) was key in determining whether a student nurse was ready to enter the children's nursing register.

A key issue for the SOMs was their preparation for their role. Whilst many SOM commented that the preparatory sessions they had attended had been useful in terms of raising awareness and requirements, at times, the delivery of the sessions raised questions for them. For example, for some preparatory sessions left participants feeling

they were more like a 'tick box' and concerns regarding proposals for future delivery of online SOM updates exacerbated their dissatisfaction with the delivery and their perceived isolation. Not all children's nurse SOMs routinely came into contact with other SOM within their practice areas. White and Ousey (2013) argue that '*huge resources*' are needed to sustain the current traditional delivery system of mentor updates, plus many mentors are often unable to attend these events. They undertook an evaluation of a multi-professional online mentor update tool, which included six hundred and fifty-two mentors over a ten-month period. Their findings identified that an online tool is '*flexible, promotes engagement for both mentors and their line managers, and in doing so provides academic staff to alternatively utilize the time saved delivering it*'. The authors further confirm the NMC has praised the package as good practice and their intention is to promote its use across other regions. The authors suggest the online update tool had been developed to overcome the problem of clinical staff '*struggling to find time*' to attend scheduled update activities, and its use '*allowed mentors to update as and when they found it most appropriate*'. Nonetheless, it is important to note that only 64% of mentors had been given the time to complete the required update whilst at work. Thus suggesting that 36% of mentors had undertaken mentor updates in their own time, an aspect which may further compound the mentors feeling around disengagement, and their lack of time to attend current updates. Whilst the authors do not comment specifically on issues of isolation, their plans to develop a supportive 'chat tool' further suggests that mentor isolation was perceived an issue for those mentors accessing the online learning tool.

Unlike previous mentor studies (Pulsford, Boit & Owen, 2002; Myall et. al, 2008; White & Ousey, 2013) children's nurse SOMs in this research study did not comment specifically on either having enough time or a lack of time in relation to undertaking their SOM role. For example, Pulsford et al (2002) undertook a survey of mentor's attitudes towards mentoring and found that mentors were increasingly not attending mentor updates due to increasing workloads and limited staffing resources. Myall et al (2008) explored the experiences of nursing students and practice mentors who indicated staff shortages and workload pressures often led to a lack of time to carry out the mentor role. This had led to many mentors completing student documentation in their own time. However, it would appear that participant's experiences in this study, in terms of what they did in order to support practice learning to ensure that a student was provided with

the opportunity to develop and undertake the requirements of the sign off assessment, it is evident that a children's nurse SOM requires significant time to undertake the role. It does seem as though there is a failure of some SOM participant organisations to acknowledge the significant additional aspects and responsibilities involved in being a SOM in ensuring students are ready to enter the nursing register, particularly when it is anticipated that a student may be failing in the final practice learning environment or when supporting multiple students.

The majority of SOMs indicated that they wanted to mentor students at sign off but whilst seen as a good thing, others identified they would like to have a real choice, rather than an expectation to undertake the SOM role. This anxiety was significantly illuminated during one interview were a participant clearly did not want to become a SOM and expressed being overly challenged by the additional responsibility. When gently probed further this particular participant talked about feeling guilt, being obliged and pressurised to undertake the role of SOM. In earlier literature mentor satisfaction depended on how much control mentors had over their workload, and also linked to their overall commitment (Atkins & Williams, 1995).

There is no mention of issues around choice within the SOM literature with which to compare these observations. Increasing demands, complexity of health care, and reduced staffing levels ultimately will have significant implications for future practitioners. In this research study SOMs were working across a range of challenging and difficult practice learning environments, currently they were able to maintain their supervision and assessment of students despite these challenges.

In summary, the findings presented in this thesis articulate that despite increasingly demanding workloads, children's nurse SOMs have accommodated the requirements and challenges of their role. Key matters identified included perceived lack of choice and concerns in relation to future on line delivery of SOM preparation. These updates require further consideration nationally from professional bodies, educational providers and employers, who ought to explore choice and define mandatory standards and delivery of SOM preparation and annual update provision. Preparation for SOMs has significant implications for practice and HEI's who have been advised to have an increased focus on nurse education, supervision and support (The Francis Inquiry, 2013).

Theme 2: Children's nurse SOM expectations

This next theme relates to children's nurse SOM expectations. The findings show SOMs have sound understanding of the part they play in providing the student with opportunities to pull everything that they (the student) have previously learnt together and what their expectations as SOM actually means in terms of all the elements the student nurse must have. The findings demonstrate that the children's nurse SOMs were vigilant in seeking the presence of key skills and underpinning knowledge required by a student nurse in anticipation of being assessed as meeting the required standard required to enter the professional nursing register.

Children's nurse SOM could articulate how they determined that a student met the requirements to enter the nursing register which was expressed in relation to 'expectations' of a student by SOMs in terms of what they were looking for prior to signing a student off. This expectation was similar across SOMs irrespective of which Trust, hospital or community setting they worked in. These expectations informed the way in which participants determined a student being able to meet the holistic needs of the child and family. These elements included a good range of key skills and underpinning knowledge, medicines management, ability to keep children safe, anticipatory skills, decision making, teaching and supporting other students, the need to be asked less and anticipate what needs to be done more and being able to recognise gaps in the knowledge and abilities and be proactive in putting this right. It was these elements which make them (the student) ready to enter the nursing register. Additionally, certain qualities were important to participants in this current study and these included, being kind, caring, friendly, pleasant and happy, indicating that generally students had to be nice, caring people to care for children and their families. All of the SOMs believed that these elements must be in place and be demonstrated consistently by the student nurse on completion of their final practice placement, in order to demonstrate they are ready or not, to enter the register.

A study of student nurses by Ousey and Johnson (2007) explored the issues of caring and culture in practice settings and how what they observe may affect student nurses. Findings suggested that students learn by observing how to be a 'real nurse'. However, student nurses reported the physical and emotional care of patients is largely undertaken

by health care workers whom they will direct and supervise once they become a registered nurse. The study by O'Luanaigh (2011) explored how nursing students learn in the clinical environment through the influence of registered nurses. He found that students did not passively acquire knowledge or simply replicate what they observed; students knew what constituted 'good' nursing. He also suggested that student nursing knowledge was gained from registered nurses who were best able to describe and demonstrate 'good' nursing.

Expectations in terms of increasing independence included the student being able to recognise their own development needs and require less direction and direct supervision. It seemed that the absence of these raised concerns about the student nurse being ready to enter the nursing register. Children's nurse SOM participants shared the view that they would not pass a student nurse who was unable to demonstrate they had the capability to work without constant direction. Whilst there are few comparable studies within this area the need for a student nurse to be able work increasingly independently is discussed in the literature and this is seen to be more important when a student is in their final placement (Anderson & Kiger, 2008; Black, 2011).

This study presents a common understanding from SOMs that student nurses must have the ability to show that they are ready to enter the nursing register by performing more like a registered children's nurse and less like a student. This was found to be by the student nurse demonstrating consistent professional behaviours and attitudes, providing anticipatory care to children and their families, showing initiative in terms of being asked to do things less, supporting and teaching others, problem solving and critical thinking which emerged strongly from the findings. A study by Duffy (2003) presents findings from her grounded study of nurse mentors which found third year nursing students (Adult nursing) were often found to have an inadequate range of nursing skills and abilities that would be required once students became a registered nurse. Nonetheless the participants in this study shared similar expectations of third year children's nursing students in terms of third year skills, which confirms expectations are realistic and have a standard that is expected at the point of registration.

Another expectation that children's nurse SOMs held was related to the idea of keeping children and their families' 'safe' particularly by the time SOMs made their final sign off

decision about a student nurse. Whilst all staff working in a health care setting must be aware of their role in terms of what to do if there is a child protection concern and the referral procedure. Different staff groups, including children's nurses, require different levels of competence, this depends on their role, nature of their work, and responsibility for child protection (Royal College of Paediatricians and Child Health, 2014). This appears to be linked to the need and responsibility for registered children's nurse to promote and safeguard children and young people's welfare (Lord Laming, 2009). It may also relate to identifying those who may cause deliberate harm to children as displayed by Beverley Allitt (The Allitt Inquiry, 1991) and this incident was referred to briefly during the focus group discussion (see Chapter 6). However, the most common term used was 'ensuring children are safe' and this did not appear to stir up the same reactions with those actions of those who had committed a criminal act. A later study discussed safety in which 22 preceptors shared their experience of supporting 'unsafe' students suggesting that mentors in their study were '*promoting student learning and preserving patient safety*' (Luhanga et al, 2008c, p.259).

In summary, the findings presented here confirm that the children's nurse SOMs share common expectations in relation to student nurse performance. The sign-off practice learning experience is viewed by the participants as an opportunity for them to find out what the student knows and challenge them, even if this means they have to expose the student to specific learning opportunities. For example, this could include managing care for a group of children and their families, medicines management or exposing the student to increasingly complex situations in order to help them utilise problem solving and critical thinking skills. The SOM thus described their role as preparing the student nurses' transition from student nurse to registered nurse, in order for them to be able to enter the nursing register. However, whilst they (SOM) shared how they try to support and help the student nurse make this successful transition they recognised their role is to also identify those students who do not meet the required standard. These common elements require further research and attention nationally from professional bodies, HEI's and SOMs, who need to explore how to capture these expectations from across the four fields of nursing.

Theme 3: Mentor decisions

This next theme relates to mentor decisions, SOMs shared their experiences of previous mentor decisions and the influence these decisions had on them, the children's nurse SOM and student nurse. The findings show insight into the part previous mentors play in providing the student with accurate feedback so that they (the student) have clear expectations and the SOM has clear feedback in terms of all the previous assessments, concerns and any other elements the student nurse has previously undertaken. A key interpretation of these study findings is that it found no evidence that children's nurse SOM are failing to fail. The findings give insight into SOM decision-making processes that have received little attention in the existing research literature.

Children's nurse SOMs are accountable for the outcomes of their actions at the point of sign off. However, conclusions drawn from interviews with children's nurse SOMs indicated a significant impact of previous mentor decisions on their work load, responsibility and accountability as SOM. The knowledge that children's nurse SOM are not failing to fail goes towards adding a new dimension to existing mentor theory, which has not focused specifically on children's nurse decision-making previously. The literature review (Chapter 3) highlighted instances where students may not have met the standard required in nursing and other related health and social care professions, but nonetheless were allowed to continue (Lankshear, 1990; Duffy & Scott, 1998; Watson, 1999; Watson, 2000; Duffy, 2003; Duffy, 2004a ; Scholes & Albraham, 2005; Dudek, Marks & Regehr, 2005; Rutkowski, 2007; Luganga, Yonge & Myrick, 2008a; 2008b; Webb & Shakespeare 2008; Finch, 2009; Middleton & Duffy, 2009; Gainsbury, 2010a, 2010c; Jervis & Tilk, 2011).

The act of a previous mentor giving students the benefit of the doubt was discussed in Duffy's (2003) research which included the notion of borderline status and how when a student was seen as 'borderline' a mentor would often pass the student. Mentors' comments include (the student) '*wasn't that bad ...No, not enough to fail her' (*Duffy, 2003, p.64). Duffy (2003) also discusses what unsafe practice means to mentors in her study. This included, the student doing something that was a direct risk to a patient's physical safety and poor clinical skills. Despite this, mentors indicated a willingness to pass some unsafe students. These current study findings contradict previous findings as

children's nurse SOMs did not pass students who were deemed unsafe. It seems that to children's nurse SOM the safety of children and their families is a must and when a student nurse does not demonstrate this they are perceived as not safe to enter the nursing register. However, this current study findings resonate with those children's SOMs in this study who found that whilst they did not fail to fail they did nonetheless have to deal with consequences of mentors' previous decisions. In the interpretation of findings from this current study, although children's nurse SOM were discussing their perception of what mentors had concluded in their previous assessment decisions, this perception is supported by the findings from the study undertaken by Duffy (2003). Therefore, aspects alluded to by children's nurse SOM in this current study, require further scrutiny into this area, especially in terms of the impact these decisions have later on for the SOM.

In summary, the findings in this theme represent previous mentor decisions and assert a lack of confidence in standards of previous mentor assessment decisions. Crucially, there was no evidence that children's nurse SOMs fail to fail students. These findings are significant and require further attention from professional bodies and HEI's, who need to capture the SOM experiences across other fields of nursing. The issue of previous/preceding mentor decisions require further attention from the NMC, educational providers and employers, who need to explore mentor assessment of students. Lack of confidence in standards of mentor assessment has significant implications given the Francis Inquiry (2013) recommendations which among others called for an increased focus on nursing education, therefore it would be judicious to apply his suggestions to all areas of nursing education and assessment of practice learning. Importantly, there was no evidence that children's nurse SOMs fail to fail students.

Theme 4: Passing and/or failing students

This next theme relates to passing and/or failing students. Children's nurse SOMs shared their experiences of these decisions and the effect it had on them. The experiences shared by the SOMs suggests that the final assessment decision which determines if a student can enter the nursing register is the most difficult decision to make. The findings give insight into the SOM decision-making processes that have received limited attention in the existing mentor research literature. Steps to be taken during SOM assessment

processes and strategies necessary to support those processes have been identified as key factors that are required in order to strengthen decision-making.

The children's nurse SOMs shared they undertook an appraisal of the student's professional appearance, attitude, willingness and reported written feedback from previous mentors, along with their own findings from the initial meeting with the student to make their initial judgement and decisions. In addition, they employed their children's nursing expectations and observation of the student nurse performance as subsequent measures to support their assessment and to monitor the student's progress. Children's nurse SOMs made decisions based upon these initial judgement and through their observations of the student. A sense of 'just knowing' a student was meeting the right level was frequently articulated by SOMs as a way of confirming, or not, the student was ready to enter the professional register. This sometimes was a result of subtle indicators which may have alerted SOMs to a potential problem and often participants referred to early feelings that some things did not feel quite right, despite at times not being sure what this was when first meeting the student. The feelings usually came about because the student did not behave or preform as expected. These intuitive feelings are aligned with 'gut feelings' and 'instincts' and importance is often placed on these in nursing. The use of intuitive knowledge has been used and discussed often by nurses in the assessment of patients (Carper, 1978; Buckingham & Adams, 2000; Hams, 2000; Herbig, Bussing & Ewert, 2001; Carr, 2005). In summary these authors suggest that the use of intuition is based on nursing experience, and as SOMs are experienced it could be that they are referring to their own expected norms and standards of a registered children's nurse. However, children's nurse SOM do not rely on intuition alone. Children's nurse SOMs were able to identify specific indicators for example: meeting learning outcomes set in the student's practice assessment documentation, communication with children and families and meeting the range of SOM expectations as discussed previously (Theme 2 – expectations, p.132).

It was evident that children's nurse SOMs used expert decision making in the assessment of student nurses (Benner, 1987, 2001), and that intuitive knowledge may be context bound to a particular field of experience, in this instance children's nursing. Furthermore, the findings suggest children's nurse SOMs used other sources of knowledge to make their assessments of students. In addition, specific nursing knowledge gained through

SOM preparation workshops, previous pre- registration nurse education and expected norms of professional practice was frequently relied upon tacit sources of knowledge. This was evident in the SOMs ability to articulate their expectations in terms of knowledge, skills and performance (SOM expectations) that a student was expected to exhibit when asked to consider how they determine their SOM assessment decisions.

In support of Benner (1987), the children's nurse SOMs participants themselves exhibited anticipatory ability, which Benner reports is an expression of nursing expertise associated with expert practice and intuitive knowing. This occurred prior to and following the children's nurse SOMs opportunity to develop a mentee-mentor relationship during the time of the sign off practice learning experience. Whilst nurses often use intuition in relation to the nurse-patient relationship, the findings from this research demonstrated that children's nurse SOMs adapted this to influence their assessment of students in practice learning settings. Whilst there is an acknowledgement that the NMC guidelines in relation to sign-off assessment responsibilities (NMC, 2008, 2010b) and the student nurse practice assessment documentation are also used, the findings suggest that children's nurse SOMs possess tacit knowledge which was deeply embedded, instinctive and intuitive.

Children's nurse SOMs share the belief that this should not be a decision made by a SOM alone but a joint decision making process between the SOM and a representative from the University (possibly the student's personal teacher). This joint approach would allow for opportunities for shared assessment and responsibility and also provide an opportunity to fully discuss and consider the student's journey and an opportunity to discuss concerns and/or positive feedback. A shared approach to assessment was previously recommended by Duffy (2003), yet whilst participants in this current study acknowledged formal arrangements for reporting concerns, many thought this aspect could be developed further. This approach would also strengthen assessment in practice and could be viewed as a form of moderation, something that is currently routinely used for theory assessment but not routinely used for the assessment of practice learning (Smith, 2012). Developing communication in order to share information about students were also identified as a way which would enable children's nurse SOM feel more supported when making SOM assessment decisions in the student's final practice learning experience.

In summary, the findings give insight into decision-making processes that have received limited attention in the existing mentor research literature. Steps to be taken during SOM assessment processes and strategies to necessary to support those processes have been identified as key factors that are required in order to strengthen decision-making. These matters require further attention from the NMC, educational providers and employers, who need to further consider this aspect of the SOM role. Lack of recognition for when SOMs are passing and/or failing students has significant implications given the impact this aspect of decision making can have on SOMs.

Theme 5: Support

This next theme relates to SOM support where participants articulated their need for support especially prior to, and following, the more difficult decisions they make, which included addressing a student's deficits, providing feedback especially when failing a student was necessary and following these events. The interpretation of the SOM experience highlighted a general lack of support in relation to how the NMC, employers and associated universities supported them through difficult experiences. The findings give insight into the lack of current support for SOMs which was an issue that has received limited attention in the existing SOM research literature.

A study by Watson (2000) highlighted employers did not support mentors with the time to attend mentor preparation or update sessions. This view was discussed in a later study by Hutchings et al. (2005) who identified that often mentors were poorly prepared for their role and ward managers reported often they were unable to release staff to attend mentor training. Challenges facing mentors when providing feedback to students on clinical performance has been discussed in the literature (Clynes, 2008), whilst the study is not focused on the role of SOMs the author does nonetheless recognise the need for support during these more potentially difficult times. Whilst a lack of support for attendance at SOM preparation and updates is not apparent in this current study, participants did question earlier decisions of their mentor colleagues and wondered if they understood their role and responsibilities as mentors, especially as their earlier mentor decisions impacted on the children's nurse SOM.

Two earlier studies by Pulsford et al. (2002) and Duffy (2003) have previously reported mentors required more support from HEIs. Later studies continued to report a general lack of support, especially at times when mentors are preparing to fail students (Watson, 2004; Kendall-Raynor, 2009; Middleton & Duffy, 2009), other studies suggested that there are not enough HEI staff to support practice mentors (Hutchings et al. 2005). Despite this, two studies by Kendall-Raynor, (2009) and O'Driscoll, Allan and Smith, (2010) identified that the lecturer presence in practice settings was declining. In this current study participants identified a range of mixed experiences in terms of how they felt they were supported by academic staff from the universities. Participants from a hospital trust, where link teachers and personal teachers may be visiting the area for a range of different reasons, were more likely to have had a positive experience than those working in the community or independent sector where SOMs may perceive that they have less contact with the link teacher and university. It is suggested that this may be due to the nature of inpatient children's services where link teachers and personal teacher visits are likely to appear to be more frequent and therefore provide a sense of being visible. Services that are not delivered in this way could be contributing to children's nurse SOM's perception that there is a lack of support.

In considering the support required by SOMs, the interpretation of the SOM experience confirms earlier concerns relating to the mentor role and support needs. Duffy (2003) called for opportunities to be made available to support mentors when they had failed a student at assessment. A later study by Kneafsey (2007) again highlighted the importance of providing a forum for mentors to discuss their decision making, to help further develop mentor skills. Nettleton and Bray (2008) also suggested increased support should be made available from both employers and HEI link lecturers. Concerns expressed by SOMs in this current study reflect those highlighted in an earlier study by Middleton and Duffy (2009), who explored the experiences of mentors supporting adult nursing students in their final placement experience suggesting that the support for mentors who support students during this time require an increased focus.

The availability of support for children's nurse SOMs was significantly influenced by the location and service design. Currently, the SOM role is undertaken within the existing mentoring infrastructure and mentor provision. Therefore it can be argued that the role of the SOM could blend into existing mentor support delivery models. However, the

differences in the SOM role, expectations and responsibilities means that support previously considered suitable for mentors undertaking assessment of students earlier in the pre-registration programme does not meet the needs of the SOM as it does not meet their requirements for access to specific SOM advice and information. The geographical spread of children's nurse SOMs across the practice learning circuit also means opportunities were sometimes unavailable for SOMs to discuss and debate issues, which was already minimal due to the complexity and multiple responsibilities already associated with those undertaking SOM roles.

In summary, the findings in this theme give insight into lack of current support for SOM, that have received limited previous attention in the existing SOM research literature. Participants require specific SOM support especially prior to, and following, the more difficult decisions, which included addressing a student's deficits, providing feedback especially when failing a student was necessary and following these events. This requires further attention nationally from professional bodies, educational providers and employers, who could consider defining mandatory standards of support for SOMs involved in supporting students.

Theme 6: Personal impact

In this theme it is evident that some children's nurse SOM experience a range of emotions which include; feelings of guilt, sadness, distress and also joy and happiness. Most participants reported that they had suffered sleep disturbance, especially the night prior to meeting with the student. Participants report that they were able to overcome all emotions, ensuring the correct decision was made, this ensuring only students who meet the requirements and the standard required pass, despite the subsequent personal impact this has on the participants.

Findings identified the children's nurse SOM role carries with it an increased sense of personal and professional responsibility and it is this sense of professional responsibility which ensures the standards of children's nursing and children and their families are safe. There is also a personal impact of their emotions which result from the decisions they make. A difference in level of responsibility was recognised by participants from when they were mentors compared with when they became SOMs. This differentiation had not become apparent until becoming a SOM at which point they were faced with the

realisation that they had ultimate responsibility to sign-off a nursing student at the end of their final practice learning experience as meeting, or not meeting the required competency standard, in order to enter the nursing register. Many of the participants felt sad and sometimes cried before meeting the student for their sign-off assessment and sleep was also often disturbed. The SOM felt responsible that maybe they could have done more for the student when the student was going to fail the assessment. Even when a student was clearly going to pass almost all SOM reported sleep disturbances the night before. Many also shared how they continued to worry about the future in terms of what if the students they have signed off goes on to make a mistake as a registered nurse.

The study by Atkins and Williams (1995) found that mentors felt satisfaction in carrying out their role, despite obvious conflicts their mentor role presented in terms of ongoing patient care needs and those associated with a lack of time and increased workload. However, Atkins and Williams (1995) study was undertaken at a time that preceded the SOM role and therefore did not specifically focus on those mentors who support, assess and provide feedback to potentially failing students on their final sign-off practice learning experience, therefore the satisfaction of these mentors may refer to those instances where students performed as expected, passed in practice or had a further opportunity to pass later on in the course.

Other previous studies (Middleton & Duffy, 2009; Black, 2011; Wilson, 2014) have also identified that mentors were sometimes distressed. Yet none have concerned the impact of the children's nurse SOM role on their physical health. The study by Wilson (2014), reported that whilst mentors found the mentoring experience rewarding, satisfying and frustrating, mentors also reported that they found the role distressing at times. Whilst her study does not focus on the children's nurse SOM experiences, her findings in relation to mentor distress resonate with findings identified within this current study.

The participants in this study shared that they would feel responsible for their students' future actions. Some participants admitted that they checked the NMC website to see if any of their previous students had attended a fitness to practice hearing. Feelings of concern expressed by mentors are also discussed in the study by Middleton and Duffy (2009). Mentors in their study had concerns about being held accountable by the NMC. In this current study, although SOM also had concerns about assessment of students, it

was more about feeling responsible if something happened. They did not refer to any professional concerns they had in relation to the NMC. Whilst their study also does not refer to children's SOMs it nonetheless raises similar issues in that mentors expressed their concerns about assessing students, however, SOM participants in this current study indicated their emotions and feelings were from their responsibility to maintain professional standards for entry onto the professional register for children's nursing in order to maintain the safety of children and their families. This implies that children's nurse SOM in this study did clearly understand their accountability. The NMC code directs that a nurse must make the care their first priority, it is by protecting those in their care and wider community that registered nurses are able to uphold the reputation of their profession (NMC, 2008b).

Lack of recognition of the physical health impact of the SOM role arising from when SOMs are passing and/or failing students has significant implications. These matters require further attention from the NMC and employers, who should acknowledge the potential impact and agree the provision of support for those involved in the assessment of students at sign off stage.

Chapter summary

This chapter has presented a discussion of the study findings on children's nurse sign off mentor (SOM) experiences of undertaking assessment and provides an accurate picture as possible as to the children's nurse SOM perspectives. It has confirmed the appropriateness of using an interpretive, qualitative, case study approach.

The research study findings have been examined and situated in the available literature. The six themes identified from the findings have been examined in turn. The findings have been compared with SOM literature where it exists, and at times where there was a lack of existing evidence for comparison, other evidence and anecdotal literature has been targeted as a means of seeking corroboration.

Findings confirm children's SOMs demonstrate many differences to those mentors who are not a SOM. They have clear expectations in what they are looking for in a student

nurse undertaking their final sign off practice placement. Whilst there is a clear understanding that practice learning expectations are set by the AEI's in order to meet the requirements laid down by the NMC, there is an impression that children's nurse SOMs also set professional expectations which are influenced by their own registered nurse standards, experiences and norms and values in relation to children's nursing. Ensuring the safety of children and their families and protecting the standard of children's nursing is seen as the right thing to do. Previous studies have not captured how SOM view their role in the sign-off assessment process.

Previous mentor decisions significantly impacted on the role of the children's nurse SOM. Failure of previous mentors to address students deficits earlier may mean that previous mentors had not fully met their responsibilities, whilst other mentors may be simply opting out of doing what is required knowing that a later SOM would be responsible. Significantly, there is no evidence that children's nurse SOMs fail to fail. Decision making appeared to be the most difficult challenge for children's nurse SOMs. It appears that SOM decisions to pass or fail a student undertaking their practice placement experience requires SOMs taking a professional stance. Again ongoing concerns about potentially making the wrong decision emerged.

Study findings also emphasise the need for support by children's nurse SOM when facing their most difficult situations and conversations, especially when a student is not meeting the standards expected and therefore the SOM is anticipating that a student may not achieve and so go on to fail their final practice learning experience assessment. Findings do suggest there is a need to provide SOM feedback and time to talk about the events that happened, their decision making and also gain feedback on their delivery of feedback to the student. There is also a need for support for those SOMs who feel a sense of isolation when not attached to a Trust or when based in the community setting.

The personal impact felt by the SOMs arose from feelings and emotions resulting from the decisions they make. It seems regardless of the assessment outcome or the ongoing concerns they had in relation to the students future competency, the SOMs feel they have ongoing professional responsibility for their decisions in terms of their students, children and their families and the protection of standards in order to maintain the profession of

children's nursing. There is a need for accessible SOM support available, especially given the potential impact the SOM role has for the future wellbeing of SOMs.

This next chapter, Chapter 8, is the final chapter and this will provide a summary of the whole thesis, research findings and how a new understanding of the SOMs experience makes a contribution to the body of knowledge relating to mentors, in particular the experiences of children's nurse SOMs. The impact the research may have on future policy and practice and how the research will be disseminated will also be presented. There remains an opportunity for developing future engagement with policymakers and professional bodies and for sharing the findings with others in relation to this topic (s).

CHAPTER 8: CONCLUSIONS

Introduction

The final chapter draws together the whole thesis presenting new understanding through the provision of a summary and how the current research study has made a new contribution to the body of knowledge relating to mentors, in particular, children's nurse sign off mentor (SOM) experiences. This chapter will also summarise the contribution this research makes to professional practice, provide a summary strengths and limitations of the study, recommendations for practice and suggestions for further research and work.

The thesis has focused on the experiences of children's nurse SOM who undertake assessment at sign off stage, in order to understand the experience from their own personal stories and perspectives. Having examined and interpreted the data from twelve children's nurse SOM provides new insight and deep understanding in terms of the SOM role, responsibilities, expectations of pre-registration nursing students in terms of the student nurse being ready to enter the professional register, their experiences of passing and failing a student nurse in the final sign off practice learning experience, support needs following difficult decisions and the emotional impact of the SOM role. The findings of the study have led to the following research contribution to professional nurse education, generated recommendations for future practice and highlighted areas that require further research

Research contribution to professional practice

Findings from the study provide insight into the children's nurse SOM experience in the context of undertaking assessment of pre-registration student nurses within the practice learning environment, and provide an original contribution to the body of knowledge. The findings have wide ranging implications, which will now be discussed and used to make recommendations for practice.

The generation of new insight and understanding in relation to children's nurse SOM are significant for all those involved in nurse education, especially when considering the

potential impact that this research study will have on professional expectations, preparation and support considerations for future SOM and for those already in post. The elements identified in this research which contribute to SOM professional practice are:

- Preparation for, and understanding of, the children's nurse sign off role and responsibilities
- Expectations of children's nurse SOM in relation to the student nurse being seen as ready to enter the professional nursing register.
- SOM experiences of passing and failing a student nurse in the final sign off practice learning experience.
- Impact of previous/preceding mentor decisions.
- Support following difficult decisions.
- Impact of the children's nurse SOM role on their physical health.

Importantly, findings from this research found no evidence that SOM were 'failing to fail' which is in contrast to previous mentor studies (Lankshear, 1990; Duffy, 2003; Gainsbury, 2010a; 2010c; Jervis & Tilk, 2011). However, there is evidence from this current study that some mentors who support students prior to the final sign off practice placement are allowing students to progress who do not meet clinical performance standards, or to whom they may be giving students the benefit of the doubt, which requires further investigation and scrutiny.

The results are also important when considering potential increased demands on SOMs in the future. A paper commissioned on behalf of the NMC suggests that there is a need for an increase in the professional expectations of all newly registered nurses, proposing that from 2015, at the point of registration, there will be an expectation that newly registered nurses possess higher levels of autonomy, critical thinking skills and knowledge base in order for registered nurses to safely and effectively function within the future health and social care system (Longley et al. 2007). The findings also purport there will be a need for an increase in both specialist and advanced nursing roles potentially blurring of professional responsibilities and boundaries; the introduction of advanced Healthcare Assistants to the professional nursing register and the development of educational packages to support their transition from Advanced HCA to registered

nurse (Longley et. al., 2007). It is further anticipated that in order to meet the rising NHS costs in delivering this system of healthcare, it is likely that the total number of nurses will continue to decline and the gap filled by recruiting more healthcare assistants. These proposed changes will all potentially impact on the SOMs by further increasing demands on the SOMs role.

Strengths and limitations of the research

The strength of any research study lies in its design, transparency and recognition of those aspects that could have been improved or approached in a different way (Creswell, 1994). Thus, in essence, all research has limitations to the findings which require discussion. The strengths and limitations in this research have been considered in order to recognise the importance and potential of the research in relation to its application whilst identifying areas where future research is needed.

Reflecting on the strengths of this research study, a key strength relates to its focus. The research aimed to examine the experiences of children's nurse mentor through the perspective of SOM. During nurse training all pre-registration student nurses are supervised and assessed by nurse mentors or other suitably prepared supervisors (NMC, 2008, 2010b), however it is the SOM who has the ultimate responsibility to undertake the assessment of their final practice placement, towards the end of the three year nurse training programme (NMC, 2010b). A majority of previous research in this area has focused on the preparation of mentors, to evaluate an aspect of the mentor role or on the topic of 'failing to fail'. Previous researchers rarely focused on the mentor's experience. This is the first study to examine the experiences of children's nurse SOM and focus on what these experiences are and what they mean to them.

Reflecting back on my personal experience, described in Chapter 2, there is now a much greater and deeper sense of understanding of the children's nurse SOM experience. The research was valuable in that the SOMs found their participation in this process supportive as it provided a legitimate opportunity for them to share their experiences. There were no obvious benefits for them in respect of helping in their day-to-day role in which they make daily decisions about levels of student supervision and support, whilst encouraging their students' independence, developing action plans and deciding if a student is meeting the required learning outcomes and thus is ready to enter the professional register. Nevertheless, SOMs welcomed the opportunity to share their

experiences with me as someone who was interested and eager to hear what they had to say. They found the process helpful in terms of having an opportunity to take time in order to reflect on what the SOM role actually means to them individually and collectively in terms of SOM experiences: preparation, responsibilities, their expectations, decision making, support needs and personal impact. They also took time to reflect and consider the emotional impact the role had and checking my interpretation was accurate through verification. Providing SOMs with this opportunity was a definite strength of this research study. Undertaking verification events to feedback and check my interpretation was accurate, provided strength to the study.

The decision to use case study allowed for an in-depth exploration and explanation of children's nurse SOM experiences. This approach has led to a new understanding of the SOM role and experiences. As a researcher I am aware and content that the findings from this research study may only be applicable to similar cases and is therefore only generalizable at the theoretical level. The case study provided an opportunity for children's nurse SOM to share experiences from many sources at the time the study was undertaken. These findings may well change if a different group were interviewed at a different time.

A further strength has been my personal professional doctorate programme journey as there is now a greater and deeper sense of my own personal understanding of research and personal growth. This is attributed in part to the strong reflective elements that are intrinsic to undertaking a Professional Doctorate programme of study and the overall reflective practice that is common. This developed out of initially just wanting to know more about a topic of interest. What followed was a rigorous in-depth plan addressing my own research training and development needs (see Appendix 7 & 9). This allowed a thorough search of the literature to take place, including the search for a suitable research design, methodology and methods. The subsequent development of research interviewing skills, the search for a suitable framework and tool for interpreting the SOM experiences, all developed a sense of growing in confidence. Research supervision, guidance and scrutiny from my research supervisors allowed opportunities for consideration, debate, defence, reflection and growth. These are a key set of research knowledge and transferable skills can now be used to undertake further research and also be shared with others in order to support their research journey. The intention of this

study was to gain an in-depth understanding of the children's nurse SOM role which has been met

A limitation of the research study relates to the geographical area in which the study was conducted. This study was undertaken in the North West of England principally to allow ease of access to participants for recruitment to the study and interviewing purposes, whilst fulfilling the study's sampling requirements. The sample size of twelve children's nurse SOMs could be questioned, but this achieved depth over breadth of insights. The twelve participants each provided in-depth accounts to fully illuminate their experiences as SOMs. The purpose of this study was to gain an in-depth account in order to gain insight and a greater understanding, and to draw out what can be learned from them. This was achieved.

A further limitation is that the children's nurse SOM may not experience events in the same way another children's nurse SOM might and these experiences may be significantly different across the different fields of nursing.

Recommendations

- The development of a regional support and advice system (possibly on-line) to allow SOM to undertake their day to day role with access to timely support as required.

- The development of a regional on-line SOM community support network to provide cohesion and support, especially for those SOM who often work in isolation (for example, community, independent and private organisations).

- Recognition of the physical/emotional impact on the children's nurse SOM through the provision of emotional health and resilience elements into SOM training and updates which prepare and support SOM who are assessing and supporting nursing students on their final sign off practice placement.

- The development of a 'toolkit' that supports the emotional wellbeing of SOM by the NMC and AEI's. This resource would be introduced and implemented during SOM preparation and SOM updates.

- Recognition of the need for academic staff from AEI's to engage with and support children's nurse SOMs, especially when they have students who are requiring intensive support and intervention, in making or following a decision to fail a student, or when a student needs to return to the placement area for their four week retrieval (A student's second final attempt).

Implications for policy and practice

The research findings and evidence from this current study present new knowledge about the experiences of children's nurse SOMs. In addition, there is potential for the importance of study findings to have external influence at a theoretical level nationally for professional bodies (NMC, Royal College of Nursing – RCN), educational providers, employers, and SOMs in the UK. These research findings add to a developing evidence base to underpin SOM practice and any future research activities aimed at SOMs within health education and practice learning settings. Thus the potential implications of the research findings relate to future policy, future pre-registration nurse education and SOM preparation and practice.

The evidence base for SOMs is in early development in the UK. The move by the NMC to embrace the introduction of SOMs in recent years has been based on scant evidence and a belief that it is suited to the pre-registration mentoring system. The substantive contribution to SOM knowledge made by this study concerns the experiences of the children's nurse SOMs within the practice learning settings within a North West of England (UK) pre-registration nursing education model. . These experiences that have received no attention in the existing mentor research literature. Steps to be taken during SOM assessment preparation procedures and assessment processes and strategies to support those processes have been identified. The knowledge gained through this study has potential for impact on both a local pre-registration nurse education practice learning environment level (the study sites) and similar settings. There is a need for more open communication between educationalists, professional bodies and nurse leaders in order to discuss the implications of this research and for the development of an appropriate action plan and calls for further research (See Appendix8).

Following data collection the verification processes undertaken with the SOMs added to the accuracy of findings. This is particularly important when the intention is for professional bodies (for example, NMC), AEI's who provide professional education, and employers to base substantive decisions on a study's findings. Ultimately, arrival at unsupported or biased findings has been countered by the use of case study research, appropriate methods and structured analytical processes.

- NMC policy: There is potential to impact on the health and welfare of children's nurse SOM. This could be achieved by an increase in awareness of the SOM experiences and development of policy in regard to personal health and influence on SOM preparation for role provision. This could improve SOM health outcomes.
- NMC and RCN: There is potential to increase awareness of the SOM experiences and development of policy in regard to engagement with the NMC and Royal College of Nursing (RCN), in order to influence formulation of policy and guidelines, development of support resources and challenge current practice in relation to SOM training and preparation. This could include engagement with practitioners to improve effectiveness of current SOM workplace practice and support.
- AEI's, NHS Trusts and Private Sector organisations: There is potential to impact on SOM experiences and implement their own local improvements. This could include engagement with SOMs and the development and implementation of formal support resources.

Research dissemination

Dissemination is necessary to allow others to be aware of research that has been completed, but also to ensure timely engagement with practitioners and professional bodies. Transferring research into practice raises a number of opportunities and challenges. Manners (2014) purports it is necessary to consider who might benefit from research and how. Having done this it was recognised the research findings from this current study have the potential to impact on:

Undertaking a professional doctorate has ensured the integration of research with the researcher's nurse education environment. Smith (2012b, p. 322) recognised potential difficulties in ensuring research can influence practice and suggests that '*peer*

networking opportunities available within professional doctorates' may indirectly influence practice development. Prior to the outset of the study, relationships with *'practitioners, managers and peers'* were developed as suggested and have continued to be maintained. Early conversations took place as to the worth of undertaking research in the area of SOM experiences. From the research outset I have engaged with practitioners, peers and colleagues to generate debate and sustain interest in the research topic. Conversations have taken place and a Gantt chart developed which presents a comprehensive dissemination plan which incorporates local, regional, national and international dissemination opportunities (see Appendix 8). Overall, this study this has resulted in a substantive enhancement of personal understanding of the children's nurse SOM experience.

Through this research study, membership was secured at the University of Salford's 'Research Forum Support Network' which has an aim to support and buddy new post-doctoral researchers in the dissemination of their research study findings into practice. Smith (2012b, p. 324) asserts *'managers are pivotal to the translation of research into practice'* suggesting good practice can therefore be disseminated where there is an interface between the '*nurse manager, the practitioner researcher and academics*', before, during and after completing professional doctorate study.

Publication

Following write-up of the thesis it was acknowledged that publication of findings will be required to allow others to be aware of the research that has been completed. To aid dissemination publication topics, as well as where to publish have been considered and a plan developed (see Appendix 8). The current emphasis is to target publications to those journals which have the highest impact factor (IF), a score which is valued in the publication of research. However, there are only five nursing education journals which have an impact factor (IF), these are: '*The Journal of Continuing Education in Nursing, Journal of Nursing Education, Journal of Professional Nursing, Nurse Education Today* and *Nurse Educator', i*ndicating IF ranges from 1,218 - 0.562 (Oermann & Shaw-Kokot, 2013, p.483). It is recognised that the IF is only one of the aspects considered in order to reach audiences that can benefit from the findings of this research study in their teaching, for example, curriculum developers, link teachers, and those who support practice learning. Therefore, a range of other professional journals will be approached who support a wide spectrum of readers including, mentors, SOMs, nursing students and

other professions allied to health and social care. These journals will include: *Nursing Times, Nursing Standard*, *Nursing Children and Young People* and other popular health and social care journals.

Conference and local dissemination

Further consideration to aid dissemination has been local dissemination, presentation of a paper or poster at conferences and these have been included in the plan developed for dissemination (see Appendix 8). Where to present was considered in order to reach audiences who support practice learning and therefore will benefit from the findings of this research study. These include: The Regional Director of Nursing Forum, Professional Doctorate/PhD students (Salford), regional and local practice learning and mentor forum meetings, the Association of British Paediatric Nurses (ABPN) forum, the Royal College of Nursing (RCN) conference and other popular health education conferences.

Locally there has been acceptance of an invitation from practice partners who wished to hear the findings of this research study. Beyond the organisation, a potential for further learning has been made possible by the invitation to prepare a presentation for the Regional Mentor Preparation Course (see Appendix 8). Further opportunities for learning is to be maximised by ensuring that both adequate time and suitable group and individual forums are available, in which it can take place (see Appendix 8).

Suggestions for further research

This section provides considerations and suggestions for further research. Undertaking this research study has provided a legitimate opportunity for the consideration of further future research in order to answer a number of the issues raised from the findings in this thesis, which may help address gaps in the research evidence available in the field of SOM.

This study has been worthwhile in terms of the degree to which an in-depth understanding of the children's nurse SOM experience has been gained. It is, however, a study of a single case. To assess the wider application of these findings to SOMs across other fields of nursing or other professional groups such as midwifery, it is necessary for them to consider the study findings in relation to their own practice learning contexts.

Until the findings from this case are applied and evaluated in other settings, their wider merits will not be known. Undertaking this research study has provided a legitimate opportunity for the consideration of further future research in order to answer a number of the issues raised from the findings in this thesis, which may help address gaps in the research evidence available in the field of SOM.

Findings suggest that further research is therefore considered in the following areas:

1. Research into the range of expectations and experiences SOMs have across the four fields of nursing when making their final sign off assessment decisions.

2. Research to consider the SOM experiences of other professional groups such as midwifery. Research could also include other health and social care professional groups, such as social workers, operating department practitioners and paramedics.

3. Research to consider the experiences of SOMs from integrated professional student groups, such as nursing and social work students.

4. Exploration of the experiences of nurse mentors who may have made the decision to give students the 'benefit of the doubt'.

5. Research studies related to the experiences of pre-registration nurse lecturers in the provision of support to practice staff in practice placement settings.

6. Research to consider the impact that the provision of emotional preparation and support has on the SOM feelings of wellbeing, to inform future SOM training and preparation and ongoing support in role.

7. Research into the need for final sign-off practice learning assessment to be a joint assessment process which may be between SOMs, student nurses and a University representative (e.g. the student's personal teacher).

Summary

This research has focused on the experiences of twelve children's nurse SOM in the North West of England (UK), this study is significant as there are no other studies which have examined the children's nurse SOM experiences to draw upon. Therefore, suggestions have been proposed for the NMC, key policy makers, nurse leaders and senior managers within health and social care organisations, and finally, nurse educators, programme leaders and providers of pre-registration nurse education in the higher education sector. These suggestions are acutely relevant as increasingly new graduate nurses will be expected to perform differently in comparison to our current registered children's nurses.

By adopting a philosophy that aims to gain a deep understanding (Yin, 2009, 2011), one might conclude that this thesis has contributed to developing a much greater understanding of the experience of children's nurse SOM of undertaking assessment from the SOM perspective. In reflecting on their experience of being a SOM, mentors shared their experiences, including what their role actually means to them, how they are prepared, their expectations of a children's nursing student at the final sign off practice placement, the impact of previous mentor decisions, the provision and level of support and the emotional impact that the SOM role has on them personally. Certainly, the findings indicate that supporting a student on their final sign off practice placement can be a difficult experience that sometimes results in the SOM suffering physical and emotional distress. Despite this, SOM were clear that they took full responsibility to make the decision to pass or fail a student. They deemed the role of SOM necessary, despite the personal cost to themselves.

Findings from this research found no evidence that children's nurse SOMs were 'failing to fail' students. Being a children's nurse SOM is about making sure the final sign-off mentor decision is always the right decision, regardless of the emotional impact, and in doing so this ensures future children are protected and that standards of care for the children's nursing profession are upheld.

APPENDICES

Appendix 1: Letter from PLSS senior management group

Edge Hill
University

21st January 2013

To whom it may concern

Following a discussion at the PLSS Management Group on the 14th January 2013, the representatives from all member Universities (University of Liverpool, Liverpool John Moores University, University of Chester and Edge Hill University) are happy to support Anita Flynn with her request to utilise PLSS Mentor database to gain data for her research project.

Yours sincerely

Mrs Mair Ning
Associate Dean, Academic Development & Quality Enhancement

Edge Hill University   edgehill.ac.uk   Vice-Chancellor
Ormskirk, Lancashire   Tel: +44 (0)1695 575171   Dr John Cater
L39 4QP United Kingdom

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Appendix 2: Participant invitation email and letter to nurse mentors

<u>Initial E-mail to sign-off children''s nurse mentors based in West Lancashire, Cheshire and Mersey Region placement areas.</u>

Dear
Please see attached letter inviting you to help with a research study about Children's nurse mentor experiences of undertaking student nurse assessment at sign-off stage.

Anita Flynn
FOHSC
Edge Hill University
St Helen's Road
Ormskirk
flynna@edgehill.ac.uk
01695 65 7079

<u>Attached Letter.</u>

Dear
As part of the Professional Doctorate I am studying for at the University of Salford, I am doing some research about children's nurse mentor experiences of undertaking student nurse assessment at sign-off stage. As a lecturer at Edge Hill University, I am passionate about enhancing the experience of both mentors and students. I am looking for volunteer 'sign-off' mentors from either hospital or community settings to assist me with my research into this little investigated aspect of mentorship. .

To participate in this research study you must be:
- A registered children's nurse
- Have experience of mentoring pre-registration nursing students.
- Have undertaken student assessments at sign-off stage (or be undertaking sign-off mentor assessments under supervision).

If you wish to participate you will be sent further information about the study and invited to take part in a focus group interview (to be held at Edge Hill University) and an individual face to face interview. Interviews will take place at a time and place convenient to you. If you are interested in taking part please reply to this email expressing your interest and I will forward you a Participant Information Sheet for you to consider.

Thank you

Anita Flynn
FOHSC
Edge Hill University,
St Helen's Road, Ormskirk, Lancashire
flynna@edgehill.ac.uk   Tel: 01695 65 7079

Appendix 3: Participant research study consent form –focus group interviews

Name of Researcher:

Title of Project: Children's Nurse Mentor Experiences of undertaking assessment at sign-off stage

<u>Please initial box</u>

1. I confirm that I have read and understand the information sheet dated 10th September 2012 Version 1 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason

3. I agree to take part in the above study.

4. I agree that anonymous quotations from any transcribed focus group can be used in publication / presentation.

Name of participant:

Signature:
Date

Name of person taking consent:

Signature:
Date:

Appendix 4: Participant research study consent form for individual interview

Name of Researcher:

Title of Project: Children's Nurse Mentor Experiences of undertaking assessment at sign-off stage.

<u>**Please initial box**</u>
1. I confirm that I have read and understand the information sheet dated 10th September 2012 Version 1 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason

3. I agree to take part in the above study.

4. I agree that anonymous quotations from any transcribed interview can be used in publication / presentation.

<u>Name of participant</u>:

<u>Signature</u>:
<u>Date</u>

<u>Name of person taking consent</u>:

<u>Signature</u>:
<u>Date</u>:

Appendix 5: Participant information sheet

I would like to invite you to take part in this research study, before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Please ask questions if anything is not clear or if you would like more information.

Title:
To examine children's nurse mentor experiences of undertaking assessment at 'sign-off' stage.

What is the purpose of the study?
Little is known about the experiences of children's nurse mentors undertaking assessment of student nurses at the sign-off stage of assessment (This refers to a person who has the authority to approve (sign-off) a student nurses proficiency at the end of a programme). The purpose of this study is to learn how children's nurse mentors undertake assessments of student nurses at sign-off stage. This research will enable nurse mentors to tell their own stories and develop the evidence base.

Why have I been chosen to take part?
I would like you to take part because you are a children's nurse sign-off mentor (or currently undertaking supervised sign-off assessments) and you have undertaken mentorship and assessment of nursing students during the past five years as an active sign-off mentor registered on the West Lancashire, Cheshire and Merseyside Practice Learning Support System (PLSS) placement and mentor database. Formal agreement to access your sign-off mentor status and details from the PLSS database was requested and endorsed by the PLSS senior management group.

Consent
If after reading and taking time to consider this information sheet you wish to take part you will need to give your consent to take part in the study and will be asked to provide written consent for the individual and focus group interviews. Your consent forms will be kept securely and separate from other data. Even after you have given consent you are free to withdraw at any time, without giving a reason. If you withdraw from the study your data will not be included in the study.

What will I be asked to do?
You will be invited to take part in both an individual interview and a focus group interview which will be with approximately 5 other sign-off mentors. You will be asked to talk about and reflect on your children's nurse mentor experiences. Each individual interview will take place at a time and place convenient to you the participant and will take around 30 - 40 minutes. Focus group interviews will take place at Edge Hill University will last approximately 60 minutes. You will be asked to maintain confidentiality of others who attend and contribute to the focus groups.

What are the possible disadvantages to my taking part?
Taking part in an individual and a focus group interview will require you to give up some of your free time in order to participate in an individual and a focus group interview.

Every effort and precaution will be made to protect your anonymity and confidentiality. However, whilst the researcher will ensure every precaution is taken they cannot ensure that all discussions in the focus group will remain totally confidential once participants leave the focus group.

As a nurse mentor has responsibility under the requirements of the NMC to report poor practice. It is important to be reminded that the researcher is required to divulge breaches of the Code of Conduct to your manager following a discussion with you.

What are the possible benefits?

This research study will provide a greater understanding of children's nurse mentor experiences of undertaking sign-off mentor assessment. At the end of the study as a participant you will be offered a summary of the study findings. Although you may not benefit immediately, it is hoped findings will influence future mentor training and future mentors.

Will my participation be kept confidential?

Yes. Confidentiality will be assured to you as a participant at all times and will comply with the Data Protection Act (2003), and the Nursing and Midwifery Council regulations (NMC, 2008a). All information which is collected about you during the course of the research will be kept strictly confidential, and any identifiable information will be removed from transcripts and only I (Anita Flynn) and my research supervisor will have access to these. All data including paper copies and data memory sticks, including back up data sticks, will be kept in a locked cabinet in a locked room at Edge Hill University. Consent forms will be kept securely and separate from other data. Research records will be kept securely for 5 years.

Prior to focus group interviews the researcher will request that all participants respect the confidentiality of other focus group members in relation to their attendance and contributions. Only first names will be used within the focus group in order to provide further protection of your privacy. All names will be removed during transcription of the individual and focus group interviews.

The exception to the maintenance of confidentiality would be solely where unsafe practice was highlighted. If this occurs then a conversation would be had with you [participant] and the manager of your practice area. Any action resulting from this would then be the result of Trust procedures and would sit outside the remit of this study.

What will happen to the results of the study?

Once the study has been completed the findings will be submitted as part of a Professional Doctorate thesis and opportunities for publication and presentation will be sought in relevant journals and conferences. You are assured of continued confidentiality and respect for your opinions, both during interviews and afterwards in the presentation of findings and subsequent publications.

Who is organising and funding the study?

This research study is being organised and funded by me and the research and findings will be submitted as part of a Professional Doctorate thesis.

Who has reviewed the study?

In this research study procedures and processes will be put in place to protect you as a research participant. At the start of the study the study will have been registered with the Integrated Research Application System (IRAS) and has been reviewed by the Research Governance Ethics Committee (RGEC) at the College of Health and Social Care at the University of Salford and Edge Hill University Research Ethics Committee to ensure your safety, rights, wellbeing and dignity are protected.

What if there is a problem?

If you have any problem or you wish to discuss anything myself (Anita Flynn) and my research supervisor (Tracey Williamson) will be available for you to contact via telephone or e-mail throughout the study. Even after you have given consent you are free to change your mind and withdraw from the study at any time.

Thank you for taking time to read this information leaflet.

Details of research staff
Researcher
Anita Flynn
Professional Doctorate Student
FOHSC
Edge Hill University
Ormskirk
Tel: 01695 65 7079 / E-mail: flynna@edgehill.ac.uk

Supervisor
Tracey Williamson
Research supervisor,

Research Fellow (Public Engagement and User Involvement in Research)

School of Nursing, Midwifery and Social Work

Frederick Road Campus

University of Salford

Tel 0161 295 6424 / Email:T.Williamson@salford.ac.uk

Appendix 6: Research participant verification event form

1. What have you valued most about the SOM research participant verification event?
2. Do the research findings accurately reflect your feedback?
Yes/No. Please comment:
3. Is there anything else you would like to see included?
Yes/No. If yes please provide details here:
4. Anything you would like to see removed from the findings?
Yes/No. If yes please provide details here:
5. Would you like to make any further comments? These are not part of the research findings but may be used anecdotally?
Yes/No. If yes please provide details here:
6. Any other comments?

Date:
Name:

Appendix 7: Extracts from Reflective Research Diary

Diary: 17th August 2011

Funny, feel nervous first catch /research supervision meeting at Salford since my return from intercalation. Think it feels real again after returning following such a difficult 16 months that said I am back now, despite feeling somewhat shaky and nervous.

Progress:

Yes, they say the first step is the hardest. Still it is difficult to think about it all: I have the same mentor research topic – now considering my actual question before I look at research design! Reading but I must devise a plan ....it all just seems such a huge task.

Diary: 26th September 2011

I have just had another research supervision meeting. I am feeling much better. We discussed a range of articles and other related literature I have found and read. I was able to pin down topic – Children's nurse mentor assessment of student learning in practice.

Progress: Massive, it seems that no research has been done on my actual research topic! Back up supervisor couldn't believe it but said she had checked as well. Now all I need to do is pin my question down specifically.

Diary: 0ctober 2011

Remain positive: I have been thinking all the time and pinning down my questions. Now need to look at a design – this is really difficult. Reading Robert Yin at the moment who I understand, I think maybe this is it but need to read some more?

I think, it was hard taking over a year out (16 months) - but had no choice and I am back now and feel much healthier, able to concentrate. Still during this time I made progress in other areas: 2nd publication from joint research study: although not directly related to my study topic, I have developed transferable skills in relation to writing for publication and other key skills and it was a great experience. So yes I feel chuffed.

Publication: Bray L, Flynn A and Saunders C (2011) The experiences of Children's Nursing Students Learning Urethral Catheterisation. Nurse Education in Practice, 11 (3): p. 168-172.

Diary: April 2012

What is happening? 2 students (from another field of nursing) have failed on their sign-off mentor (SOM) placement and need a second attempt. Mentors have been informed but one mentor is refusing to take their student back for second attempt and has gone higher in their own organisation! Another mentor says her student is 'unsafe' but what is confusing is she has not highlighted this until now and has signed off nearly all their competencies anyway.
So are they actually a fail and maybe not 'unsafe'?

This afternoon a student nurse (Children's) who had been failed her placement has now reported they were being bullied by her mentor and maybe her new personal teacher? They had already moved to a new personal teacher because they were not happy with previous teacher and had refused to stay with them. Now they want to go back to them? This will need further investigation.

Progress

Case study.

I have been keeping a dairy just to record my thoughts and keep an eye on my progress since I returned to the course and work – but now will maintain it as part of my research design. Reading and thinking as much as I can which is usually at the end of a busy day – is this progress? It is definitely a confusing time as the more I read and think I understand it seems the more unclear and confused I have become the next day.

Preparing for my interim assessment but work pressures remain high which is impacting and making it hard to find the head space to think. Looking back it has been a horrendous 10 months both at work and home with so many competing pressures. I have to ensure we get through validation at work so I have less time than planned to prepare for interim. Work, life, study balance – does it exist? Maybe I can't do this or maybe I wasn't ready to start back when such a busy time was going to happen at work! How do others cope in this situation – maybe I need to find out?

Diary: 17th May 2012

Reflection: Did not pass Interim – I still feel very disappointed with myself and everything I have done so far. Work pressures have been immense and I was not able to take any time at all to prepare either the interim document or time to prepare before I met the panel (so at least I could have defended better). Think it is time to reflect on how to manage as I can't do it all in my own time? A comment today was they can't see the point of a doctorate as it will not help me in my role!

Progress: Some – revalidation is over.

I have already started to revisit my interim assessment. Also attending a research workshop at lunchtime on Qualitative Data Analysis which I am looking forward to. Lunchtime updates definitely work for me. However, still nervous about interim next month – I have tried my best to be much more assertive in also prioritising both my study needs and work.

Diary: 29th June 2012

Interim assessment – passed today so just feeling utter delight and relief. Feel pleased that the assessors on the panel really liked my subject and asked lots of questions and challenged some of my decisions. I found this helpful; they said I had come a long way since my last interim assessment and that I defended my planned research and decisions well.

Progress

One mountain climbed (relief) and now I have another mountain to climb.

Finish Ethics so ready for submission!

Diary: August 2012

Reflection

Again ask myself what is happening? A few students have just failed their final practice placement – They all only have one further attempt. I know one of the student nurses as they have been on my radar for the past year for me. The student is really nice and kind but she has struggled throughout her second and third year, and she has needed a lot of support (hours). For me it again raises questions about how this student has got to this stage - their final sign-off placement. I spent 3 hours the other week with the student, her SOM and PEF (her personal teacher was off), they were so helpful and nice to her but she could not remember what had been said or what she had to do. To get the telephone calls this week to say the student has failed at this end point is not unexpected but is a concern as it has been compounded as I am sharing with the others who have also had calls.

Sitting here during these few moments of reflection I have thought about how the sign-off mentors maybe feeling in each of these situations. I did not know what it was like for the children's nurse mentors day to day. In my role I hear about students who fail but I don't know about other experiences in their role on a day to day basis or what it is like to be a sign-off mentor faced with this difficult decision - I definitely want to find out more.

Impact of hospital care/failings: I wonder if the recent failing being discussed constantly in the media are still fresh and therefore have impacted on SOM. Especially as local trusts have been discussing and meeting with staff and faculties. As 'gate keepers' maybe sign-off mentors are feeling this pressure more or maybe they simply pass students when appropriate and fail students when they should when maybe previous mentors had given students the benefit of the doubt? I just don't know the answer to this?

Progress
Progress is slow but moving forward.

Diary: 5th October 2012

Ethics application complete really but attending workshop anyway at lunchtime (just to ask final questions about the process so I can reassure myself). The research workshop: Revision: Ethics application and process.

This element has been really difficult for me but it has made me make final decisions about design, methods, information for participants and how I will recruit, questions etc. Pinning it all down has been a useful process.

Diary: 29th October 2012

Did not get through ethics – nothing major just need a letter from PLSS senior management group to say I can access SOM from the system. The ethics panel fed back my application was a very comprehensive application. They had a couple of questions about topic – they wanted to ask if it had been done before (my reviewer was not a nurse). I got a little annoyed as I thought the panel made decisions about the ethics of the study not make comments on my topic area? When I get the letter from the PLSS senior management group they will be able to take chairs action.

Wonder why there is not a system where you present your ethics application and then this going back and forth would not be needed? It would put me off if I did not have to do –maybe that is why lots of good ideas and questions do not become actual research.

Progress
Made some, I email a request for access (outlining my study etc.) to the PLSS senior management group committee (they meet every 3 months).

Diary: 5th February 2013

Reflection

I may have been reading too much literature all at once as there appears to be a significant amount of negativity in the nursing press surrounding nurses, fitness for practice and mentor decision making. This has been compounded as I have recently watched the BBC programme 'Undercover Filming Only Option' (BBC, 2009) again. It was about a registered nurse caring for older clients and she took part in undercover filming about the poor care clients were suffering for the BBC. It was certainly distressing and depressing to watch as a registered nurse and lecturer. Shockingly, it had initial poor outcome for the registered nurse working undercover, as the NMC suspended her, they later reinstated her following public pressure. This has made me think about my own planned research with sign-off mentors as I will be asking questions and the answers may upset the NMC.

Also been reading a summary of the Francis report (The Francis report, 2012), which made more depressive reading about care standards and nurses. Wonder why other professionals involved do not seem to have received equal amounts of focus/negativity?

My thoughts return to latest publications and talk suggesting mentors 'failing to fail'. My own thoughts and views about this no doubt been influenced by the press over time. However, my personal experience is in conflict with this generally negative perception of nursing. As 'gate keepers' sign-off mentors have a tough role and maybe they feel some sort of added pressure or have they continued to pass students when appropriate and have had to find the courage to fail students when maybe previous mentors had given students the benefit of the doubt? If sign-off mentors are willing to fail a student why did they feel they could and how did they make these decisions when other mentors were not able to do so? There is no substantial evidence about their experiences as a sign-off mentor that mentors and others could learn from it.

Progress
Ethics: Need to complete and submit ethics to gain approval from Salford.
IE Plan: I have developed a plan for IE. I have to prepare a report and have chapters written for later this year. This will require a significant amount of effort and work in order to progress.

Still pressures at work v time for professional doctorate – this will not change so I need a way to get over my feelings about it.

Diary: September 2013

Progress

Massive time delay in relation to Ethics: then it has taken e-mails and telephone calls to chase.

IE: I am currently finishing off writing draft chapters and preparing for internal review (IE) both of which were on my mind constantly. I thought I was making progress in May but still seem to be writing drafts and redrafting constantly – at times it is like walking in treacle. I need to make sure that 'my voice' is more evident in my writings but is it is hard to find and I also think I need the confidence to take the leap. Saying that I am making progress and I am at last on target.

I have made a significant amount of progress this year; at times it seems to be coming together. Booked in 2 interviews for October, exciting and hope they don't change their minds or anything. Again seems like there is no change with pressures at work v time for professional doctorate - maybe this is how it just is?

Diary: 28th October 2013

Just had my IE – I think it was the most nervous I have ever felt and I felt myself shaking for a few moments. When I looked at my watch nearly 2 hours had passed! It was such an intense couple of hours but it was great to discuss my research: the journey along the way, topic, why, literature searching, design, methods, ethics, first few interviews etc. After it was over the hardest part was waiting whilst the panel deliberated. When I was told I passed I felt a bit dizzy and glad I was sat down. Think Tracy could tell, she is also delighted.

Progress

Yes. It is surreal as I am sat here on the train typing and telephoning. It is coming together, I just couldn't see it for ages but today it has all just come together. Have some changes to make to my chapters, nothing much.

Diary: 28th January 2014

Recruitment to all 12 individual one to one interviews and 2 focus group interviews

Interest has been steady and subsequently recruitment has been good. I had a number of enquiries asking for more information and some of these decided not to participate. I have

commenced data collection: I have carried out 4 interviews and the remaining 8 are all confirmed for end of January, February and early March.

During recruitment of participants an isolated incident occurred in which someone offered to 'cherry pick' the best participants for me, this meant identify their best sign off mentors. 'If you let me know I can find the best sign offs'. I gently, but firmly said no. I think they are trying to just help the recruitment process along. *At the time the offer to potentially 'cherry pick' their best SOM was considered to be a naïve comment rather than a deliberate act to prevent any contact with any SOM in particular. However, it is has been on my mind all day so will discuss with supervisor at next supervision.

Interviewing is much more difficult than I thought it would be, but I can already see that my individual interviewing skills have developed, even after 4 interviews. Looking back to the first interview I can see how nervous and tentative I was, listening to my voice later helped me to recognise this and the need to focus more on what the participant was saying rather than what was going on (I could visualise myself worrying about and reading my next question even though I know them off by heart). However, my confidence with asking the questions, actively listening and leaving a space for mentors to think before they answered the question had grown, even by the second one to one interview.

I knew two mentors fairly well - through visiting the practice placement areas and I thought this may have made me or them more nervous or uncomfortable, however after a few minutes it was actually fine. I also tried some deep breathing and relaxation exercises before my 3rd interview (some early advice from supervisor) and this seemed to help, however when I started to think about my feelings of nervousness I actually feel somewhat 'nervous inside' all the time, even when not interviewing. Maybe it is excitement and not nervousness?

Progress:
Slow but steady. Four individual interviews completed: some issues that have been raised and discussed by the sign off mentors already.

Diary: 10th March 2014

I had a research supervision meeting this morning. It was a catch up meeting and we discussed progress so far: I have nearly completed data collection: I have carried out 12 interviews. Focus group interviews also progressing nicely: one participant unable to attend - I looked at a number of alternative dates but the date was moving further and further into the distance and

I did not want to lose any another mentor or more by moving the date or lose the momentum from the individual interviews.

I can see that my interviewing skills have developed. Looking back to the first individual interview I can see how nervous and tentative I was. My familiarity with asking the questions, actively listening and leaving a space for mentors to think before they answered the question continued to grow throughout.

Early findings suggest there may be some potentially good data:

- SOM feel NMC is passing the buck to them

- SOM preparation important

- SOM have clear expectations of students at sign-off – different to other students.

- No evidence yet that sign-off mentors 'failing to fail' (which is a sort of surprise to me). Rather SOM indicate that previous mentor decisions sometimes a problem and that these impact.

- Lack of support for difficult decisions

- SOM find it very hard undertaking their role: Emotional impact- the level was unexpected but was increasingly expressed and discussed.

A decision not to undertake online survey element was taken – we (supervisor and I) discussed this at length and supervisor agrees there is nothing to gain. We discuss verification meeting as this will allow an opportunity to check out findings with sign-off mentors.

Progress:

Steady but need to complete data collection.

Progress is always forward – very slow sometimes and quicker on other weeks. I have found it is important to do something/anything to just to keep moving forward. This approach helps me to keep going when time is short – So I add a table or appendices or read something.

Diary: 11th April 2014

I had a research supervision meeting this morning. On the way home on the train I have time to reflect and make a journal entry: We (supervisor and I) discussed progress and early findings. No sign that sign-off mentors failing to fail, still a surprise to me.

Six emerging early themes coming from data: these have grown from earlier findings and are:

- Sign-off role preparation, role and responsibilities

- Children's nurse sign-off mentor experiences

- Expectations of students by children's nurse sign-off mentors

- Previous mentor decisions
- Support following difficult decisions
- Physical impact

Progress

Remains steady, I need to complete findings chapter and a draw up a research impact Gantt chart (not sure how it should look). I realise I am actually feeling 'panicky inside' as I sit on the train back to work. Not sure why? Maybe talking about the findings make it real and the timeline discussed will make it happen? Maybe it is because there is so much to do and what if no one finds the research study interesting afterwards?

Diary: 16th May 2014

I received a strange e-mail today. One of the lecturers has contacted me re a student who has recently failed her sign-off mentor placement and their subsequent 4 week retrieval (2nd and final opportunity). The lecturer explains they have been supporting the student and that the SOM and whole placement team have been extremely supportive towards this particular student nurse and invested much time and effort. However, the lecturer states that following their visit last week the SOM and whole placement team seem to have been left emotionally drained and deeply saddened by the events, more so following the recent 4 week retrieval placement period in which the student nurse did not meet 2 outstanding learning outcomes, meaning the student nurse not only failed the placement but also the course. The lecturer is asking if I would send a letter to the placement area to try and help the team cope with the events.

I sit and reflect on this request as this was the first time that I have been asked to intervene to support a placement SOM and team following an event like this. Increasingly individuals are aware of my research topic but not aware of any findings yet, so I am left wondering why the lecturer is thinking about the placement team this way and why I have been asked to write a letter (does the lecturer feel unable – why?). Think I may have a question for further future research.

The research findings in relation to the emotional impact the SOM role had on the participants I interviewed ring clearly in my mind and so I sit and draft a letter to the ward manager, SOM and wider placement team. I offer thanks for the support they gave, share some feedback and offer follow up face to face support if required by the SOM and/or team. The letter and offer

of support was extremely well received and it is something I would not have done prior to this research.

Progress:
Extremely busy at work and managed a lot of work each evening for a few weeks but this week I have not written anything in relation to writing chapters, so feel guilty. Have read some articles on intuition though. Still the pressure never seems to go away.

Dissemination
Have been developing research impact Gantt chart – 2nd draft.
Been out in practice and attending practice focused meetings here – so have managed to speak with a couple of PEFs and they are eager for me feedback findings to their mentors and SOM. I have also spoken to mentorship programme lead and arranged to present findings on the mentorship course (x5 groups across the region – module leader has said she will help me prepare interactive on-line session so all the groups have access to the same and I don't have to be in five places at once).

Diary: 23rd May 2014

Supervision meeting with Supervisor: Having given much thought to event above and feel better about it.

Supervisor happy and we had a good discussion about my ideas for dissemination. We also discussed findings chapter and verification event in June with participants. Supervisor confirmed it is OK to do one of these via telephone as they are unable to attend a meeting I have set up, feel better about that. One meeting is very early in the morning at the start of an early shift – that will be shock to my system. Will design a verification form as soon as I finish this entry, having an hour on the train to get back home/back to work has been a godsend.

Progress
Yes, but still lots to do

Appendix 8: Research Impact Gantt chart

1. **Quality of life:** improved environment, social cohesion, health, education and cultural advances.
2. **Policy:** the impact that research could have on the creation and application of government policy.
3. **Business and commercial:** impact this research could have on specified market places, potential financial and efficiency savings, new business and job creation.
4. **Knowledge Transfer / Exchange:** the benefits of knowledge transferred to a business / third party and vice versa to the university eg benefits to other researchers and students.
5. **Communications and engagement:** how the research and its impacts will be communicated. This needs to be specific about which journals and conferences would be appropriate to reach the potential beneficiaries and why. Rather than general statements about the usual types of journals that would be used.

(Themes Adapted from: Stir.ac.uk good research practice guidelines 2010)

September 2014	November 2014	December 2014	March 2015	April 2015	May 2015	June 2015	July 2015	August 2015
Regional Teaching: mentor preparation course\n\nFeedback to X 5 mentor groups undergoing initial mentor training	**Local** One to meeting with associate Dean of faculty (Research and innovation).\n\nOpen university twitter account	**Regional** Present at: HENW\n\nPresent at Director of nurses forum (who can influence support for their SOM)\n\n**Local Media**	**National** Engage with NMC Professional body: to share and discuss research, findings and further potential research needs/opportunities.\n\nWorking group: NMC good practice SOM guidelines\n\n**National** HPC: engage to discuss research, findings and identify further research opportunities.	**National and international** Publication sought in key Nursing impact factor (IF) journals: Journal of Continuing Education in Nursing; Journal of Nursing Education; Nurse Education Today; Journal of Professional Nursing and Nurse Educator (IF range from 1.218 to 0.562).\n\nOther journals will be targeted which will include low IF journals in order to reach audiences that can use research findings in their teaching and practice.	**National and Regional**\n\nPresent at: Practice Educator's forum.\n\nWorking group: Work with practice educators to develop good practice guidelines.\n\n**National** Present at Association of British Paediatric Nurses (ABPN) forum.	**Local** Present findings: EPRC Research Seminar lecture series\n\n**Regional, National and International** Present findings: Centre for learning and teaching (CLT) conference at Edge Hill University.\n\n**Public** Online ETHOS	**Regional** Present findings: Research Forum (Edge Hill) and Professional doctorate/PhD students (Salford)	**National** NMC Professional body: continue to engage.\n\nSubmit paper and poster to present findings at Royal College of Nursing (RCN) conference.

				Regional Meetings: Produce a one page summary for circulation at practice learning and mentor forum meetings. Local Influence curriculum of Pre-registration nursing programme. Meet with programme leaders of other professional programmes (NSW, SW, ODP, Midwifery and paramedic) Teaching: Edge Hill Sign-off Mentors preparation/annual update course (Feedback findings).				
1. Quality of life 4. Knowledge transfer/exchange	1. Quality of life 3. Business & commercial 4. Knowledge Transfer / Exchange	4. Knowledge Transfer / Exchange 5. Communications & engagement	1 Quality of life 2. Policy 5. Communications & engagement	1 Quality of life 4. Knowledge transfer/exchange 5. Communications & engagement	1. Quality of life 4. Knowledge transfer/exchange 5. Communications & engagement	1. Quality of life 4. Knowledge transfer/exchange	4. Knowledge transfer/exchange	1 Quality of life 2. Policy 5. Communications & engagement
Ongoing Evaluation of how research has been received								

Year 2

September 2015	October 2015	November 2015	December 2015	April 2016	May 2015	June 2016	August 2015
Regional Teaching: nurse mentor preparation course Feedback to X 5 mentor groups undergoing initial mentor training.	**National and international** Present research and findings at NTS conference. **Local** Present research & findings at EPRC Research Seminar lecture series	**National and international** Further publication sought in key Nursing impact factor (IF) journals: Journal of Continuing Education in Nursing; Journal of Nursing Education; Nurse Education Today; Journal of Professional Nursing and Nurse Educator (IF range from 1.218 to 0.562). Other journals will be also targeted which will include low IF journals in order to reach audiences that can use research findings in their teaching and practice.	**National** Continue to engage with NMC Professional body to help develop and implement good practice SOM guidelines and support changes.	**Regional** Teaching: Sign-off Mentors preparation course/annual update course. Feedback research/findings to SOM. **Local** Curriculum: feedback to Pre-registration nursing students and other students on professional programmes (NSW, SW, ODP, Midwifery and paramedic)	**Regional** Continue to work with practice educator's forum.	**Regional , national and international** Present update on findings (research impact work) at Centre for learning and Teaching (CLT) conference at Edge Hill University.	**Regional** Provide an evaluation report on research impact and plan for next steps
1. Quality of life 4. Knowledge transfer/exchange	1. Quality of life 4. Knowledge transfer/exchange 5. Communications & engagement	1. Quality of life 4. Knowledge transfer/exchange 5. Communications & engagement	1 Quality of life 2. Policy 5. Communications & engagement	1. Quality of life 4. Knowledge transfer/exchange 5. Communications & engagement	1. Quality of life 4. Knowledge transfer/exchange	1. Quality of life 4. Knowledge transfer/exchange	1 Quality of life 2. Policy 5. Communications & engagement
Ongoing Evaluation of how research has been received							

Appendix 9: Research Training Record:

Research Domains (from Researcher Development Framework)
A: Knowledge and intellectual abilities
B: Personal effectiveness
C: Research governance and organisation
D: Engagement, influence and impact

Date	Type Development/Training	Location	Comments
February 2007	Research Methods Theory module [M level]	Salford University	Towards meeting research development training requirements for Domain A, B and C.
May 2007	Professional Biography Theory module [M level]	Salford University	Towards meeting research development training requirements for Domain A and B.
January 2008	Practitioner Researcher 1 Theory module [M level]	Salford University	Towards meeting research development training requirements for Domain A, B and C.
May 2008	Reclaiming leadership Theory module [M level]	Salford University	Towards meeting research development training requirements for Domain A, B and C.
January 2009	Practitioner Researcher 2 Theory module [M level]	Salford University	Towards meeting research development training requirements for Domain A, B and C.
19th May 2009	Research Ethics Panel training Attended training and attended subsequent Ethics approval Panels x 2.	Edge Hill University	Towards meeting research development training requirements for Domain A and C.
11th June 2009	Ethnography	Salford University	Towards meeting research training development requirements for Domain A and C.

	Developing an alternative theoretical perspective.		
8th October 2009	Research exchange Lunchtime seminar series Peers discuss their PhD/Doctoral research to date and invite discussion and questions.	Edge Hill University	Towards meeting research development training requirements for Domain A and D.
20th October 2009	Research exchange Lunchtime seminar series Peers discuss their PhD/Doctoral research to date and invite discussion and questions.	Edge Hill University	Towards meeting research development training requirements for Domain A and D.
17th November 2009	Research exchange Lunchtime seminar series Peers discuss their PhD/Doctoral research to date and invite discussion and questions.	Edge Hill University	Towards meeting research development training requirements for Domain A and D.
10th December 2009	Research Seminar Leadership assessment Leadership in research seminar Researchers discuss their research and invite discussion and questions.	Salford University	Towards meeting research development training requirements for Domain B and C
2009-2010	Joint Research project Research study Project led by Dr Lucy Bray Developed skills and experience in relation to research study planning, data collection, themes, data analysis and research project time management.	Liverpool Children's Hospital/Edge Hill University	Towards meeting research development training requirements for Domain A, B, C and D.
2009-2012	Joint HEI Champs project: Brief interventions. Mapped health promotion through pre-registration programme [In collaboration with	Champs and Joint HEI research project	Towards meeting research development training requirements for Domain A and B.

	other HEIs] developed training materials and we have implemented BI training across all our programmes. This project has been evaluated independently across all 4 HEI by Manchester Met University.	(Champs, Liverpool, LJMU, Edge-Hill and Chester)	
2010	Publication: Bray L, Saunders C & Flynn A (2010) Paediatric Catheterisation: exploring and undertaking. Children's nurse perceptions and practice in an acute setting. Journal of Clinical Nursing, 19 (21-22). 3235-3243.. Writing for publication skills and experience.	Joint publication with colleagues from Liverpool Children's Hospital/Edge Hill University	Towards meeting research development training requirements for Domain A, B, C and D.
21st January 2010	Research supervision .	Dr Tracey Williamson Salford University	Towards meeting research development training requirements for Domain A, C and D.
November 2010-Feb 2011	Project management: DH funded project: provision of training for Parents/carers of children who have life threatening/life limiting conditions. Project management planning and time management.	Edge Hill University	Towards meeting research development training requirements for Domain B and D.
During interrupt year March 2010 – end of June 2011	Interrupt year Continued Independent thinking and reading		Towards meeting research development training requirements for Domain A and B.

Resumed to course July 2011.	Type Development/Training	Location	Comments
July 2011	IRAS on line training programme	IRAS website Completed on line	Towards meeting research development training requirements for Domain A and C.
2011	Publication: Bray L, Flynn A & Saunders C (2011) The experiences of Children's Nursing Students Learning Urethral Catheterisation. Nurse Education in Practice, 11 (3). 168-172. Writing for publication skills and experience.	Joint publication with colleagues from Liverpool Children's Hospital/Edge Hill University	Towards meeting research development training requirements for Domain A, B, C and D.
17th Aug 2011	Research supervision	Dr Tracey Williamson Salford University	Towards meeting research development training requirements for Domain A and C.
16th Sep 2011	Literature searching for Post graduate research projects	One to one session Edge Hill University	Towards meeting research development training requirements for Domain A , B and C
26th September 2011	Research Supervision	Dr Tracey Williamson Salford University	Towards meeting research development training requirements for Domain A and C.
20th Oct 2011	Institutional research development day: Research, Ethics approval. Current research projects. Applying for funding Becoming an ERPC fellow.	Research Event organiser Professor Annette Jinks FOE Edge Hill University	Towards meeting research development training requirements for Domain A, B, C and D.
4th November 2011	Research Supervision	Dr Tracey Williamson Salford University	Towards meeting research development training development requirements for Domain A and C

1st December 2011	Research Supervision	Dr Tracey Williamson Salford University	Towards meeting research development training requirements for Domain A and C
2nd December 2011 10.00am - 12.00pm LINC IT1	Introduction to publications: print, electronic and other media: The wide range of resources [beyond the traditional resources] available for researchers including images and archives, institutional repositories, thesis databases, external library Sources (COPAC, SCONUL etc.).	Edge Hill University	Towards meeting research development training requirements for Domain A, B and C
6th December 2011 10.00am - 12.00pm	Advanced Ref Works Workshop to develop RefWorks skills. Included: viewing, searching and sorting references; using My List; importing references indirectly; sharing references and backing up data.	Edge Hill University Staff Development Room 2nd Floor LINC Facilitator: Yvonne Smith	Towards meeting research development training requirements for Domain A, B and C
26th Jan 2012	Development workshop Publication: Preparation and submission of paper for publication Refresher for writing skills and writing for publication.	Edge Hill University	Towards meeting research development training requirements for Domain B and C
16th May 2012	Research Supervision	Dr Tracey Williamson Salford University	Towards meeting research development training requirements for Domain A and C
17th May 2012	Research workshop: Qualitative Data Analysis	Edge Hill University	Towards meeting research development training requirements for Domain A and C
20th June 2012	Research Supervision	Dr Tracey Williamson Salford University	Towards meeting research development training requirements for Domain A and C

28th June 2012	Research Workshop Focus Groups and Interview Workshops: Conducting focus groups and interviews.	Edge Hill University FOHSC	Towards meeting research development training requirements for Domain A, B and C
29th June 2012	Research Supervision	Dr Tracey Williamson Salford University	Towards meeting research development training requirements for Domain A and C
5th October 2012	Research workshop Revision: Ethics application and process	Edge Hill University Board room FOHSC	Towards meeting research development training requirements for Domain A, B and C.
7th October 2012	Research workshop Submission of research for Ethics Approval Edge Hill University	FOHSC Ethics Committee Edge Hill University Feedback from panel	Towards meeting research development training requirements for Domain A, B and C
December 2012 due for completion Oct 2014	Project management and supervision of competency framework research project. Project planning/time management.	Edge Hill University	Towards meeting research development training requirements for Domain A, B and C
January 2013	Research Workshop Managing your data	Edge Hill University	Towards meeting research development training requirements for Domain A, B and C
14th March 2013	Research Seminar: Findings from Clinical holding research project (Dr Lucy Bray) Researchers present their research projects and invite discussion and questions.	Edge Hill University	Towards meeting research development training requirements for Domain A, B and C
18th March 2013	Research Supervision	Dr Tracey Williamson Salford University	Towards meeting research development training requirements for Domain A and C

30th April 2013	Project: Student focus group (skills booklet pilot)	Edge Hill University	Towards meeting research development training requirements for Domain A, B and C
May 2013	Research Supervision	Dr Tracey Williamson Salford University	Towards meeting research development training requirements for Domain A and C
June 2013	Research workshop Doing online surveys: Survey Monkey Workshop	Edge Hill University	Towards meeting research development training requirements for Domain A, B and C
June 2013	Research workshop Writing your Thesis	Edge Hill University	Towards meeting research development training requirements for Domain A, B and C
12th September 2013	Research Supervision	Dr Tracey Williamson Salford University	Towards meeting research development training requirements for Domain A, B and C
2nd October 2013	Project supervision: Submission of competency skills project for Ethics Approval. Revision of research ethics process and considerations, data collection options, data analysis and research project time management.	Edge Hill University	Towards meeting research development training requirements for Domain A, B and C
October 2013	Research Supervision and final preparation for IE	Dr Tracey Williamson Salford University	Towards meeting research development training requirements for Domain A, B and C
10th March 2014	Research Supervision	Dr Tracey Williamson Salford University	Towards meeting research development training requirements for Domain A and C
11th April 2014	Research Supervision	Dr Tracey Williamson Salford University	Towards meeting research development training requirements for Domain A and C

May 2014	Development of research impact chart. (Researching topic and developing chart)	n/a	Towards meeting research development training requirements for Domain D
23rd May 2014	Research Supervision	Dr Tracey Williamson Salford University	Towards meeting research development training requirements for Domain A, B, C and D
6th June 2014	Presentation Centre of Learning and Teaching (CLT) conference	Centre of Learning and Teaching (CLT) Conference Edge Hill University	Towards meeting research development training requirements for Domain A, C and D
19th June 2014	Research Seminar: Findings from My Child in Pain Project (Professor Bernie Carter). Researchers present their research projects and invite discussion and questions.	Edge Hill University	Towards meeting research development training requirements for Domain A, C and D
July 2014	Institutional leadership conference Motivational speaker	Edge Hill University Leadership conference	Towards meeting research development training requirements for Domain B and D
July 2014	Research Supervision	Dr Elaine Ball Salford University	Towards meeting research development training requirements for Domain A, B, C and D
September 2014	PhD/Professional Doctorate research support group.	Edge Hill University	Towards meeting research development training requirements for Domain B, C and D
October 2014	Research Supervision	Dr Elaine Ball Salford University	Towards meeting research development training requirements for Domain A, B, C and D

Appendix 10: Literature review table – summary of included papers

Author	Journal	Focus	Methods and sample	Key Findings
Alavi & Cattoni (1995).	Journal of Advanced Nursing	Construction of nursing and nurse training discussed. Aim: To explore what elements makes a good nurse and what has influenced nursing/nurse training. Australia	Historical paper and use of personal narratives	Evaluates the position of nursing in the university setting.
Ali & Panther (2008).	Nursing Standard	Student-mentor relationships and mentor role. Reviews concept of mentorship in nursing and explores the role and responsibilities of the mentor in enhancing the learning experience of nursing students. UK	Discussion paper	Mentorship is an integral part of the experienced nurse's role Nurses have increasing responsibility for assessing students. Mentors need to appreciate the expectations, responsibilities and accountability involved in the mentor role. Mentor role provides opportunities for professional development
Atkins & Williams (1995).	Nurse Education Today	Mentor role and mentor responsibilities Aim: To explore the mentoring of undergraduate nursing students. UK	Qualitative data collection Semi-structured interviews n=12	Mentoring undergraduate nursing students is a complex and skilled activity, requiring educational preparation, support and recognition The potential for mentoring to further the personal and professional development of mentors highlighted
Anderson & Kiger (2008).	Nurse Education Today	Supporting students in practice.	A qualitative phenomenological study utilising one-to-one, semi-structured interviews was adopted.	Student nurses can be supported to be independent this helps build; confidence, professionalism in relationships,

		Aim: This study explored the perceptions of the support received by children's student nurses on their final placement as they Prepared for their role as staff nurses. Scotland (UK).	Students n=6	learning to manage care, developing knowledge and gaining insight, and being included and supported. The opportunity for final stage students to work independently in whatever setting they are placed is recommended as important.
Andrews & Chilton (2000).	Journal of Advanced Nursing	Mentor experience Aim: to explore mentor effectiveness in a district general hospital (American model of mentorship). North Wales (UK)	Quantitative Pre validated postal questionnaire n=22	Mentor role had positive impact. Some mentors weak in challenging students. Some mentors had a lack of confidence to fail students. Evidence of mentors failing to fail
Andrews and Roberts (2003).	Nurse Education Today	Mentor role and mentor responsibilities Aim: Explore the role of the Clinical Guide (written guide) in relation to pre-registration nursing students. UK	Qualitative	Important to provide students with support and guidance which supports student nurse learning in practice. The Clinical Guide encourages Higher Education Institutions and health care providers to develop partnerships to support students and deliver and monitor learning in practice.
Andrews & Wallis (1999).	Journal of Advanced Nursing.	Student-mentor relationships. Mentorship in nursing: a literature review. UK	Literature review on mentoring role.	Difference in terms used, mentor roles and mentor responsibilities. No national minimum requirement or common preparation route for how practice mentors are prepared.
Armitage & Burnard (1991).	Nurse Education Today	Mentor role and mentor responsibilities Aim: To explore mentor roles and responsibilities. UK	Quantitative	Confusion over mentor and preceptor terms. Mentor roles may help narrow the theory-practice gap for students.

Barker (2006).	Journal of the American Academy of Nurse Practitioners	Mentoring role Aim: Explore mentoring and mentor role. USA	Quantitative Methods unclear.	Mentoring and mentor role is a complex relationship.
Barker, Blacow, Colgrave et al. (2011).	British Journal of Nursing	Sign-off mentor role. Informative: Implementation of sign-off mentorship.	Informative paper.	Informative: Implementation of sign-off mentorship.
Beecroft, Santner, Lacy, et al. (2006).	Journal of Advanced Nursing	Mentor role. Aim: To explore new graduate nurses' perceptions of mentoring.	A six-year programme evaluation (1995-2005).	The effective mentor role is used to role model and offers support and guidance to students. Some new graduates reported feelings of disconnection, unimportance. A mentor's lack of commitment, training and management support contributes to the frustration and failure of the graduate nurse.
Beskine (2009).	Nursing Standard	Student-mentor relationships. Discusses related and interdependent aspects of mentoring that are essential for successful practice placements. UK.	Discussion paper	Mentoring students encourages effective working relationships between student and mentor including: relationships, placement orientation; facilitating and evaluating learning, assessment and accountability.
Blais & Bath (1992).	Nurse Educator	Assessment of drug calculation skills of nursing students. Aim: To explore drug calculation skills of pre-registration BSc nursing students. UK	Mixed methods Aspects of methods unclear	Built on previous drug calculation studies to analyse the dosage calculation errors of nursing students.
Black (2011).	PhD thesis, London South Bank University	Assessment	Qualitative Semi-structured interviews with adult nursing mentors	Mentors do fail students who need to fail. However, mentors

		Aim: Experiences of adult mentors who fail a student in their final placement. UK	n=19	use courage when failing students in their final placement.
Boley & Whitney (2003).	Journal of Nursing Education.	Assessment Grade disputes: Considerations for nursing faculty. USA	Discussion paper	Grading students' work and performance is not an easy task. Faculty are urged to be confident in their decisions, especially when patient safety issues exist. Nursing instructors should not be fearful of failing a student solely on the basis of poor clinical performance.
Bourbonnais & Kerr (2007).	Journal of Clinical Nursing	Assessment in final placement Aim: To explore the preceptorship of students in the final clinical placement. Canadian hospital. Canada	Qualitative One-on-one tape recorded interviews with nurses who had previous experience as a preceptor. n=8	Preceptors play an important role with students prior to graduation. Both the hospital and educational institutions need to ensure that nurses are given the necessary support, recognition and resources. The overriding theme from the analysis was 'safe passage' - for the patient and the student. Challenges to the role were lack of recognition by other nursing staff as well as limited support from some faculty advisors. .
Bradbury-Jones, Irvine, Sambrook (2010).	Journal of Advanced Nursing	Mentorship in nursing Aim: Explore effect of mentorship role on nursing students in clinical practice.	Longitudinal study (2007-2009), underpinned by hermeneutic phenomenology. n= 13 first-year nursing students. Annual, in-depth interviews were conducted with the students on their trajectory from the first to third year of the undergraduate programme.	Mentorship role empowers nursing students in clinical practice. Empowerment of nursing students in clinical practice can be represented in the form of 'spheres of influence'. Efforts to promote the empowerment of nursing

				students in clinical practice need to be multi-layered and targeted.
Bray & Nettleton (2007).	Nurse Education Today	Mentor role. Exploring the role of assessor and mentor.	Mixed methods Questionnaires & self-selected semi-structured telephone interviews. n=110 (questionnaires) n=20 (Interviews with nurse mentors & mentees). Numbers of each not clear	Poor response rate 13% Role confusion remains. Mentoring can be both stressful and emotionally draining particularly if managing a difficult relationship or a struggling student.
Brown (2001).	Journal of Psychiatric and Mental Health Nursing	Assessment – validity and judgements. Mentor experience What are the criteria that mentors use to make judgements on the clinical performance of student mental health nurses. UK	Mixed methods Content analysis of documents, quantitative method not discussed n=150	The exploratory study of the formal written communication at the end of clinical nursing practice modules found:
Burns & Patterson (2005).	Nurse Education in Practice.	Student-mentor relationship. Aim: To explore clinical practice and placement support. UK	Qualitative Some aspects unclear	Mentor role supports learning in practice. Support needs of the mentor needs to be reviewed.
Cahill (1996).	Journal of Advanced Nursing.	Mentor-student relationship Aim: An analysis of the student nurses' experiences of mentorship. UK	A qualitative analysis of student nurses' experiences of mentorship Group discussion and individual interviews. n= 16 third-year students on a traditional RGN programme.	Onus on the student to develop a relationship with his/her mentor and students argue that this can be quite emotionally draining on them. Mentorship was described in terms of assessment and appraisal. Students' apparent preoccupation with achieving a satisfactory ward report influenced both their relationships and behaviour with trained staff.

Calman, Watson, Norman & Redfern, (2002).	Journal of Advanced Nursing	Mentor assessment Aim: To explore assessment and preparation of assessors-student views. Scotland, UK.	Qualitative The directors of the 13 programmes (seven nursing and six midwifery programmes) were surveyed. 12 group interviews with students (six nursing and six midwifery student groups) from seven institutions. Students from all four branches were represented and 72 students (36 nurses and 36 midwives) were interviewed.	A limited number of approaches to clinical assessment are used in Scotland. Students' views suggested that they had little confidence in methods of clinical competence assessment and there was no formal validity and reliability testing within institutions. A lack of consistency in the training of student assessors in the clinical areas was identified.
Cameron-Jones & O'Hara (1996).	Journal of Nursing Management	Assessment Aim: To explore mentor role and experience (American model of mentorship).	Quantitative Pre validated questionnaire Nurse mentors n=87 Student nurses n= 39	Supportive aspects of mentor role identified by students and mentors. Need for mentors to challenge students more.
Carnwell, Baker, Bellis & Murray (2007).	Nurse Education Today	Perceptions of roles. Aim: Managerial perceptions of mentor, lecturer practitioner and link tutor roles. Wales, UK	A three-phase study Four focus group interviews of National Health Service managers and Higher Education managers (n=22).	Qualitative content analysis revealed four themes: role characteristics and competencies, role differences, role conflict, and future options.
Casey & Clark (2012).	Nursing Standard	Sign-off mentors Informative: A collaborative approach to support trainee sign-off mentors.	Informative	Informative: Support for trainee sign-off mentors.
Cassidy (2009a).	Nursing Standard	Assessment – validity of judgements. Aim: Examines the issue of subjective assessment of student nurses to enhance the valid assessment of clinical learning outcomes, in order explore the interpretation of competence in student nurse assessment.	Discussion paper supported by author's personal reflections as a mentor and teacher.	Similar to Cassidy 2009c. The use of live episodes of care is proposed for mentors and students. Promotes the use of reflection on clinical episodes as they unfold to support student learning.

Cassidy (2009b).	Nurse Education in Practice	Student-mentor relationship. Aim: Explored mentor's decision making when assessing pre-registration nursing students on the borderline of achievement in clinical practice.	Quantitative Methodology unclear	Counselling skills enhance the confidence of mentor's decision making when assessing pre-registration nursing students on the borderline of achievement in clinical practice.
Cassidy (2009c).	Nurse Education Today	Assessment – validity of judgements. Aim: Examines the issue of subjective assessment of student nurses to enhance the valid assessment of clinical learning outcomes.	Similar to Cassidy 2009a. Discussion paper supported by author's personal reflections as a mentor and teacher.	The use of live episodes of care is proposed for mentors and students. Promotes the use of reflection on clinical episodes as they unfold to support student learning.
Chesser-Smyth (2005).	Nurse Education in Practice	Student learning in practice. Aim: The lived experiences of general student nurses on their first clinical placement. Ireland	A phenomenological study. n=10 General student nurses on their first clinical placement in an Irish School of Nursing.	The presence of mutual respect and regard for others had a positive impact on the students' self-esteem. The acquisition of knowledge led to an increase in confidence levels that subsequently reduced anxiety. The learning process that was dependent upon the collaborative support and facilitation in the clinical learning environment
Chow and Suen (2001).	Nurse Education Today	Mentor roles and responsibilities: Students' perceptions. Aim: Multiple-phase study on a mentoring scheme for nursing students in one university in Hong Kong.	Multi-phase study. Interviews with Year 2 students (n=12) and Year 3 students (n=10) used to design a questionnaire for subsequent programme evaluation. An evaluation questionnaire based on the interviewing results was developed for further evaluation of the mentoring scheme.	Students' perceptions of the mentor's roles and responsibilities. A series of strategies were designed to improve the preparation of mentors.

Clemow (2007).	Nurse Education Today	Preparation for mentor role Aim: An evaluation of skills rehearsal in a mentorship course	The curriculum documentation was analysed and, one month after completing the course and in three focus groups participants described their experience of learning through simulation.	The findings revealed that all participants used unhelpful as well as constructive behaviours that potentially influenced the reliability of their support, supervision and assessment of learners. The participants' shift in belief that the role of the mentor was a fixed concept to a perspective and value laden concept was evident. This new understanding illuminated the participants' problem solving strategies for understanding valid and reliable assessment.
Clifford (1994).	Nurse Education Today	Assessment Discussion: Explore the assessment of clinical practice and the role of the nurse teacher.	Discussion paper	Role of nurse teacher multifaceted and therefore restraints on availability.
Clinton, Murrells, & Robinson, (2005).	Journal of Clinical Nursing	Assessment Aim: To explore drug competency of student nurses prepared through degree and diploma programmes. UK	Comparative study of BSc and Diploma students (numbers unclear). A cross-sectional survey design	Findings: No difference identified between graduates and diplomats in England in their level of competence. Further research suggested into other aspects of competence.
Clynes (2008).	Journal of Children's and Young People's Nursing	Assessment – mentor/preceptors experiences. Aim: To explore preceptor's views and experiences in providing assessment feedback to post registration students - children's nursing on their clinical performance. Ireland	Qualitative Semi-structured interviews Preceptors for post registration nursing students. n=10	Providing feedback on clinical performance to student nurses in children's nursing is challenging for mentors. Insufficient student contact time, busy wards and inadequate preparation inhibits the feedback process.

Clynes & Raftery (2008).	Nurse Education in Practice	Assessment Feedback is an essential element of student learning. UK	Discussion paper	Feedback is difficult but an essential element of student learning in practice. Suggest variations exist in practice and suggest guidelines for practice. The benefits of feedback are highlighted and include increased student confidence, motivation and self-esteem as well as improved clinical practice.
Collis Pellatt (2006).	British Journal of Nursing	Student-mentor relationships. Aim: The role of mentors in supporting pre-registration nursing students.	Qualitative Other aspects unclear.	The benefits of feedback include increased student confidence, motivation and self-esteem as well as improved clinical practice. Barriers to the feedback process are identified as inadequate supervisor training and education, unfavourable ward learning environment and insufficient time spent with students.
Darling (1985).	Journal of Nursing Administration	Historical mentor role. Aim: Explored role of mentors. North American study	Methodology unclear. interviewed nurses, physicians and health care executives	Findings from this study <u>first</u> report the concept of 'toxic nurse mentors'. However, the lack of information in terms of sample selection, interview data and analysis makes the author unable to justify her findings.
Devis & Butler (2004).	Nursing Times	Mentor experience Aim: Assessment of a study day to recognise the value of mentors. Hospital Trust UK	Quantitative The study day programme content and its usefulness for practice were evaluated using a short questionnaire. n=unclear.	Results showed that attendees valued sessions on the importance of mentoring, learning styles, managing difficult students and managing time.

Dolan (2003).	Journal of Clinical Nursing	Assessment Aim: To evaluate the introduction of written evidence to support the assessment of student nurses' clinical competency. Wales, UK.	Mixed method An evaluative research study Focus groups & content analysis n=8	Although the introduction of written evidence to support clinical competency was welcomed, many felt that too much evidence was required. Many variations in the evidence obtained from students, in particular the amount of evidence written by each student. The findings indicate that further revisions are necessary.
Dudek, Marks & Regehr (2005).	Academic Medicine.	Assessment – Fail to fail. The perspectives of the clinical supervisors. University of Ottawa, Canada	Qualitative Semi-structured interviews with 21 clinical supervisors at the	Clinical supervisors (including non-nursing) also fail to fail students.
Duffy et al. (2000).	Nursing Standard	Mentor experience Aim: Mentor experience of mentoring Scotland (UK)	Quantitative Questionnaire n=71	The nurse lecturer's role in mentoring the mentors needs to be explored.
Duffy (2003).	Undertaken for NMC, London	Assessment - Fail to fail. Aim: Factors that influence the decisions regarding assessment of students' competence in Practice. UK	Qualitative Grounded Theory 14 lecturers 26 mentors	Evidence mentors fail to fail. Mentors reluctant to fail students in practice settings. Raised concerns about fitness to practice of some registered nurses. Highlighted difficulties with borderline students.
Duffy (2004).	Nurse Education Today *Findings from study above	Assessment- Fail to fail Aim: Factors that influence the decisions of mentors. 3 institutions in Scotland UK	Qualitative Grounded Theory 14 lecturers 26 mentors	As above: Evidence mentors fail to fail. Mentors found it difficult to fail a student as this suggested they were poor mentors. Mentoring can be both stressful and emotionally draining

				particularly if managing a difficult relationship or a struggling student. Difficulties with borderline students.
Duffy & Hardacre (2007).	Nursing Times	Student support – students failing in practice. Aim: A two-part unit examines the issue of nursing students who fail in clinical practice. Part 1 explores reasons for failure, assessment and the emotional challenges mentors may face when supporting failing students. Part 2, discusses the management of failing students. UK		There is a need to support failing students in practice assessment.
Duffy & Scott (1998).	Nurse Education Today	Assessment Aim: The education-practice gap. UK	Discussion paper	This paper explores issues relating to this concept: the balance of knowledge and power in the education-practice arena and the personal issues involved in failing a student
Duffy & Watson, (2001).	Nurse Education Today	Role of nurse teachers in practice. Aim: To explore the role of nurse teachers in practice placements. Scotland, UK.	An interpretative study Nurse teachers n= 18	Nurse teachers had a multifaceted role which included providing advice and support.
Durham, Kingston, Sykes. (2012).	Nurse Education Today	Sign-off mentor role Implementing a sign- off mentor preparation workshop: A tripartite approach.	Discussion paper	Discusses the implementation of a development programme for existing experienced mentors. The approach was seen to be effective in developing the knowledge and skills of mentors

				to ensure they were prepared for the final practise based assessment as a sign off mentor.
Finch (2009).	Unpublished Professional Doctorate Thesis	Assessment. Aim: To explore why Practice Assessors find it difficult to fail social work students. UK	Qualitative Study. Practice Assessors Experiences of Assessing Marginal or Failing Social Work Students.	Findings: practice assessors fail students but find it difficult to fail social work students.
Fisher (2009).	MIDIRS midwifery digest	Sign-off mentors Commentary: How midwifery sign-off mentors can be supported in their role. UK	Commentary	Commentary: The challenges facing clinicians, managers and academics.
Fisher & Webb (2009). .	Learning in Health and Social Care	Sign-off mentors Aim: Explore what midwifery sign-off mentors need. UK	Midwifery sign-off mentors	Priorities and impact of experience and qualification on assessment of students.
Fitzgerald, Gibson & Gunn (2010).	Nurse Education in Practice	Assessment. Aim: assessment of pre-registration nursing students in practice. UK	Mixed methods Reviewed documentation and undertook interviews	No evidence of mentors failing to fail.
Gainsbury, (2010a).	Nursing Times	Assessment - Failing to fail. Aim; Explore mentors assessment of students UK	Methodology not clear. Large anonymous survey. n = 2000. Some methodology aspects unclear.	Mentors failing to fail. Mentors passing students despite doubts over ability. Mentors admit to fudging paperwork.
Girot (2000).	Journal of Clinical Nursing	Assessment Aim: To explore the current assessment of graduates and diplomats in practice in the UK.	Discussion paper	Need to use student portfolios of evidence to support assessment of learning. Promotes partnership approach to assessment (mentor, student, academic).

Glasper (2010).	British Journal of Nursing	Sign-off mentors Informative: Additional options for achieving sign-off mentor criteria. UK	Informative:	Advice/guidance for achieving sign-off mentor status.
Grandell Neiemi, et al. (2003).	Journal of Clinical Nursing	Assessment of drug calculation competency Aim: The medication calculation skills of nurses in Finland.	Mixed method Observation and Questionnaire. Nurses (n = 546) – not clear who were registered and who students.	The nurses found the mathematics and dosage calculation easy but the pharmacology difficult. The findings support the need and importance of checking and maintaining medication calculation skills.
Gray & Smith (1999).	Journal of Advanced Nursing	Mentor role and responsibilities. Aim: Explore the professional socialisation of diploma of higher education in nursing students (Project 2000). Scotland, UK	Qualitative A longitudinal qualitative study. A purposive sample of 17 students 10 Interviewed and kept a diary. 7 kept a diary only.	Findings indicate that the mentor is the linchpin of the students' experience and that some students develop intuition much earlier than previous work has stated. Onus on the student to develop a relationship with his/her mentor and students argue that this can be quite emotionally draining on them.
Gray & Smith (2000).	Journal of Advanced Nursing	Mentor role and responsibilities Aim: To explore the qualities of an effective mentor from the student nurse's perspective Scotland, UK	Qualitative - Grounded Theory. A longitudinal qualitative study. n=10 students Interviewed on five occasions during the three years of their course.	Findings indicated that diploma students quickly lose their idealistic view of their mentor and over time develop an insight into the qualities they perceive are required of an effective mentor.
Hall, A. (2006).	Journal of Community Nursing	Mentor role and responsibilities. Aim: To explore Mentorship in the community. UK	Qualitative n=14 Community mentors	Similar concerns to Hayes (2001) study about mentor limitations in capacity, assigning students own case loads. However, benefit of mentor role

				to both community mentor and student identified.
Haroon-Iqbal & Jinks (2002).	Singapore Nursing Journal	Assessment Aim: Peer review of clinical education assessment. Singapore	Quantitative Mentor survey n=36	Results of a clinical mentor survey found most mentors felt adequately prepared for their teaching and assessment role .
Hayes (2001).	Clinical Excellence Nurse Practitioner	Nurse-mentor relationship. Aim: To explore factors that facilitates /hinders mentoring in the nurse practitioner preceptor/student relationship. USA.	Qualitative Questionnaire Aspects unclear.	Mentor capacity issues and difficulties assigning students own case loads. However, benefit of mentor role to both nurse practitioner and student identified.
Heaslip & Scammell (2012).	Nurse Education in Practice	Assessment of borderline students. Failing underperforming students: The role of grading in practice. UK	Convenience sample. Mentors n= 112 Students n = 107	Only 59% of mentors (n=67) admitted they had confidence to fail. Grading in practice can help assessment process by helping to identify borderline students.
Henderson, Twentyman, Heel & Lloyd (2006).	Nurse Education Today	Students 'perception. Aim: To explore the students' perception of the psychosocial clinical learning environment.	An evaluation of placement models. N=389 undergraduate student nurses.	Preceptoring is an effective clinical placement strategy that provides psycho-social support for students. However, clinical education units that are more sustainable through their placement of greater numbers of students can provide greater psycho-social support for students than traditional models.
Hill (1998).	Journal of Child Health Care	Assessment. Aim: How the competence of student nurses is assessed UK	Quantitative Questionnaire – some aspects unclear	Identified no common agreement and differences in what aspects and how students are assessed. Suggested further research required.

Hunt, Gutteridge & Hughes (2011).	Nurse Education Today	Assessment. Aim: A comparison of theoretical and practical assessments. England, UK.	A comparison of theoretical and practical assessment results. 52 universities.	A quarter of universities failed no students in practice. Those students who did fail more likely to fail in year 1 and least likely in year 3.
Hutchings, Williamson & Humphreys (2005).	Journal of Clinical Nursing	Mentor experience Of supporting learners in clinical practice. UK.	Qualitative Focus groups n=12	Mentor capacity issues No clear benefit of mentor role identified.
Jervis & Tilk (2011).	British Journal of Nursing	Assessment – Mentors failing to fail. Aim: Mentors role in assessment of competence. UK.	Qualitative Interviews Ethics unclear	Reports mentors still failing to fail students. However, narrative on failing to fail is not progressed from Lankshear (1990) study.
Jinks (2007).	Nurse Education Today	Mentors and mentor role.	A review of the literature.	A review of nineteen reports on mentor research primarily focused on mentors identified that most of these studies utilised postal survey approaches to collecting data. Identified methodological considerations of undertaking research with clinical mentors in the UK. Identified the need to have more in-depth research related to mentors and particularly the area around perceptions and experiences utilising qualitative methodologies.
Jinks & Williams (1994).	Nurse Education Today	Preparation, mentor role and responsibilities. Aim: Explore experience of mentoring P2000 diploma 3rd year nursing students. Staffordshire, UK	Mixed methods Postal questionnaire n=61 Face to face interviews n=10	Those who felt adequately prepared for their teaching and assessment role had undertaken a formal teaching and assessing course. The findings have implications for the desirability of community nurses to

				undertake formal teaching and assessing courses. Suggested a need for adequate clinical staff preparation for changed needs of a curriculum.
Jukes & Gilchrist (2006).	Nurse Education in Practice	Assessment of drug calculation competency. Aim: explore concerns about numeracy skills of pre-registration nursing students. UK	Convenience sample of second year students. n= 37	Similar to earlier studies concerns remain about numeracy skills of nursing students. Recommends students are tested throughout their pre-registration programme.
Kendall-Raynor (2009).	Nursing Standard.	Assessment – failing students. Universities accused of ignoring mentors over failing students. UK.	Commentary	Universities accused of ignoring mentors over their concerns about failing students.
Kneafsey (2007).	Nurse Education in Practice	Mentor support for student learning. Mentor views about their role in supporting student nurses in gaining safe clinical skills in moving and handling. UK.	Qualitative Focus groups and individual interviews. N=15 hospital based mentors	Findings highlight the importance of a joint approach to education between Universities and Trusts. Mentors need to be aware of students' learning needs, taking care to ensure that knowledge underpinning clinical decision making is transparent.
Lankshear (1990).	Nursing Standard	Assessment Aim: To explore the assessment of students UK	Qualitative Interviews	Study **first** identified that mentors failing to fail students who should not pass.
Lloyd Jones et al. (2001).	Journal of Advanced Nursing	Mentor role and responsibilities Aim: Explore early contact with the mentor for preparation of nursing and midwifery students. UK.	Mixed methods Nursing and midwifery students Diaries n=81	Positive elements to mentor role. Contact with the mentor for preparation for placement may have negative implications for the student.

Luhanga, Yonge & Myrick (2008b).	Nurse Education Today	Assessment. Aim: To explore the experiences of precepting an unsafe student: the role of the faculty. Canada	Grounded theory Interviews n=22 preceptors	Preceptors must be provided with sufficient and appropriate support throughout the preceptor-ship experience especially when they are supporting an unsafe student.
Mallik & Aylott (2005).	Nurse Education in Practice	Mentor preparation and support Aim: Facilitating practice learning in pre-registration nursing programmes. UK and Australian models.	A comparative review of the Bournemouth collaborative model and Australian models	Clinical exposure for UK students has increased while Australian students have short focused 'off campus' placements. In the UK, Practice Educators (PEs) provide support for 'qualified' mentors who have a key role in the assessment of student competence. Clinical Facilitators (CFs) in Australia, prepared through completion of two day workshops/courses, undertake a combined facilitator and assessor role.
Marriott (1991).	Nurse Education Today	Mentor role and responsibilities Aim: To explore the emerging mentor role in terms of the support, supervision and instruction of nurse learners in clinical areas (UK and North America).	Literature review of evolving mentor role	Positive aspects of role but difference in UK and North America models. More research needs to be carried out into the mentorship of nurse learners in Britain in view of its increasingly wide use, especially with the advent of Project 2000 and the implications of supernumerary status for learners.
Middleton & Duffy (2009).	British Journal of Community Nursing	Assessment of a student on their final placement (Prior to introduction of sign-off mentor).	Qualitative study Focus groups n=12 (community mentors)	Community nurse mentors require support and development opportunities in relation to mentoring and assessing final placement pre-registration students.

		Aim: Experiences of mentoring a student (Adult) immediately prior to registration. Community health practice placement, Scotland (UK).		
Morle (1990).	Nurse Education Today	Nurse education, Mentor role and mentor responsibilities: Discussion paper about the introduction of P2000 pre-registration nursing course and mentorship UK	Discussion paper	Recommends a time to pause and reconsider the changes and issues.
Myall et al. (2008). ,	Journal Clinical Nursing	Mentor role Aim: Explores the role of the mentor in contemporary nursing practice in the UK	Survey On line Survey (Students) Postal Q for mentors	Mentorship is pivotal to students' clinical experiences and is instrumental in preparing them for their role as confident and competent practitioners. There is a need to provide mentors with adequate preparation and support.
Nettleton and Bray (2008).	Nurse Education in Practice	Mentor experience	Mixed methods n=unclear	Role confusion continues Current mentoring schemes might be doing our students a disservice.
Neary (2000).	Nursing Standard	Assessment Aim: To explore assessment of clinical competence. UK.	Questionnaire Students n= 300 Mentors n= 155	Differences in what is assessed – no common agreement. Suggests further work to determine.
Pellatt (2006).	British Journal of Nursing	Mentor role and responsibilities. The role of mentors in supporting pre-registration nursing students.	Review of the literature	Findings mirrors the findings of Andrews and Wallis (1999) in relation to the importance of the mentor role in supporting students in practice but identified that better training, support and an evaluation of mentor performance is needed.

Phillips, Davies & Neary (1996a).	Journal of Advanced Nursing	Mentor experience. The practitioner teacher: a study in the introduction of mentors in the pre-registration nurse education programme in Wales (Part 1).	Mixed method Semi-structured interviews Reflective diaries Questionnaires Observations	Unclear role specification by the use of the terms mentor, preceptor and supervisor
Phillips, Davies & Neary (1996b).	Journal of Advanced Nursing	Mentor experience. The practitioner-teacher: a study in the introduction of mentors in the pre-registration nurse education programme in Wales (Part 2).	Mixed method Semi-structured interviews Reflective diaries Questionnaires Observations	Unclear role specification by the use of the terms mentor, preceptor and supervisor
Pulsford, Boit & Owen (2002).	Nurse Education Today	Mentor role and responsibilities. Aim: Are mentors ready to make a difference – a survey of mentors' attitudes towards nurse education. UK	Quantitative Survey	The survey findings of mentors' attitudes towards nurse education include: mentors need to have time and recognition for the mentor role.
Rooke (2013).	Nurse Education in Practice	Perceptions of sign-off mentor role Aim: An evaluation of nursing and midwifery sign-off mentors, new mentors and nurse lecturers' understanding of the sign-off mentor role. UK	Qualitative An evaluation. n= 114 new SOM n= 37 preparation for mentorship students n=13 nursing and midwifery lecturers	SOM role presents important benefits to patients. Concerns regarding varying levels of support available for SOMs. Anxieties about level of responsibility. Anxieties that some mentors may leave SOMs to manage under-achieving students.
Rutkowski (2007).	Nursing Standard	Assessment – failing to fail. Aim: To provide an overview of the issues assessing student competence and failing o fail during practice placements. UK	Discussion paper	An overview of the issues relating to the reluctance of registered nurses or mentors to fail students in their competencies and to identify possible causes for this (which includes lack of support, time, confidence).

Scholes & Albarran (2005).	Nursing in Critical Care.	Assessment -Failure to fail. The consequences. UK.	Discussion paper	Failing to fail: The consequences of inaction.
Sharples (2007).	Nursing Standard	Sign-off mentor role Informative UK	Informative paper	Information about sign-off mentor role.
Sibson & Machen (2003).	Nurse Education in Practice	Mentor role Aim: Explores the issues related to placing third year undergraduate students with Practice Nurses for their adult branch community placement. UK	Evaluation Practice nurses	Practice nurses are an untapped educational resource. The placement was evaluated highly by both students and Practice Nurses. The students enjoyed a higher than anticipated level of autonomy and were able to achieve all their learning outcomes. The Practice Nurses reported the presence of students had a positive influence on their practice.
Spouse (1996).	Nursing Times,	Mentor role and responsibilities. Aim: To investigate the relationship between student and clinical supervisor (known as a mentor) and its influence on nursing students' development of professional knowledge during his or her clinical practice. UK	Longitudinal naturalistic study Methods not clear. n= 8 nursing students	The effective mentor provides a model for student centred learning the influence of the clinical mentor and the nature of the relationship were central to students' knowledge growth.
Spouse (2001).	Journal of Advanced Nursing.	Mentor role and responsibilities. Aim: To investigate factors influencing the professional development of pre-registration nursing students' during their practice experiences. UK	Longitudinal study using mixed methods. Review of student documentation. Observation and interviews across 12 student practice placement settings. n=8 nursing students	The mentor role and relationship bridges theory and practice. The most significant influence on student learning is effective mentorship. Characteristics of successful mentorship include: participation, scaffolding,

				opportunities for development and partnership to enhance practice learning.
Tracey & Nicholl (2006).	Nursing Management	Mentor role and responsibilities. Aim: To review mentoring and benefits of networking. UK.	Review	The effective mentorship role benefits from networking to provide a model for support.
Twinn & Davies (1996).	Journal of Clinical Nursing	Mentor experiences Aim: Explore mentor experience of supervising P2000 students UK	Qualitative. No detailed discussion on methodology. Used qualitative semi-structured interviews (followed by six case studies of students) n=37.	Positive aspects of mentor role.
Tzeng (2003).	Journal of Clinical Nursing	Assessment of drug competency. Aim: To explore nursing competencies of student and registered nurses Taiwan hospital, Taiwan.	Qualitative An exploratory study.	Both student and registered nurses demonstrate a lack of competency.
Veeramah (2012a).	British Journal of Nursing	Mentor preparation and role. Aim: Effectiveness of the new NMC mentor preparation course.	A cross-sectional survey. n=346 mentors A self-administered postal questionnaire (response rate of 57.5%).	Overall, respondents felt adequately prepared for their role as mentors and were more confident in their ability to support pre-registration students in practice. However, a significant number of respondents received little protected time to complete the theoretical and practical components of the course. Many indicated the need for more input on the practice assessment document used for assessing nursing and midwifery students.
Veeramah (2012b).	Nursing Times	Assessment	Survey	As above.

			Postal questionnaire. Students n= 346 (199 returned).	58% response rate. Two key barriers to effective mentoring: lack of allocated time and demands of patient care. Inadequate help and support can lead to fail to fail.
		Aim: To explore the barriers to good mentoring. UK		
Watson (1999).	Journal of Advanced Nursing	Student experience of mentor role Aim: Views and perceptions of students on mentoring role in one theory practice Module in a CFP Project 2000 course. Scotland, UK	Qualitative. Methodology unclear (discusses phenomenology, ethnography and case study approach). An investigative case study of pre-registration nursing student's experiences. n = 15 mentors n= 35 student nurses	Little benefit of nurse mentor role. Mentors sometimes passed students who should not pass.
Watson (2000).	Nurse Education Today	Mentor support. Aim: The support that mentors receive in the clinical setting. Scotland, UK	Mixed method Unstructured interviews & questionnaire	Mentor role is a cause of stress for mentors. Mentors need more time to undertake role. Mentors need support from link teachers. Mentors may pass a student not bad enough to fail, especially in years 1 and 2.
Watson, S (2004).	Nurse Education Today	Mentor support. Aim: To explore support mentors receive in the clinical setting. Scotland, UK	Quantitative An exploratory study Questionnaire (previously piloted)	Support mentors receive is not consistent. Mentors need to have access to adequate support and sufficient time allocated.
Webb & Shakespeare (2008).	Nurse Education Today	Student-mentor relationships. Aim: Judgements about mentoring relationships in nurse education UK	Qualitative Critical incident technique in interviews n=15	Similar to earlier studies mentor role showed evidence of significant emotional labour. Mentoring can be both stressful and emotionally draining particularly if managing a difficult relationship or a struggling student.
Weeks, Lyne & Torrance (2000).	Clinical Effectiveness in Nursing	Assessment of borderline students.	Qualitative Methods unclear	Written drug dosage errors made by students pose a threat to clinical effectiveness.

		Aim: To explore the assessment of drug competency.		There is a need for a new approach.
Wilkes (2006).	Nursing Standard	Student-mentor relationship A review of the literature.	Literature review	Student-mentor relationship is complex and students wanted a mentor who was supportive and was caring for patients and students.
Wilson-Barnett et al. (1995)	Journal of Advanced Nursing	Mentor support. Aim: Clinical support and the project 2000 nursing student. UK	Mixed methods Semi-structured interviews Observations n=not stated	Mentors provide good clinical support to project 2000 nursing students.
Wimbleton (2012).	Nursing Standard	Sign-off mentors Informative/discussion UK	Informative/discussion	Sign-off mentors must have the skills and confidence to fail poorly performing students.
Wright (1990).	Nurse Education Today	Mentor role and responsibilities. Aim: To explore the mentor role in a diploma program. UK.	Unclear	Mentor role offers positive future potential in nursing
Wright (2005).	Nurse Education Today	Assessment of drug competency. Aim: to explore the most effective way of teaching drug calculations to a group if 2nd year diploma and degree pre-registration nurses. UK	An action research project. A diagnostic tool distributed to 71 end of 2nd year students - 70 returned.	Need to use effective ways to teach drug calculation skills to address mathematical concepts, teaching of drug calculation formulae and then practising these skills in the clinical setting.

DH and NMC: Policy and guidance papers included (but not appraised)

Author	Paper	Subject Relevance
Department of Health (1999).	Making a Difference: Strengthening the Nursing, Midwifery and Health Visiting Contribution to Health and Healthcare. London: DH.	Nurses, nursing and nursing education.
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