

# Enhancing the learning of student nurses in a community “sign off” placement: implications for students, health services and higher education

A project submitted to Middlesex University in partial fulfilment of the requirements for the degree of Doctor of Professional Studies.

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May 2014

## **Acknowledgements**

**Thank you to all the students, NHS Staff and education colleagues who participated in this project.**

**Thank you to Barbara Workman, my supervisor, who provided the perfect balance of encouragement and prodding to ensure that I crossed the finishing line.**

**Thank you to my long suffering family and friends who have been supportive in my DProf endeavour and especially to my husband Roger for his unique combination of practical support and motivation techniques.**

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## Abstract

This action research project explored the implications for student nurses, health services and Higher Education Institutions (HEIs) of placing students for their final “sign off” placement prior to registration with district nursing teams who nurse patients at home. The placing of students with District Nursing teams for the “sign off” period is unusual in the London area. The stated aim of the Department of Health is that students should have more experience outside of the hospital setting (DH 2006) and the Nursing and Midwifery Council has a specific standard that students acquire practice experience in the home setting (NMC 2010). The literature review highlighted a tension between those aims and a national trend of reduced district nursing numbers and fragility in the student nurse mentorship preparation system in the London area.

Data was obtained over a two year period from interviews with ten students, their mentors in practice, NHS managers and educationalists and the researcher’s own learning log. Key findings from the data were that despite the initial concerns expressed in the HEI that students could be disadvantaged compared to their hospital based peers, the students placed with District Nursing teams successfully completed the placement gaining the requisite skills and management experience. The objective of designing a sustainable process at the author’s institution to support these placements was achieved and the resource implications explored. Although not explicitly stated as an objective of the research intervention, the students felt competent and confident to apply for staff nurse posts in District Nursing teams and most were successfully appointed.

Arising from the reflexive analysis of action research, a recommendation is made that the NMC should reconsider a standard that all students should gain experience in the home setting (NMC 2010) and consider developing a more realistic standard which would allow some students to focus on the home setting and others to explore other settings outside of hospital.

Recommendations for the local context are made to maintain and develop the processes which were put in place as a result of this action research intervention to support students and practitioners during the sign off period of the pre-registration nursing programme.



## Chapter 1: Introduction

### *1.0 Introduction*

This action research report tells the story of how I collaborated with others to provide positive learning experiences in community settings for student nurses in their final 12 weeks of practice experience at the end of their educational programme. During this period the student must be supervised and assessed by a practitioner known as their “sign off mentor” (NMC 2006) and if successful, the student will then proceed to join the UK nursing register. After a significant “false start” which will be explored, the question for this project became:

*“How can we enhance the learning of student nurses undertaking community based practice placements with District Nursing teams in their final twelve weeks prior to registration?”*

The professional and regulatory body for nursing, The Nursing and Midwifery Council (NMC) sets standards for pre-registration nursing education (NMC 2010) including the role of mentor. A mentor is a nurse who has successfully completed a Nursing and Midwifery Council (NMC) approved preparation programme to be able to facilitate and assess the learning of a nursing student in practice (NMC 2008). The NMC has a requirement that the preparation of student nurses should involve 4,600 hours of learning and that those hours of learning be equally divided between theory and practice (NMC 2010). The mentor guides the student’s practice and assesses their progress. The “sign off” mentor is an experienced mentor who, in addition to the roles of facilitating learning and assessment, ultimately makes the judgement that the student at the completion of their programme can join the UK nursing register (NMC 2006). In order to take on the role of sign off mentor, the practitioner must be offered additional preparation and support (NMC 2006). The mentors in this study all worked as part of District Nursing teams who provide nursing care in patients’ homes.

As Robinson et al (2012) have pointed out, mentorship has long been regarded as the cornerstone of nurse education and therefore the experience of mentor and mentee has been the focus of considerable research. In contrast they argue the considerable work and complex relationships involved in identifying placements and maintaining the relationships between Higher Education Institutions (HEIs) and service providers is under-researched and they describe it as a “hinterland” that enables delivery to take place (Robinson et al 2012:2). This project is a contribution to that under- researched hinterland with specific reference to learning outside of the hospital setting.

The Nursing and Midwifery Council (NMC 2010) require that students be provided with consistent clinical supervision in a supportive environment during all practice learning. The NMC standards (2010) refer to students undertaking “practice learning experiences” in different settings and the focus of this project is on the requirement that towards the end of the undergraduate programme there must be a continuous period of at least 12 weeks of practice learning (NMC 2010). Although the NMC uses the term “practice learning experience” students, practitioners, managers and educationalists refer to these experiences as “placements” and discuss “placement capacity”( Baglin and Rugg 2011, Robison 2012). This study is focussed on students undertaking a community based practice placement, namely a continuous period of learning in practice under the supervision of a mentor, in their final twelve weeks prior to registration.

### *1.1 The London Context*

This project, which commenced in 2009, was located in a HEI in North London which is involved in the educational preparation of student nurses. The HEI had access to community nursing placements in three London Boroughs. Each of the London Boroughs had a population of approximately 300,000 and the large populations, social economic characteristics and ethnic diversity offered learning opportunities and provided logistical challenges for the students. As will be seen in the literature review there appears to be fewer descriptions of learning in the community setting in the London area compared to outside of London. This report therefore brings a

particular geographical focus and some insight into the logistics involved in inner-city placements.

This story is important for the participants but it also has a wider significance because it was conducted at a time of growing anxiety about the nature of the educational preparation of student nurses (Willis 2012). My concern is in effect a “subset” of the more general concerns about how student nurses are prepared for the world of work: namely that the Department of Health in the UK is increasingly arguing that the whole of the National Health Service should become “primary care led” (DH 2009) and that more care should be delivered outside of hospitals. This project worked towards addressing the concern that student nurses do not spend enough time with patients outside of the in-patient ward environment.

As part of the NHS London readiness to work project, Robinson et al (2012) reviewed the sustainability and management of nursing mentorship in London and highlighted that identifying and maintaining practice placements for nursing students in London is problematic and resource intensive and especially so in relation to community placements. A range of factors contribute to the complexity in the London area.

London has a wide range of hospitals with some serving a local population, others offering a regional service and others meeting specialist needs (NHS England 2013). Many patients treated in London hospitals will be discharged to community services outside of the capital; however London universities only have access to their local community services. There is therefore an immediate imbalance between acute placement availability and community placement availability.

This imbalance has led to a real tension and sense of competition for placements. London has nine Higher Educational Institutions who offer pre-registration nursing programmes, some of which are geographically very close to each other and whilst each has a number of acute units they relate to, patients from those hospitals can be drawn from, and discharged to, the same geographical areas. In the 1990s I worked closely with placement providers especially in inner London to rationalise

arrangements and improve the management arrangements. These research projects formed part of my APEL application (Camden Primary Care Trust and Islington Primary Care Trusts 2000). In practical terms this is best illustrated by my first experience of liaising with a clinic in Camden where I found students from three universities, Middlesex, City and London South Bank, all placed with the same service attending at the same time with three different sets of assessment documentation. The solution devised in the 1990s and continuing to the current day is for Middlesex students to be placed in Camden community placements and the other two institutions use neighbouring Islington for some of their community placements. It has taken until 2014 for a pan London assessment document (Fish et al 2014) to be brought into use which means that regardless of the student's institution, the mentor will at least be dealing with the same assessment documentation.

Another aspect of the London context is that, compared to elsewhere in the UK, primary care services are underdeveloped (NHS England 2013). Recent years have seen significant improvement in health outcomes for some hospital services in London such as stroke services and cardiac care (NHS England 2013); however the standard of primary and community care has remained an area of concern. Patient satisfaction with primary care has been shown to be 7% below the national average (NHS London 2007). Recent work on the medical General Practitioner (GP) workforce in London has shown that 16% of London's GPs are over 60 years of age, compared to 10% nationally (RCGP 2013). Many GP services continue to operate from very small premises with little space for accommodating any extra staff including students. The Royal College of General Practitioners have said that approximately 30% of primary care estate will not be fit for purpose in 10 years time (RCGP 2013). These pressures on General Practice services in London have meant that attempts to place student nurses with practice nurses in health centres as an alternative to district nursing placements have been very limited. In my own institution the use of practice nurse placements continues to be very marginal with GPs in smaller practices expressing concerns about premises and staffing constraints as reasons. The larger health centres which offer placements to medical

students and which receive funding as teaching practices, have declined to take nursing students as they do not attract the same funding.

The age profile of GPs is also reflected in the age profile of nursing staff working in community settings. In 2010 a scoping exercise was undertaken by NHS London (Fergy 2011) to assess the readiness of London NHS Trusts in relation to modernising nursing careers with a particular focus on the issues raised by the move towards an all-graduate nursing workforce. In the data collected from senior nurses Fergy (2011) highlighted their support for the move to an all-graduate profession but also highlighted concerns. The report contains an illustrative quote from a nurse manager in a community setting;

“Some registered nurses do not want to be developed. We have a big problem with existing staff in the community who are 50+. How much pressure should we put on them? (Fergy 2011: 6)”

Although not explicit in the quotation, the manager’s reference to “pressure” is indicative of the impact of organisation change and service reconfiguration on frontline staff (DH 2008) which is another factor which has impacted on community placements in London.

Organisational change has been a consistent thread throughout the period of this project. Management re-organisation of community health services in London has been even more complicated than in the hospital sector. At the outset of the study, the three services where the students were placed were community trusts in their own right. Following NHS reorganisation London’s 18 community health care providers were integrated with other types of provision. Nine are now integrated with an Acute Trust, five integrated with a Mental Health Trust, two are social enterprises and two are aspiring Community Foundation Trusts (NHS England 2013). In the local context, our partners for community placements are now integrated with a Mental Health Trust in two instances and with an Acute Trust in another instance. As this project report was being written the potential for more coherent planning of practice placements in London continued to seem very challenging

(Robinson et al 2012). Following the changes of the NHS Act 2010 and for the first time since the NHS was founded; there is no strategic health authority for London. However the NHS England regional office has produced its document “London: a call to action” which sets out its plan to “provide more care in community settings” (NHS England 2013: 5). For nursing education the successful conclusion of the pan London assessment documentation project is an indicator of how universities and health care providers can work together to provide a more coherent approach to placement issues.

In summary the provision of undergraduate nursing placements in the community setting in London are affected by a range of historical and current factors including an imbalance between hospital and community provision, underdevelopment of primary care services, an aging workforce profile and service reconfiguration.

### *1.2 My background and the community of practice*

My role in this project is embedded in a nearly a working lifetime of experience from the perspective of one or other of the stakeholders in this project. I have been a student nurse and as a qualified nurse I have taught students in practice in the community setting. However since 1988 I have worked as an educationalist concerned with the learning of student nurses originally in a School of Nursing, then in a College of Health Studies and now as a lecturer in a Higher Education Institution (HEI). During the study period I undertook a number of roles that assist my “ways of knowing” (Carper 1978) about the learning of student nurses in the community setting. Apart from the time- limited curriculum development group, I continue in the other roles.

The figure below seeks to illustrate these roles:

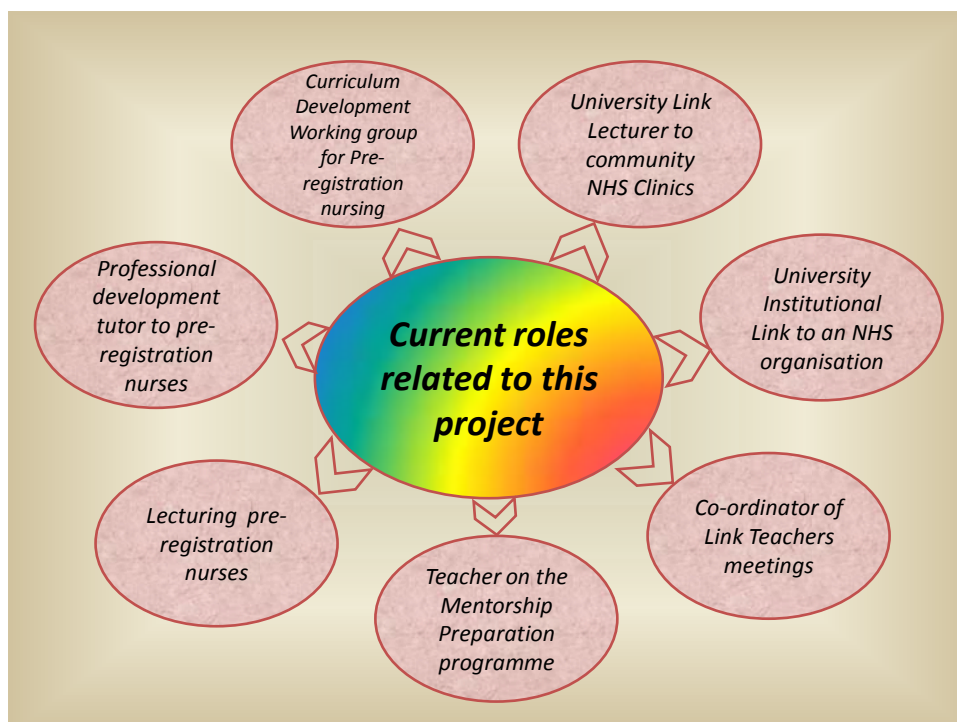


Figure 1 Current roles related to this project

As can be seen from figure 1, I am involved in teaching and the personal and professional development of the students. I am also involved in teaching the professional programme which prepares the practitioners who facilitate and assess the students in practice (The NMC approved "Mentorship Preparation Programme" NMC 2008), and I am thus involved in "teaching the teachers".

In addition to the teaching roles, I am involved in several roles in the University which directly support those practitioners. I am the link lecturer to several clinics which means that I offer the practitioners support in their role with students, but I also work strategically with the management of NHS organisations to oversee the systems for the placement of students in these settings. I formally chair Quarterly Review Meetings with one of those partners to review placement issues: availability, quality and development for one London Borough. Internally at the University I act as co-ordinator of the Community Link teachers' forum where all the colleagues who do the same role across the three boroughs come to share their concerns and issues.

My links with colleagues in practice and education means that I have ready access to a community of practice. Wenger (2002:13) offered a definition of community of practice:

*“Communities of practice are formed by people who engage in a process of collective learning in a shared domain of human endeavour..... In a nutshell: Communities of practice are groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly (Wenger 2002:1).*

In my case the community of practice shared a concern about the availability of community placement but were also passionate about the need for students to have the opportunity to learn in the community. We were a group of District Nurse mentors, nursing academic staff who liaised with community placements, academic staff with specific responsibility for placements and nursing managers involved in education and the recruitment of newly qualified students. As the project progressed this passion extended to a growing concern about District Nursing and the need to replenish the nursing expertise in the community setting.

The extensive NHS reorganisation (DH 2008) during the period of this project has meant that all the NHS stakeholders who were part of the community of practice have had to move to new organisations (and in some instances reapply for their jobs) during the project period and several are now working in different job roles compared to when the project was commenced. It was very fortunate that none of them lost their job in the process and although several of them now have additional responsibilities, all did maintain a work interest related to community placements and apart from one exception, all remained connected to the project. Ironically this project which entailed implementing a change has been a point of continuity for the participants in the community of practice.



### 1.3 An Insider Researcher

I came to this project as “insider researcher” (Coghlan and Brannick 2010) as someone who would be undertaking a number of working roles and who would be deliberately studying herself and those roles and studying the system of which they were a part. In this case I was part of one complex system, a Higher Educational Institution, which in turn was interacting with a much more complex system the National Health Service. Coghlan and Brannick (2007) have designed a diagram which illustrates the intended focus for both the researcher and the system.



Source: Doing Action research in your own organisation (2<sup>nd</sup> Ed) Coghlan, D. and Brannick, T. Sage Publications, London 2007

**Figure 2 Coghlan and Brannick's (2007) diagram of focus of researcher and system**

When I first saw this diagram I had no difficulty in placing myself in Quadrant 3 in that I was an individual engaged in a reflective study of professional practice. However I was also an individual hoping to effect change on the system but at the outset there was no conscious call from the system to change. In this report I hope to illustrate how the focus of research shifted over time to Quadrant 4.

### *1.3 Relationship of Recognition of Prior Learning to this project*

In addition to the current roles I am undertaking, I brought to this project a range of expertise accumulated from other projects related to student nurses learning in the community setting. I had submitted these projects with reflective commentaries as part of the Recognition of Prior Learning (RAL) claims for this Doctorate in Work Based learning. I therefore found it fitting that this final project was underpinned by that earlier work and this project is therefore another step in a journey of developing expertise. One element of the RAL claim was about methods of learning in this setting. I reflected on the three editions of an open learning text that I had written for students learning in the community which were part of the Nursing Times Open Learning course for conversion of enrolled nurses to registered status (Brown and Johnston 1989, Brown and Brindle 1991, Brown and Elliot 1993). The claim also involved my first experience of action research where I had worked with a colleague to address a problem of student learning as identified by community practitioners; we had envisaged an intervention and then studied the application of that intervention in practice.

Another element of the RAL claim was about my participation in research projects funded by the NHS which were led by a Community NHS Trust. In these situations I had not been the lead researcher but a very active member of either the steering or working groups of the projects (Camden PCT and Islington PCT 2000, 2003). These projects were very much focussed on getting the “system” right. For example one of the projects looked at how placements were measured in the community and came to the conclusion that the placement of a student for very short placements of two to three days a week was often as demanding for the practitioner as to have the student placed for a whole week. Out of this project came a common agreement that all placements agreed between the University and the Trust would be counted in “placement units” with a unit being “the placement of a student for one week or part thereof.” To someone external to the system this conclusion may seem so mundane as to be irrelevant. In the original study this conclusion became very important in terms of all parties to the educational process sharing common

understanding. Little did I understand at the time how over a decade later I would be reflecting further on the emotional work involved in supporting a student in the workplace and how much of the energy involved in that work has to be invested early and how much more of this energy is therefore conserved in a longer placement.

#### *1.4 Rationale for the project*

In 2009 at the outset of this project the HEI annually recruited a cohort of 330 student nurses. These students shared all their learning in year one of their three year programme and then divided into Adult branch, Mental Health branch and Child branch as students became more specialised in those branches of nursing. This project is exclusively focussed on Adult branch students which was the larger branch with 252 students. When the curriculum had been devised in 2005 the university had responded to the Department of Health NHS Plan (DH 2000) which envisaged more care being delivered in community settings. Although it was acknowledged at the design stage of the 2005 curriculum that finding sufficient community placements would be challenging, the curriculum was designed with an 8 week placement in a community setting, typically with nursing teams who cared for patients in their own homes. In the local boroughs these teams were variously known as District Nursing Teams and Adult Community Nursing Teams.

In 2009 due to reconfiguration of NHS services the actual availability of community nursing placements had reduced despite the continuing emphasis in health policy on provision of care outside of hospitals. In fact by 2009 the length of placement in the home setting had been reduced to 4 weeks. Therefore at the outset of the project the HEI was seeking to place over 200 adult branch students for 4 week placements and even that shorter period of time was becoming a challenge.

In view of my interests and responsibilities, senior staff at the university asked me to “look at what could be done” to resolve the “problem” which was defined as one of “shortage of placements”. I therefore decided to tackle this work based problem as my final project for my D Prof studies. This decision was met with some concern

by colleagues who thought it would be a dull topic. However I saw it as truly work based dilemma: all the policy documents were exhorting educational providers to increase learning opportunities in the community setting but in practice this was proving exceptionally difficult. There was great tension between the policy rhetoric and the reality of implementation, and moreover no educational providers seemed to want to admit to the problem for fear of being seen as not able to deliver the curriculum.

### *1.5 Impact of early collaboration on focus of project*

This was a problem which could only be solved in collaboration with other stakeholders. It is not a university which decides the number of student nurses it will recruit rather the decision is taken by the providers of health service in an area acting collectively who in turn, communicate that decision to a the strategic health authority which at the time was the London Strategic Health Authority. Therefore when the curriculum had been devised health providers had assured the university and the professional body that there were sufficient community placements. However since that time an increasing number of service configurations had decreased the availability to 50% of what had been assured at the curriculum validation. Even that reduced availability now appeared to be threatened.

Following an internal discussion with immediate colleagues, the next step in the project was therefore to explore the issue with one placement provider. This early meeting in turn became crucial for the focus of the project. This stakeholder provided one third of the community placements accessed by my organisation and therefore their perspective had a crucial impact on the development of the project.

Together with the Head of Practice Based Learning at the university I approached the managers in the local community provider service to discuss how we might increase the number of placements available to our students. They agreed that it was not easy to identify the placements but they wanted to ask entirely different questions. They asked questions such “why did the university only place students in the community in the second year of their three year programme or early in the

third year?” “Why did we never place students in the community for their final three month placement immediately prior to qualification?”

Initially we were very taken aback by their line of questioning and pointed out that it was difficult enough to find sufficient one month placements. However they went on to explain their rationale, namely, that they were aware that students were not likely to apply for posts on qualification in the community because they had not undertaken work there in the final months of their programme. Secondly they were aware of students who had the courage to apply and been appointed but those students had found it a “great culture shock” and many had resigned and re applied to work in the hospital setting and some, they thought, had stopped nursing altogether. One manager then put forward a proposal that they would maintain the existing placement numbers but offer in addition, as a pilot, two students a three month placement at the conclusion of their three year programme. As the strategic health authority counts placement units as a week of placement, this meant that this interaction had increased placement units by 24. It would only alleviate a small amount of pressure on our placements; however the question raised by the placement provider was a much more telling one than that which I had been initially exploring. As the Head of Practice Based Learning at my institution was present when this offer was made and I made it clear that I would be prepared to explore this initiative, a decision was made on the spot to undertake the pilot as the key stakeholders were all present. There was a sense that it was an offer that could not be refused. At the time we didn’t know whether students would come forward but I was confident that they would as I knew from my other roles that evaluations of community placements frequently included student requests to be placed for longer in the community environment.

As an insider researcher I was therefore in a rather strange position. I had not designed any particular intervention but I had already partially achieved the original aim which was an increase in placement units (albeit at this stage on a pilot basis) and I therefore needed to refocus. However I had unearthed a much more serious problem which was the employer’s view that short one month placements were not

meeting the curriculum requirement of preparing the students to work in the community setting. I therefore reformulated my research question as

*“How can we enhance the learning of student nurses undertaking community based practice placements with District Nursing teams in their final twelve weeks prior to registration?”*

Internally the Head of Practice Based Learning and the Placement Manager were asking how will this affect the students, will there be any adverse consequences? Will there be issues of equity; we clearly cannot offer this opportunity to everyone. How shall we select the students? The professional body has particular requirements of those who mentor students in their final twelve weeks, how shall we prepare the practice based mentors? What is known about undertaking a placement in this setting?

The placement provider who first made this suggestion and offer of placement displayed a quiet confidence that the outcome would be beneficial and lead to students applying to work in the settings. Would this confidence become a reality?

These were the questions which needed answers and I had to find a research approach which could address them.

### *1.6 Terms of Reference*

My overall aim for this project became:

*“In collaboration with NHS partners, students and my own colleagues, consider how the introduction of a sign off final placement in a community setting could contribute to the wider preparation of student nurses, their fitness for practice and how this process would inform future curriculum development.”*

My objectives were as follows:

1. Design and implement a sustainable structure at my own institution and with stakeholders to support sign off placements in a community setting.

2. Evaluate the process and the student placement experience and identify the implications for students, provider organisations and Higher Education Institutions and utilise this information to inform the process of curriculum development for the new graduate programme of September 2011.

3. Critically review the emerging literature on the sign off period to identify important issues for the partners in the process, the planned curriculum development and the employability of student nurses in the community setting.

4. Disseminate the learning from Objectives 1-3 and contribute this learning to the understanding of the factors that impact on employability of student nurses in community settings, the process of curriculum development and the development of sign off placements in other new areas.

### *1.7 Gaining Access*

Gaining access to address my objectives was uncomplicated as in my university role as the university institutional link to the area which was offering itself as a pilot for study, I had responsibilities and access in my work role. Likewise in my work role at the university, I would be identifying the students who would be undertaking the pilot. In addition my institution was formally obliged, for commissioning purposes with the London Strategic Health Authority, to undertake regular evaluation of any new initiative and in particular was obliged to report about employability of students.

Although all stakeholders were aware of these requirements, and access to evaluative data was part of an on-going agreement, it would be vital to gain consent from any individual participating in the project so that they would be aware that the reports could be more widely disseminated. In addition, as with all research projects, there would need to be fully informed individual consent for reporting of individual comments as research data. I therefore approached the university ethics committee (Appendix 1) and the ethical considerations are more fully explored in Chapters 3 and 4 which look at the methodology and project activity.

## Chapter 2: The historical context

### *2.0 Introduction*

This chapter on the historical context is included to reflect the discussion in the community of practice about the requirements for community placement, the planned curriculum development and the project objective about seeking a sustainable process. There was a strong sense in the community of practice that they did not want to waste energy developing a project which did not “fit in” with what was being asked of us by the professional body and the health service. Although the members of the community of practice felt on the basis of their own knowledge that the planned intervention was a good fit with those requirements, they wanted to see their “tacit knowing” (Grant 2007) confirmed by explicit reference to those requirements. Coghlan and Brannick (2007) argue that the dynamics of doing research in your own organization involves building on the insider knowledge you have already and this project included insider knowledge of both the Higher Education sector and the NHS. Stringer (2007) argues that the first stage of action research – which he calls the “Look” stage of the process -is to gather information to extend the participants understanding of the experience and perspective of various stakeholders. I was therefore tasked to enhance the existing knowledge of the group by undertaking a chronological review of relevant documentation which would clarify the expectations and requirements in relation to community placement. As this project was being undertaken at a point when the nursing profession in England was being moved to all graduate profession (Willis 2012), it seemed appropriate to begin that chronology with the previous major restructuring of nurse education in 1986 (UKCC 1986).

### *2.1 The historical context: 1986-2000*

In 1986 the professional body for nursing, the United Kingdom Central Council (UKCC), proposed to change the employment status of student nurses in the UK



from hospital employee to a predominantly supernumerary student as part of the major restructuring of nurse education entitled Project 2000: a new preparation for practice (UKCC 1986). Although this document did not address community placements directly it signalled the following policy direction by the nursing professional body:

*“We feel the time has come for a break with the hospitals as the basis for so much initial preparation and for new thinking about how placements and practice experience could be developed in relation to a whole range of care settings” (UKCC 1986:19).*

This policy direction was not accompanied by any detailed implementation plan. Ten years later the English National Board (ENB) for Nursing, Midwifery and Health Visiting, which was the English part of the UKCC, reported on a major national research project (Thomson et al 1996) which explored the demands being made on community practitioners by their responsibilities for teaching students. In order to address their wider aim, this study also asked questions about the time spent by students on placement outside of hospital. At this time nursing degree programmes were delivered in higher education setting and the nursing diploma programmes were typically delivered in schools of nursing and of the 95 centres (a mixture of HEIs and Schools of Nursing) who responded to the question there was huge variation from 5 to 105 days spent on community placements. A key finding of the report was that there appeared to be “no obvious rationale for this variation other than the availability of placements to a particular centre” (Thomson et al 1996:3). Therefore despite the aspiration by the UKCC in 1986 to develop placements in a wide range of settings, the reality ten years later was a hugely uneven picture. The report also called for further work to be done “so that accurate information on the effects of student placement on practitioners’ work patterns can be assessed” (Thomson et al 1996:3).

Jones and Akehurst (2000) undertook a study to look at the economic impact to health care providers of providing clinical placements. Their conclusion was that

despite being supernumerary the average second or third year student benefitted a hospital by on average £3.46 for every hour spent on placement because of their ability to contribute to the workload. They concluded that community based clinical placements could not free staff time in the same way and they calculated that there was a cost of £0.48 for each hour students spend in the placement area. This economic disadvantage of students may therefore be one explanation of why identifying community placements continues to be challenging.

In 1998, ten years after the introduction of Project 2000 (UKCC 1986) there was considerable public and professional debate about nurse education which often was expressed as a concern that nursing had become too academic (DH 1999). The UKCC responded by appointing a commission to review pre-registration nursing and midwifery which produced a report entitled "Fitness for Practice" (DH 1999) which highlighted problems with the organisation and supervision of practice placements. This review contained a specific recommendation in relation to length of placement at the end of the student's programme:

*"To enable nursing and midwifery students to consolidate their education and their competence in practice, there should be a period of supervised clinical practice of at least three months towards the end of the pre-registration programme." (UKCC 1999: 58)*

However none of the thirty three recommendations specifically referred to the balance of placements between the hospital and community sectors.

## *2.2 The historical context 2000 – 2004*

In 2002 the UKCC was replaced by the current professional body the Nursing and Midwifery Council (NMC). One of the last actions undertaken by the English National Board (as part of the UKCC) was the production of a document jointly with the Department of Health called "Placements in focus" (ENB and DH 2001). In spring 2000 the Department of Health established a clinical placements working group with the aim of identifying ways to increase the supply of practice

placements and ensuring national consistency in their standards and quality. The remit of working group was wider than nursing and included all health professions and many of the principles it established continue to underpin the quality review process of educational placements in the health professions. One of the specific aims of the working group was to share ideas about the identification and development of new opportunities for practice experience (ENB and DH 2001:7) and development of more practice placement opportunities ( ENB and DH 2001:11).

There were two specific references to community placements in the ENB/ DH document. At this historical juncture the provision of community services were being re-organised into new health care provider organisations called Primary Care Trusts and the “ Placements in Focus” report (ENB and DH 2001) called on the new bodies to “work with local education commissioners and partner HEIs to enable the development of more practice placement opportunities (ENB and DH 2001:11). The other reference to community placements was less directive and more an

*“Primary care packages of learning could be developed whereby students would be based with a practice mentor/assessor but would undertake a variety of experience with different people (DH and ENB 2001:21)”*

This type of placement design often referred to as a “hub and spoke” (Roxburgh et al 2012) has become more common in community settings and documented examples will be included in the second section of this literature review.

A year later MacLellan and Leyshon (2002) based in an inner London Primary Care Trust discussed the challenge of providing the type of high quality placements envisaged by Placements in Focus (ENB and DH 2001). They developed an interprofessional project across the trust to produce learning materials and mechanisms of support. Interestingly the need to attract nurses to start their career in the community and the challenges faced by inner city trusts where there are multiple hospital employer competitors for newly qualified staff was a key part of their motivation: *“Our ability to provide students with high quality clinical*

*placements is seen as a significant recruitment opportunity that we must capitalize on if we are to maintain optimum staffing levels.” (MacLellan and Leyshon 2002).*

A similar vein of thinking in my local community of practice moved the focus of this project from being a general concern about community placements, to a specific intervention to place finalist students in a community setting.

### *2.3 Historical context 2004 to commencement of project activity*

The level of concern about the preparedness of students for practice did not abate following the recommendations of Placements in Focus (DH and ENB 2001). In 2003, and funded by a scholarship from the NMC, a qualitative research study by Duffy (2003) involving a sample of lecturers and mentors associated with three universities in Scotland aimed to explore their perceptions that some students nurse were being passed in placement despite concerns about their competence. Her findings were that students were being given the “benefit of the doubt” and being allowed to progress despite mentor concerns. Duffy (2003) documented how some students performed poorly from the first year but somehow scraped a pass in practice and then the final mentor lacked the confidence to fail also.

The NMC responded to the growing concern about nursing education by publishing national standards for pre-registration nurse education (NMC 2004) and these were subsequently updated in 2010 (NMC 2010). These standards contain a number of key references to learning in community settings which inform this project.

The NMC is legally required under the Nursing and Midwifery Order to establish standards; minimum requirements by which programme providers determine programme content, learning outcomes and assessment criteria. The programme of students participating in this project is underpinned by the previous version of the standards (NMC 2004) and the curriculum development was informed by the new standards (NMC 2010). In terms of the requirements for community experience there is no substantive difference between the two versions. However the 2010

version places even more emphasis on learning in a community setting and the salient points for this project and for future practice will be highlighted.

The NMC 2010 document is clearly divided into elements which are requirements, (mandatory), guidance (best practice but not mandatory) and advice.

The law underpinning pre-registration nursing across the UK is based on a European Commission (2005) directive on “the recognition of professional qualifications”. The relevant article 31 is set out in the recent NMC document in Annexe 1 – Directive 2005/36/EC (NMC 2010 p 93). It states that “training shall take place in hospitals and other health institutions and in the community...” This directive in turn has an annexe which applies to Adult Nurses (NMC 2010: 95) which specifies where Clinical instruction (what in UK would be called “practice based learning”) should occur and is as follows:

- General and specialist medicine
- General and specialist surgery
- Child care and paediatrics
- Maternity care
- Mental health and psychiatry
- Care of the old and geriatrics
- Home Nursing

Statements emanating from an EC directive are clearly requirements and therefore mandatory. As the list includes “home nursing” the implication is that every student should have a practice placement in the home setting.

However the list above does not specify hours in each area and it also has two important qualifying statements at the end of the list:

*“One or more of these subjects may be taught in the context of the other disciplines or in conjunction therewith.”* And:

*“The theoretical instruction must be weighted and coordinated with the clinical instruction in such a way that the knowledge and skills referred to in this Annex can be acquired in an adequate fashion (NMC 2010 :95).*

Higher Education Institutions (HEIs) have therefore a clear list of where practice experiences are meant to be provided but the qualifying statements allow for some ambiguity. On the one hand it is easy to see how “Care of the old” could be “taught in the context of the other disciplines” as the majority of patients/clients are elderly. It is harder to see how “clinical instruction” in “home nursing” could be taught other than in the home. In the UK this would require each student to have a placement with a community nursing team.

The second qualifying statement with its reference to knowledge and skills being acquired “in an adequate fashion” (NMC 2010: 96) again allows for significant variation in interpretation.

In summary, the legal basis of the place of community placements in pre-registration nursing is therefore ambiguous. On the one hand there is an EC directive which specifies a requirement for adult branch nurses to have placement experience in “home nursing”. However the hours of experience are not specified and the qualifying statements allow this experience to be “taught in the context of other disciplines”. However the spirit of the directive is clear in that there is an expectation that all adult students will have knowledge and skills related to home nursing.

To further complicate matters, apart from the annexe of the EC directive the term “home nursing” is not used as a phrase elsewhere in the NMC document (NMC 2010). Rather the document uses a different term, namely “community practice learning”. Helpfully this term is clearly defined in the glossary:

### *“Community Practice Learning*

*This refers to the student’s experience of care delivered outside the hospital setting. This type of care delivery is designed to put the needs of service users first, giving them easy access to care at their convenience, rather than concentrating on the practicalities of service delivery. It could include a range of community settings outside of major hospitals, such as caring for people in their own homes, general practice, local in patient units, nursing homes and other residential facilities, walk in centres, schools and the person’s workplace. It also gives students a chance to gain experience in NHS, Independent and third sector services.” (Taken from glossary NMC 2010:135)*

As can be seen from this glossary description a whole range of practice areas are envisaged of which care “in the home” is but one option. At this point HEIs and placement providers might relax and view the challenge as a manageable one as the glossary list provides a range of options. In terms of the three levels of requirements, guidance and advice it is not clear what the status of a glossary definition might be but one might assume that it has the status of “guidance”. However within the NMC documentation there is a further reference which is pertinent to this study. The documentation comes complete with a competency framework and the domain Nursing Practice and Decision making includes the statement:

*“Adult nurses must also be able to carry out accurate health, clinical and nursing assessments across all ages and show the right diagnostic and decision making skills. They must have confidence to provided effective adult nursing care in the home, the community and in hospital settings to individuals and communities. They must be able to respond to a range of health care needs and levels of dependency including: intermediate care, critical care, acute care, long term conditions, palliative care and end of life care.” (NMC 2010:17)*

Here it can be seen that not only is there an expectation that students should have some experience of home nursing but indeed that students “must have the confidence to provide effective adult nursing care in the home.” This is the competency statement for what is expected at the end of their three years of education and therefore it could be read that the outcome of the education is that the student should be competent to provide this care as a qualified practitioner. This is indeed a high expectation.

The information from the professional body is therefore arguably confusing and contradictory. In particular the competency statement does not sit easily with the reality of the student learning experiences in the home that can be provided for **all** students. If the competency statement was altered slightly to omit the specific reference to home but to include community, then the expectation would be realistic. In my professional role I made this point forcibly within my own institution during the consultation on the NMC 2010 standards and asked for it to be included in our institutional response to that consultation. However the final version of the competency statement continues to have the explicit reference to the home setting rather than the wider community settings, (non institutional settings such as GP surgeries and clinics).

In addition to the NMC pre-registration nursing standards (NMC 2004, 2010) the other key professional body which informs this project is a set of standards to support learning and assessment (NMC 2006). These remain the current standards with some minor additions made in 2008 (NMC 2008) but do not contain any explicit reference to pre-registration learning in the community setting. However these standards introduced the concept of a “sign off” mentor into UK nursing.

The Standards to Support Learning and Assessment in Practice (NMC 2006) outline the standards expected of practitioners who act as mentors for pre-registration nursing and midwifery students and they provide guidance for individual mentors and for their employing organisations. In response to the concern about mentor consistency and the concerns exposed by Duffy ( 2003) about the potential for



unsuitable individuals to join the nursing register, the standards identified an enhanced role for the practitioner who would act as mentor for the student in their final placement prior to registration as a nurse. This enhanced role was given the name of “sign off mentor” (NMC 2006: 6). In 2008 a new edition of the standards were produced (NMC 2008) with minor amendments and therefore references to the standards are now typically referenced as 2008.

Initially the term led to some confusion amongst practitioners with many believing that as anyone who has completed the Mentorship Preparation Programme can assess a student (and therefore sign the assessment documentation), that all mentors come under the heading of being a “sign off mentor”. However, the NMC uses the term in a very specific way in the nursing programme to refer to the final placement in the student’s third year and the obligation of the sign off mentor is

*“...to make a judgement about whether a student has achieved the required standards of proficiency for safe and effective practice for entry to the NMC register” (NMC 2008:6).*

These mentors are therefore typically those who have had some years’ experience of mentoring. There is an NMC requirement that the local register of mentors held by provider services must be annotated to note which mentors have “sign off status”.

Students who commenced their programme of study after September 2007 have had to meet additional requirements when undertaking the final 12 weeks of continuous placement immediately prior to registration. These students must be supervised by a sign off mentor who in turn must satisfy the NMC requirements as outlined in Table 1 below.

Expectation of a sign off mentor
Clinical currency and capability in the field in which the student is being assessed
An understanding of the NMC registration requirements and the contribution they make to the achievement of these requirements
An in-depth understanding of their accountability to the NMC for the decision they must make to pass or fail a student when assessing proficiency requirements at the end of a programme
A working knowledge of current programme requirements, practice assessment strategies and relevant changes in the education and practice for the student they are assessing
A working knowledge of current programme requirements, practice assessment strategies and relevant changes in the education and practice for the student they are assessing

Table 1 NMC Expectations of "sign off" mentor (NMC 2008)

The key difference between mentors and sign off mentors is around the final assessment of practice. Individual mentors who assess students as they progress during their typical pre-registration programme are accountable for assessing their practice. The sign off mentor is not only responsible for the assessment decision on their longest placement (a minimum of 12 weeks of placement), they also have responsibility for confirming all practice requirements and therefore entry to the professional register (NMC 2008). In recognition of this responsibility the NMC recommends that all sign off mentors need protected time for undertaking the role and recommend that this is one hour per week,. This is in addition to their recommendation for all mentors that they need to spend 40% of their time in direct or indirect supervision of the student (NMC 2008).

The preparation of mentors in District Nursing teams in relation to these standards became an integral part of the project activity. The NMC standards ( 2006) specified that sign off mentors would in the future need to be prepared by being supervised on at least three occasions by an existing sign –off mentor or practice

teacher ( NMC 2006; section 2.1.3). However the 2006 standards said preparation of the first wave sign off mentors could be decided by placement providers in a local process. In devising the local process I needed to ensure not only the robustness of the arrangement for the current wave of mentors and students but also that this preparation would form part of a cascade effect which could impact on future mentors.

**The impact of health policy on pre-registration learning in the community**

This final section on the historical context will refer to the search of two key health policy documents rather than educational policy documents for reference to learning the community. The first document addressed the nursing workforce and the second addressed the government’s vision for primary and community care. Finally reference will be made to significant trends in the district nursing workforce which have impacted on learning in the community.

In 2006 the Department of Health published a workforce policy document called Modernising Nursing Careers and included a chart about how the profession would change which included the extract below:

Coming from	Going towards
A nursing workforce focused on hospital based care	Care taking place in and outside hospital with the workforce moving between, Nurses starting their career in the community

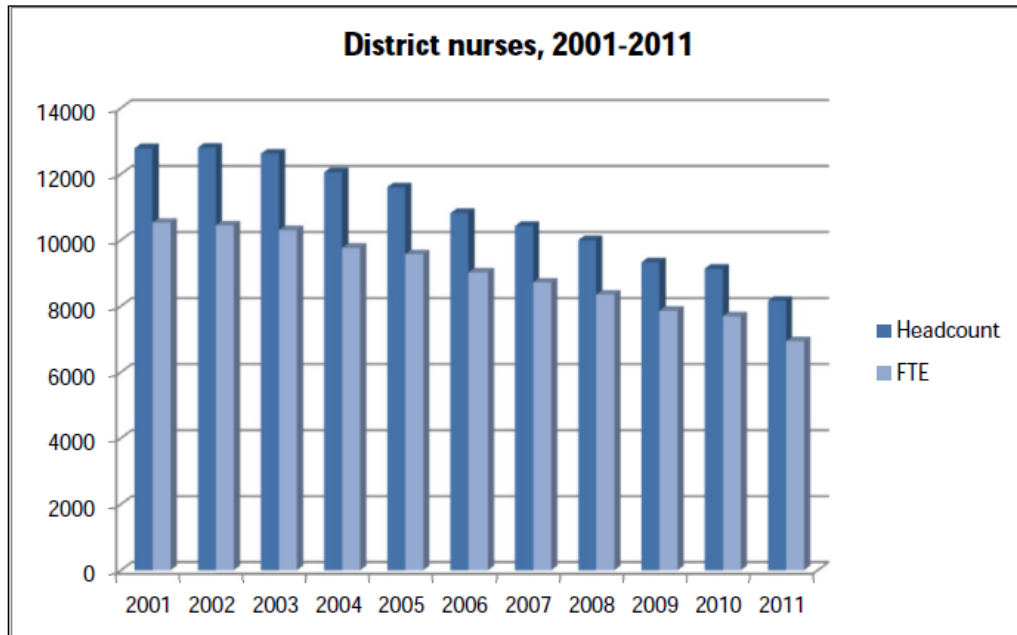
Table 2 Extract from table in Modernising Nursing Careers (DH 2006)

The key sentence in the chart was the reference to nurses starting their working lives in a community setting which by implication suggests a preparation which allows newly qualified staff to feel equally at home in a hospital or community setting. The same policy document contained a series of actions including a pledge to “work with others” to explore whether changes are needed to the content of the

pre-registration programme. When the modernising nursing careers programme concluded in 2011 (DH 2011), it did not report on a specific work stream in relation to the pledge and referred the reader to the NMC 2010 standards as the outcome of the action.

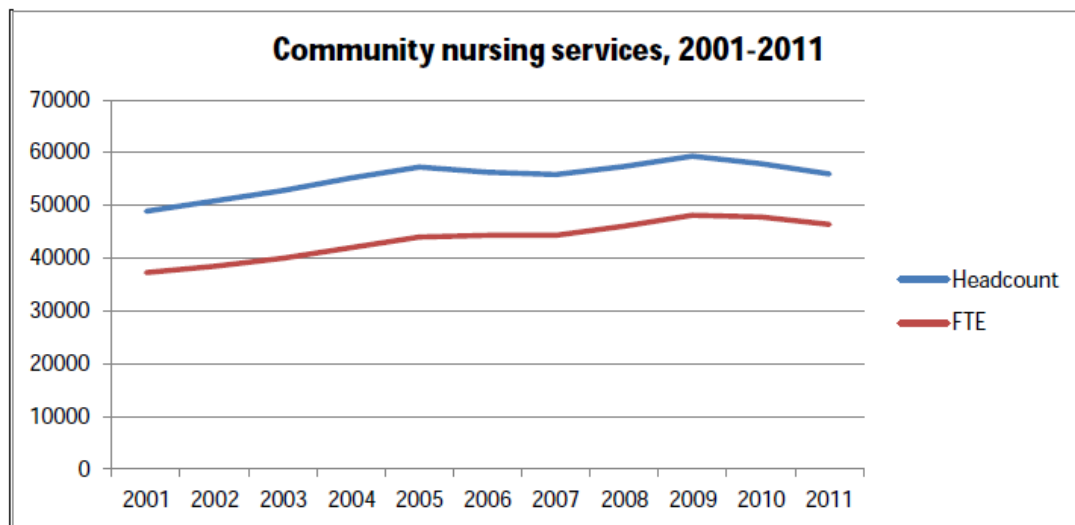
The second key health policy document during this period outlined how community services would adapt to meet the government's wider vision about the NHS as a whole. In July 2008 as part of a major review of the NHS the then Labour government had produced their policy document "NHS Next Stage Review: our vision for primary and community care (DH 2008). This vision explicitly committed the government to "encourage more healthcare to be provided in community settings" (DH 2008:8) but included only two paragraphs on "training tomorrow's clinicians." The document acknowledged that the growing demand for primary and community care would "have important implications for how we train the primary and community clinicians of the future" (DH 2008:8) but did not specify what these would be.

In contrast to the policy documents about the nursing workforce and the vision for the NHS, the practitioner members of the community practice were frequently raising concerns about decline in district nursing numbers which seemed to run contrary to the policy aspiration. The higher education stakeholders in particular were concerned about the anecdotal information from practitioners who were complaining about decreases in staff numbers, and particularly a decline in the more experienced team members who had previously been at the forefront of mentoring students. These concerns were therefore investigated by reference to the NHS workforce statistics data and the decline in district nursing numbers in the UK during the previous decade was stark:



Ref Community Nursing Workforce in England (RCN 2012)

The picture in relation to the total community nursing workforce was less clear initially with an overall rise in nursing staffing levels in the community for most of the previous decade indicating a substitution of less qualified staff for the experienced district nurses who had been lost to the profession. However as I continued to monitor the figures during the timeline of the project, the anecdotal concern about reduction in staffing was replicated in the national figures with the total numbers of staff showing a reduction at a point when the government’s policy document was arguing for expansion (DH 2008).



Ref Community Nursing Workforce in England (RCN 2012)

These concerns felt by local practitioners also found a national voice in the professional organisations representing district nursing including The Queens Nursing Institute (QNI) and the Royal College of Nursing (RCN). The QNI trained district nurses in the UK until the 1960s and it is now a campaigning organisation dedicated to improve the nursing care of people in their own homes. In 2003 it had published a report entitled “District Nursing - the invisible workforce” (QNI and ENB 2003) highlighting both the decline in nursing numbers and the mismatch between the growing need for the service as the population aged and the actual resource made available. This was followed by further reports in (QNI 2009, QNI 2011a, 2011b) urging policy makers and educationalists to act to address the growing need for a skilled workforce in the community setting. The RCN published their vision for community nursing in 2010 highlighting similar concerns and setting out 27 core conditions to ensure services survived and became more efficient (RCN 2010). One of the core conditions was that community nursing should be reinvigorated as a career choice and this was particularly pertinent to this project.

## Conclusion

This chapter on the historical context has chartered the troubled history of community placements since the major changes to nurse education in the 1980s (UKCC 1986). It has highlighted that educationists and practitioners have sought to ensure that more of the practice hours in the pre-registration curriculum be spent on community placements but that progress in this aspiration has been limited and that even the national standards for pre-registration nursing ( NMC 2010) contain contradictory message about community placements. The origins and requirements of the sign off mentor concept have been introduced. Finally reference had been made to recent health policy (DH 2006, DH 2008) which set the practice context for this project and to the decline in the District Nursing workforce which was not signalled in any policy document but which has led to a loss of experienced staff from the community setting.

## Chapter 3 Methodology

### 3.0 Introduction

This chapter outlines the methodology chosen for this project. Firstly I outline how this project was well suited to an action research methodology and give a rationale for choosing community based action research which is a participatory and emancipatory approach to action research.

Secondly I outline how this approach led to decisions about the participants and to the data collection methods. Finally I explore the techniques of data analysis and how I ensured rigour and trustworthiness in this study.

### 3.1 The research approach

As the project developed the collaborative nature of the project became increasingly explicit. All of the objectives set out in Chapter 1 were reliant on joint working between the stakeholders. The overarching research question remained:

*“How can we enhance the learning of student nurses undertaking community based practice placements with District Nursing teams in their final twelve weeks prior to registration?”*

Additional research questions became:

*What does the emerging literature on the sign off period identify as important issues for the parties in the process?*

*How can students and mentors best be prepared for a sign off placement?*

*Does undertaking a sign off period in the community impact on the employment and employability of students in that setting?*

*What are the features of a sustainable process for the continued placement of finalist students in the community setting?*

Apart from the review of the literature these were all questions which needed to be addressed by a research approach which clearly focussed on social processes and which ideally facilitated the social interaction between the relevant stakeholders. The intent of qualitative research is to understand a particular social situation and it is often employed to gain understanding of how groups interact (Robson 2011). My concern was how two major organisations – higher education and the national health service – worked together to provide educational experiences for students. I therefore adopted an interpretative inquiry approach which would allow me to understand what was happening in the real world. An interpretative paradigm allows the researcher to understand individuals' experiences by focusing on actions and interactions and thus investigate the experience and explore the multiple realities of all participants, their perceptions and experience (Friedman 2001:162). In the early stages of the project consideration had been given to adopting a case study design as this type of descriptive research looks intently at a specific context and assist in gaining a holistic understanding of an event or situation (Gomm et al 2000). However once it became clear that a change intervention was going to be put in place and moreover there was the possibility of studying the same change intervention over a period of time and in different locations, I decided that an action research design would be the most fitting as it is ideally suited to studying change and typically studying change over a number of cycles (Williamson et al 2012, Baumfield et al 2008). Although some approaches to action research envisage processes of inquiry that are predominantly based on a practitioner's reflections on his or her professional practice (Mc Niff and Whitehead 2009), the research questions in this project required a more participatory approach working alongside stakeholders as participants in the project (Stringer 2007) and this requirement influenced the type of action research selected.

### *3.2 Action Research*

Waterman, Tillen, Dickson & de Koning (2001:11) define action research as:

*'A period of inquiry, which describes, interprets and explains social situations while executing a change intervention aimed at improvement and involvement. It is problem-focused, context-specific and future-orientated. Action research is a group*



*activity with an explicit critical value basis and is founded on a partnership between action researchers and participants, all of whom are involved in the change process. The participatory process is educative and empowering, involving a dynamic approach in which problem identification; planning, action and evaluation are interlinked. Knowledge may be advanced through reflection and research, and qualitative and quantitative research methods may be employed to collect data. Different types of knowledge may be produced by action research, including practical and propositional.'*

Many elements of this definition were applicable to the project in that there were a number of stakeholders involved who would all participate in the change process, there was an identified problem about the lack of third year finalist students in a community setting and an intervention to change the situation had been proposed. In particular my first research objective to "Design and implement a sustainable structure at my own institution and with stakeholders to support sign off placements in a community setting" meant that I needed to aim at a type of improvement and involvement which would have longevity.

There are different approaches to action research (Williamson et al 2012) and subtle differences of emphasis and suitability for different situations. I had first become familiar with AR in the 1990s at a time when there was a considerable interest in the methodology from nursing researchers (Wallis 1998) and in developing this project I returned to the work of Hart and Bond (1995) where they identified four specific typologies of action research : experimental, organisational, professionalising and empowering. The latter two in particular seemed to be relevant to this project.

Distinguishing criteria	Professionalising	Empowering
1. Educative base	Reflective practice	Consciousness –raising
	Enhancing professional control and individuals' ability to control their work	Enhancing user control and shifting the balance of power
2. Change intervention	Practitioner-focused	
	Professionally led	User/Practitioner focussed
3. Improvement and involvement		
	Towards improvement in practice defined by professionals and on behalf of users	Towards negotiated outcomes and pluralist definitions of improvement

Table 3: Comparison of professionalising and empowering action research typologies (based on Hart and Bond 1995:383)

In the early stages of the project before the development of the research question and my specific objectives, the concern had been about community placements in general and the stressful nature of the process of identifying placements and my early impetus would have been a close fit with the professionalising agenda of gaining control over this aspect of my job role. My original thought was that I might be undertaking a form of practitioner enquiry which is a form of action research popular in both education and healthcare whereby the individual practitioner focuses on the classroom or health setting to both solve problems and promote knowledge (Baumfield et al 2008). However as the project became focussed on the specific intervention with the third year students and the development of a sustainable process, the empowering typology as outlined by Hart and Bond (1995:383) became more relevant as the sustainability of the project would rely on the involvement of a range of stakeholders with commitment to the outcome and

the “negotiated outcomes” and “pluralist definitions of improvement” elements of the empowering typology (see table 3 above) seemed particularly relevant. The empowering typology links directly to the participatory action research tradition which emphasises the emancipatory potential inherent within AR methodology, involving a transformation of some aspect of a community’s situation or structures (Carr and Kemmis1986). This approach also has a particular view of the researcher as an equal with other participants in the study who helped them to use the data generated to review their situation and to make a change (Carr and Kemmis 1986). One of the authors who has been linked to participatory action research is Ernest Stringer whose text “Action Research “(Stringer 2007) is now in its third edition. He uses the term community based action research which seemed particularly apt for my project:

*“Community based action research works on the assumption that all the people who affect or are affected by the issue investigated should be included in the process of inquiry. The community is not a neighbourhood or a suburb, but a community of interest” (Stringer 2007:6).*

This description of action research as a participatory process that involves all those who have a stake in the issue engaging in systematic inquiry into the issue to be investigated seemed pertinent. In my community of interest I had already engaged with fellow educationalists, the practitioners who mentored students and the managers who employed them following qualification. I now knew that I needed to find a systematic way of including the other key stakeholder, namely the students undertaking the placements.

Stringer’s (2007) emphasis on community based action research helped me to clarify my approach as a participatory one distinguished from practitioner enquiry (Baumfield et al 2008). In practitioner enquiry there is an emphasis on the individual teacher or practitioner making changes in their own workplace and systematically reviewing these. In this project I would be making changes in my own institution and the service areas that we linked with and whilst I would be utilising my own

reflections on the process, the driving force of the project would be the data from the diverse stakeholders.

As outlined in Chapter 1, I had a number of roles related to students learning in the community which meant for the duration of the project I needed to adopt the dual roles of practitioner and researcher. The project entailed obtaining data from my university colleagues and in that aspect I was truly an “insider researcher” (Coghlan and Brannick 2007) undertaking research in my own organisation. However even when I was obtaining data in the NHS, I was known to the staff in my capacity as university link lecturer and therefore I needed to explicitly acknowledge the impact of this on the research process. As Coghlan and Brannick (2007) argue a practical issue you have to deal with is that you may be too close to the issues and the people in the organization and he points out that you have to work more consciously and explicitly at the process of inquiry (2007:67).

Coghlan and Brannick (2007) urge the use of a journal as a mechanism for developing reflective skills in this situation and as a mechanism for both noting information significant to the project and as a means of helping you to reflect on experiences as they arise. Initially I considered using the journal as a mechanism for coping with being too close to the issues but then realised that this mechanism also had the potential to contribute to data generation. The role of the researcher as research instrument is fundamental to the epistemology of action research (Coghlan and Brannick 2007, Stringer 2007) and the use of a journal or learning log can actively contribute to the data. McNiff and Whitehead (2009, 2010) support the idea of using a journal as an interpretative, self –evaluative account of the researcher’s experiences, thoughts and feelings and as an analytic tool where data can be examined and analysed. In discussion with my supervisor, I adopted the term “learning log” for a document which came to include factual data and my own reflection on the research process and then increasingly, as the project progressed it became a vehicle for “thinking aloud” the data analysis.

My original research question had been “how can I enhance the learning of student nurses undertaking community based practice placements with District Nursing teams in their final twelve weeks prior to registration?” and could have been a question answered by a process of practitioner enquiry. However once the research objectives were developed the dynamic changed, and the “I” became a “we” and indeed my first objective was only achievable with partners:

*“Design and implement a sustainable structure at my own institution and with stakeholders to support sign off placements in a community setting”.*

A sustainable structure would be a structure that would run without my intervention and be sustained even if I changed roles within the organisation. The participatory and collective nature of the endeavour meant that the title of the final project emphasised the implications for all stakeholders.

Stringer (2007) also highlights the “cultural style” of action research and his philosophical approach to research emphasising that the research process should be one that builds capacity in the participants:

*“It links groups that potentially are in conflict so that they may attain viable, sustainable, and effective solutions to problems that affect their work or community lives through dialogue and negotiation (Stringer 2007: 21).*

Community based action research as advocated by Stinger (2007) is part of an emancipatory tradition within action research (Reason and Bradbury 2005) which emphasises the importance of the relationship of the researcher to the participants. Robinson et al (2012) state that the whole area of community placements is associated with some conflict and tension between stakeholders and therefore a research approach which both explicitly acknowledged conflict, and which also actively sought solutions seemed particularly pertinent.

Within the community of practice, I would openly state my position that solutions to complex problems are best derived from people with a combination of knowledge and experience of that problem. However emancipatory approaches in

action research need to be embedded in practical actions which address power differentials (Reason and Bradbury 2005; Stringer 2007) and therefore, for example, I ensured that all interviews of participants were conducted at their preferred location rather than in my workplace.

### 3.3 The research process and action research cycles

Stringer (2007) refers to a methodical process of inquiry in action research which he expresses succinctly as “Look, think, act”. He argues that this simple routine enables people to commence their enquiries in a straightforward manner and build in greater detail as the complexity increases. This routine is set out in table 4.

Look	<ul style="list-style-type: none"> <li>• Gather relevant information</li> <li>• Build a picture: Describe the situation ( define and describe)</li> </ul>
Think	<ul style="list-style-type: none"> <li>• Explore and analyze: what is happening here?</li> <li>• Interpret and explain: How/why are things as they are? ( Theorize)</li> </ul>
Act	<ul style="list-style-type: none"> <li>• Plan</li> <li>• Implement</li> <li>• Report</li> </ul>

Table 4: A basic action research routine. Reference: Stringer 2007

This “basic routine” is descriptive of what happened in the early stages of the project in that I used opportunities such as meetings with colleagues who linked to community placements, routine meetings with mentors to “build a picture” and to describe the situation. As Coghlan and Brannick (2007) argue it is very important at this stage to be open about your own opinions and to be prepared for disconfirming data and alternative explanations (Coghlan and Brannick 2007:40). In the “think” stage of the basic routine an NHS manager argued that students were not accessing third year placements and this was impacting on their employability in community settings. This crystallised the intervention for the “Act” stage and shaped the subsequent design which emerged.

### 3.4 Data Collection

The project had several sources of data collection including minutes of meetings from within the community of practice, the literature review, interview data with the stakeholders and the learning log. The latter became an important source of factual data in addition to a record of my own understanding and thinking about the project.

Once the decision had been made to place two third year sign off students in different clinics in one London borough and to study this experience from the perspectives of all the relevant stakeholders, this intervention became cycle one of the project. The systematic study of a phenomenon in repeated cycles is a feature of action research which adds rigour to the process (McNiff and Whitehead 2009). At the time that the decision was made about the first two students it was unclear whether other boroughs would also join the project and therefore the flexible emergent nature of research design in qualitative research (Robson 2011) was an important consideration as it would allow the precise details of subsequent cycles to emerge. In the event dissemination of data from cycle 1, and the positive reaction to the planned intervention, meant that two other boroughs adopted the intervention and joined the project. Table 5 outlines the data collection sources from each cycle.

Cycle 1	Sources of data
	<ul style="list-style-type: none"> <li>• Learning log data related to student and mentor preparation</li> </ul>
	<ul style="list-style-type: none"> <li>• Individual semi structured interviews with 2 students</li> <li>• Individual semi structured mentor interview</li> </ul>
	<ul style="list-style-type: none"> <li>• Learning log data related to student and mentor evaluation.</li> </ul>
	<ul style="list-style-type: none"> <li>• Learning log data related to higher education and service reaction to the placements</li> </ul>
Cycle 2	<ul style="list-style-type: none"> <li>• Learning log data related to student and mentor preparation</li> </ul>
	<ul style="list-style-type: none"> <li>• Individual semi structured interviews with 8 students</li> <li>• Individual semi structured interviews with 2 mentors</li> <li>• Individual semi structured interviews with 2 NHS managers</li> </ul>
	<ul style="list-style-type: none"> <li>• Learning log data related to student and mentor evaluation.</li> </ul>
	<ul style="list-style-type: none"> <li>• Learning log data related to higher education and service reaction to the placements</li> </ul>

Table 5: Sources of data for cycle one and cycle two

The interview is listed in the table above as semi-structured in that I devised an “areas of exploration” format which I used for each interview. This format was deliberately very “loose” in that it allowed participants to prioritise what they wanted to say from their perspective. The format entailed asking all the participants to talk about their expectations of the project and their actual experience. As cycle one unfolded it became clear that both participants were intending to apply for a staff post in a community setting. In keeping with the emergent nature of qualitative design in real life settings (Robson 2011) a third area was added to the interview which was “employment/employability”. The same areas of exploration were used with all participants in order to capture the different perspectives. Conducting interviews across the range of stakeholders allowed for triangulation of data (Denzin and Lincoln 2000) whereby I could compare the data from the different stakeholders and to see whether similar or distinct themes emerged.

McNiff and Whitehead ( 2009) place great emphasis on writing action research reports as the project goes along and not waiting for a final “writing up stage” arguing that the iterative process of writing different versions facilitates the learning that emerges from the project. During cycle two I was required, in my work role ,to report back to the curriculum development sub group which was reviewing practice placements for the new curriculum due to commence in September 2011. The experience of drafting this report highlighted that in addition to the two cycles with the students that I had been gathering data on processes in the university setting throughout the period and I came to characterise this process as the “long thin” cycle 3.

Cycle 3	Sources of data
	<ul style="list-style-type: none"> <li>• Learning log data across the whole time period of the project.</li> <li>• Individual semi-structured interviews with Higher Education colleagues with responsibility for practice based learning.</li> <li>• Reports written for the curriculum development team meetings</li> <li>• Reports to the framework management team for pre-registration nursing</li> </ul>

Table 6: Sources of data for cycle three

In summary data collection was obtained from two iterative cycles in the practice area over a two year period with the learning from cycle one influencing cycle 2. In



addition a third cycle was undertaken over a slightly longer period which explored the intervention and the wider infrastructure of placement support needed to support the intervention.

### *3.5 The research process: Data analysis*

There were several data sources for this project. One source was interview data from stakeholder participants. Other sources included minutes of meeting within the community of practice and my learning log which contained field notes from meetings with mentors and my own personal reflections on the project as a whole.

Following the first cycle I had two in-depth interviews from the students, an in-depth interview from a mentor and entries in my learning log from 2009 to 2010 to analyse. Following the second cycle, I had eight student interviews, four mentor interviews, and two manager interviews involved in placements and entries in my learning log from 2010 to 2012.

The method employed for analysing the large amount of interview and other data was what Robson (2011) calls thematic coding analysis which he describes as a generic approach to the analysis of qualitative data. Although it is possible to use a range of computer software to analyse data (Creswell 2014), I had no training in this area, whereas I had experience of manually conducting thematic analysis from my master's education and in research working groups for the studies previously submitted for accreditation for this doctorate. The terminology used in thematic analysis does vary and sometimes instead of "code" terms such as incidents, segments, units, data bits or chunks are used (Bernard and Ryan 1998). This approach to data analysis has also been described as the constant comparative technique (Fram 2013) and can be used in conjunction with a variety of qualitative research data. However the terminology "constant comparative technique is usually associated with the methodology of grounded theory developed by sociologists Glaser and Strauss in 1965 (cited in Robson 2011) whose focus was on deriving theory from immersion in the data. My own approach was more exploratory and my aim was to gain insight into the participant's perspective and therefore the

more generic term “thematic coding analysis” (Robson 2007) seems more appropriate.

Robson (2011) has set out a number of phases for coding analysis and the table below sets out as an example how this approach was followed in relation to the interviews. See Appendix 7 for an example page of analysed data.

	Phases of thematic coding analysis (based on Robson 2007: 476)	Phases of thematic coding analysis in this project
1.	Familiarising yourself with the data. <i>Transcribing data, reading and reading, noting down initial data</i>	Personally transcribed all interviews verbatim, read and reread. Made notes in learning log during transcription
2.	Generating initial codes. <i>May be done by first devising a framework or inductively by interaction with the data. Extracts from the data are given codes in a systematic fashion across the entire data set, with similar extracting being given the same code.</i>	All interviews were coded following this approach using an inductive approach. In this project I initially worked on students interviews as a batch of data, then moved to mentor interviews, manager interviews and HEI staff. Once analysis on individual batches were completed, I looked for commonalities and points of disagreement across the participants
3.	Identifying themes. <i>Collating codes into potential themes, gathering all data relevant to each potential theme. Checking if the themes work in relation to the coded extracts and the entire data set. Revising the initial codes and/or themes if necessary.</i>	This process was conducted in several stages. I initially ascribed themes based on the code. These were then shared with a critical friend who also read the data and the themes were condensed. Finally the themes were shared with the participants.
4.	Constructing thematic networks. <i>Developing a thematic “map” of the analysis</i>	This stage was attempted but not fully developed as it seemed more productive to contrast the learning from the data to the project objectives.

5.	Integration and interpretation. <i>Making comparisons between different aspects of the data using display techniques such as tables and networks. Exploring, describing, summarizing and interpreting the patterns.</i>	This was undertaken but with little emphasis on tables and networks. The final report used multiple quotes from stakeholders as this seemed to be the most effective way to illustrate the themes.
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Table 7: Phases of thematic coding analysis (based on Robson 2007:476)

In keeping with the community based action research approach (Stringer 2007) the final stage 5 above was conducted in a collaborative way with discussion of the emerging findings in a range of fora where participants of the community of interest were present.

### 3.6 Ensuring rigour and trustworthiness

Qualitative validity means that the researcher checks for the accuracy of findings by employing certain procedures and is based on determining whether the findings are accurate from the standpoint of the researcher, the participant, or the readers of the account (Creswell 2014, Silverman 2013). In qualitative research a variety of terms have been used to address validity such as trustworthiness (Lincoln and Guba 1985 cited in Silverman 2013), authenticity and credibility (Creswell 2014). A variety of procedures were incorporated into this project to ensure trustworthiness as the use of more than one strategy has been recommended to increase the rigour (Creswell 2014).

The first strategy was the use of triangulation, namely the use of different data sources to build a coherent justification for the themes (Robson 2011). Data sources included interview data, a learning log and minutes of meetings. Interview data was sought from students, mentors, managers and higher education representatives. A further strategy was the use of what has been described as “member checking” to determine the accuracy of findings and this involves sharing findings with participants and seeking their opinions on accuracy. As Creswell (2014) has pointed out this does not mean taking back raw transcripts to check for accuracy, rather the

researcher takes back major findings or themes and provides an opportunity for participants to comment. I was fortunate that I had several forums where I could do this as part of routine work such as the meetings of fellow link lecturers and curriculum planning meetings with mentors and fellow educators. However I also set up specific events to focus specifically on the research findings (see appendix 6).

Another important strategy advocated by Creswell (2014) is to use the report to clarify the bias the researcher brings to the study. In the introduction to this report I set out my involvement in the networks relevant to the study and have further explained my position as insider researcher in this chapter. An intriguing aspect of trustworthiness is that prolonged time in the field is advocated as a way of ensuring trustworthiness (Reason and Bradbury 2001, Creswell 2014) but this immersion can also negatively affect objectivity. I therefore used the strategy of “peer debriefing” (Creswell 2014), which is also sometimes called a “critical friend”, which involves locating a person who reviews and asks questions about the study to ensure that the account will resonate with people other than the researcher. As Creswell (2014) argues the strategy of involving an interpretation beyond the researcher and invested in another person, adds validity to the account. I was fortunate that I had a close working relationship with a fellow educator who was also a community nurse but whom, for reasons of disability, was no longer working as a link lecturer to community clinics. She therefore had the appropriate knowledge base, relevant recent experience but some detachment from the immediate situation.

A final strategy to increase validity that is recommended is to use the final report to present negative or discrepant information that runs counter to the themes emerging from the data. McNiff (2009) and Creswell (2014) point out that by presenting contradictory evidence or surprising omissions from the data that this makes the account more realistic and therefore more trustworthy. The use of a learning log where I would often speculate about problems or express fears about the project became an important device in the project, as I examined those anticipated problems/fears in the light of the actual data, and this procedure allowed me to observe unexpected patterns.

### *3.7 Generalisation*

In action research the term generalisation is often replaced by the term “transferability” (Herr and Anderson 2005) and it is argued that the person wishing to transfer the knowledge to their own context needs to make the judgement on “transferability” rather than the original investigator. An important aspect of the “transferability” is the amount of detail in the final report about the project activity which is required to allow someone to make the transfer to a new context. The next chapter will provide detailed descriptions of the project activity to allow those judgments to be made. In the case of this study sufficient written detail about the process of preparing the students and placement areas were lodged with the university to lead to other areas which had not had “sign off” students to replicate the process (see appendix 8 for a published example of how the process was replicated).

### *3.8 The research process: gaining access and ethics committee approval*

As outlined in chapter 1, I was well connected to my community practice via the various roles that I undertook in my day to day work and this meant that the “look” stage of the project appeared initially to progress seamlessly as part of my daily work. However it became essential to formalise the data gathering and to make the research process more explicit to the stakeholders. This took two forms: briefing of all stakeholders and then a formal application to the university ethics committee. The first stage involved discussing the potential project and its objectives within the community of practice and alerting all parties that as data would be shared more widely and for research purposes it would be essential to seek the formal consent of participants to share that information. The process for this stage involved presentations as part of regular and existing meetings between the university and services or regular meetings of the community link lecturers. The project became a standing item at these meetings with a requirement for report back on progress and discussion. In retrospect it would have been very helpful to have established a formal steering group which would have guided the project rather than being a

standing item on several agendas which meant that participant information whilst very forthcoming was over reliant for dissemination on my role as a facilitator.

My own institution was required to provide regular evaluation reports to NHS London about learning in practice and theory and therefore this project came under the heading of evaluation of learning in practice. There was a requirement to report on this via the Framework Management Team for the Pre-Registration Nursing Team. Our NHS partners viewed this project as part of the routine evaluation and therefore access to mentors and managers was not problematic. However as would be compliant with research governance requirements members of the partnership board advised that if I wanted to disseminate the views of individuals I would need to obtain their individual consent.

I therefore made an application to the University ethics committee and produced the requisite participant information sheet and consent form (see appendix 3). As can be seen I highlighted that I would be interviewing students, NHS staff and university staff. In writing this report I have been able to give students and mentors fictitious names and I have carefully selected quotes which do not have locality identifying data and therefore to an external reader, it would not be possible to pinpoint the student or the mentor or the employing organisation. However I have interviewed two senior NHS managers and two senior university staff who may be more easily identifiable and whilst I have anonymised their quotes as with other participants, I was therefore very open about this possibility in my interview preamble.

### *3.9 Early ethical considerations*

The ethical principle of non-maleficence, of doing no harm (Benjamin and Curtis 2010) became an important consideration early in the project as discussion with colleagues in the higher education institution contrasted my personal enthusiasm for placing the finalist students in the community setting with their caution about changing the current practice which was to place finalist students in ward setting

only. Clearly if harm did result the project would be adversely affecting students at a critical point in their programme.

Before the placements commenced I therefore discussed this aspect with the Head of Practice Based learning for my own institution to ensure safeguards were in place. She was anxious that it could disadvantage students in terms of skill acquisition and she felt that we had to consider the implications if the students undertook this placement but then decided they wanted to work in an inpatient setting on qualification. We therefore devised a selection process for students which would directly address these considerations by a process of information giving which would highlight the community opportunity but which would also alert the student to possible disadvantages in an explicit way and offer strategies for completion of particular technical skills in their penultimate placement.

In terms of mentors, I also had to consider that the offer of the two placement opportunities for the pilot had come from a manager rather than a work based mentor. Therefore in the same way that we selected students I felt that we had to ask for volunteers who wanted to undertake the sign off mentorship role. This was also relevant to the emancipatory approach as outlined in Table 3.1 above (Hart and Bond 1995) which emphasises the importance of enhancing the control of research participants and the importance of negotiation.

### *3.10 Conclusion*

This chapter has explored the definition of action research that I adopted for this project and my rationale for choosing a participatory community based action research approach. The methods of data collection and analysis have been explained and the measures for ensuring rigour and trustworthiness - use of triangulation, member checking and peer debriefing – have been introduced. The next chapter will describe how these processes were applied in the project activity.

## Chapter 4 Project Activity

### *4.0 Introduction*

This chapter will use the phases of action research as outlined by Coghlan and Brannick (2005) to describe the project activity: Diagnosing, Planning action, Taking Action, Evaluating the Action and preparing the next phase. In this project two full cycles were undertaken whilst the students were in practice and each will be detailed in turn. The two cycles in clinical practice were underpinned by a longer third cycle in the university setting which preceded them and continued after them. This third cycle might be described as a “long thin loop” and this third aspect involved following the same cyclical stages in the university setting and describes the work involved in embedding the project to ensure that it became integrated into the mainstream of student placements.

This chapter will also set out how the following objectives set out in Chapter 1 were integrated into the project activity:

1. Design and implement a sustainable structure at my own institution and with stakeholders to support sign off placements in a community setting.
2. Evaluate the process and the student placement experience and identify the implications for students, provider organisations and Higher Education Institutions and utilise this information to inform the process of curriculum development for the new graduate programme of September 2011.
3. Critically review the emerging literature on the sign off period to identify important issues for the partners in the process, the planned curriculum development and the employability of student nurses in the community setting.
4. Disseminate the learning from Objectives 1-3 and contribute this learning to the understanding of the factors that impact on employability of student nurses in community settings , the process of curriculum



development and the development of “sign off “ placements in other new areas .

#### *4.1 Diagnosing*

It is not easy to identify when the diagnosing phase commenced. Throughout my time as a lecturer I experienced what could be described as a general anxiety about community placements (or rather the lack of them). In my recognition and accreditation of prior learning claim I reported on two projects where I had worked with a researcher in an NHS trust looking at different aspects of community placements (Camden Primary Care Trust and Islington Primary Care Trust 2000, 2003). However as outlined in Chapter 1, towards the end of the academic year 08/09 in discussion with the Head of Practice Based Learning in my institution, we were again revisiting the question of community placements for students undertaking the adult pathway and I said that exploring “different ways of gaining experience in community nursing could be the focus of my final DProf project.”

Once the conscious decision had been made to undertake the project I realised that I had a range of data sources which could inform the diagnostic stage of the project and these included students’ evaluations and the regular discussions of the community link lecturers. At the time I chaired the regular meeting of community link lecturers and therefore it seemed appropriate to review the minutes of that body.

The student evaluations did not yield significant data in relation to shortage of placements as the students accepted that their short four week placement as what was “on offer”. Student evaluations demonstrated that generally students valued the learning from the placements and found them enjoyable. As educationalists we were therefore succeeding in not allowing the considerable anxiety that we were experiencing in finding placements to impact on students. This “hinterland” of student placements, as described by Robinson et al (2012) was successfully being managed.

As I had acted as the main university contact with one Trust and also worked as a link lecturer with their mentors, it seemed appropriate that my first attempt to seek a collaborative approach to the problem would involve an approach to that trust. Therefore in September 2009, I attended a meeting with the manager of their practice development unit along with the Head of Practice Learning of my own institution. In approaching that meeting our aim was to review different ways to develop the capacity of community placements in her organisation. We approached the meeting in a spirit of collaboration. In the event it proved to be both a “difficult meeting” and a meeting which focussed the project in an unexpected way.

As outlined in chapter 1 the manager had a very clear view that she did not want any further second year students which was the usual point in the three year programme when students were placed in her Trust. She requested that we stop the placements in the second year and send her some third year students for a longer period. This proposal would have destabilised the university’s placement plans which have to be confirmed at least some months ahead. The outcome of this rather uncomfortable meeting was that she agreed to accept two students on their final placement of their programme, that is for a 12 week period and that this would be *in addition* to the existing allocation of students. These two students and their sign off mentors in effect became Cycle 1 of my project and locally these placements became known as the “community sign off pilot”.

This was a crucial meeting as, at that stage, I had not decided on an action research methodology although I had been in what Coghlan and Brannick (2010) now describes as the “constructing” phase of the action research cycle. Now an important stakeholder had redefined the problem from one of too few places overall, to one of too few places at the curriculum point which mattered for employers and for student employability. Moreover the meeting had generated a specific intervention which would firstly increase placement units and secondly, in the employer’s opinion, increase the employability of our students. After some discussion with my colleagues I decided that we would “run” with this specific

intervention, which I would use an action research approach, and we would evaluate this specific intervention from the perspective of the HEI, the students and the NHS Trusts. This decision making process really demonstrated that this project was open to responding to ideas from any of the participants in the community of practice and adhered to Stringer's (2007) tenet that community based action research works on the assumption that those affected by the problem should be engaged in the process of investigation (Stringer 2007: 11).

Although access had been given to the area where the pilot was being conducted, it would be necessary to obtain consent from participants if I wanted to use their views as part of the research data. An application to the ethics committee had been submitted in July 2009 with a more open-ended title of "An exploration of primary and community care placements in the pre-registration nursing programme". I therefore approached the university ethics committee to explain about the refocusing of the project and completed a revised application form which included a participant information sheet and consent form (see Appendix 3).

Another important aspect of the project activity at this stage was the difficulty experienced at the time undertaking a literature search as outlined in objective 3. Apart from the NMC Standards (2006) and the subsequent edition with minor amendments (NMC 2008) there was little written information about preparing sign off mentors. Furthermore I was surprised to find at that point that only one recent study (Middleton and Duffy 2009) which discussed the placement of students in the community immediately prior to registration. However this was an important study as it gave some insight into the concerns of mentors about the responsibility of supervising students at this point in the curriculum and this informed my plans for preparation of mentors. This difficulty was reported back to the community of practice and there was a strong feeling that cycle 1 of the pilot should go ahead and a decision was then taken to continue to monitor the literature and to incorporate the learning *after* the project activity. The emerging literature on the "sign off" concept now sits in Chapter 5 following the project activity chapter as this was where it occurred chronologically.

However in attempting to undertake the literature review I uncovered other relevant material about how the number of District Nursing posts had been reduced in recent years and this led me to consider the pressures on those holding the qualification and how this might impact on their ability to mentor students. As so much of action research relies on building relationships with participants, sensitivity to the pressures experienced by practitioners is a core skill for action researchers (Wallis 1998). This became an important topic for discussion within the community of practice and this led to a request for me to review the wider historical background relevant to community placements. This material has already been presented in Chapter 2 on the historical context.

#### *4.2 Planning action*

As outlined in Chapter 2 placing students in their final 12 weeks prior to qualification entailed preparing mentors for the role of sign off mentor as specified by the professional body. Prior to this point there were no plans for preparation of District Nursing sign off mentors as our institution had decided that all final placements would be in hospital wards. Together with the employer a process was agreed for this which entailed identifying two potential mentors and then with the help of clinical practice facilitator employed by the trust we arranged the requisite three preparatory sessions. One of these took place before the student arrived; two were undertaken as the placement progressed.

The other major activity was devising a university process to select two students to undertake the placements. From the university perspective there was some anxiety about this as there was concern that a student undertaking such a placement could be disadvantaged as they may not be able to achieve certain skills in the community setting. Also if they decided after undertaking the experience they wanted to apply for an inpatient post, would the fact that they had done their final placement in the community “count against them”? There was also concern that either no student would come forward or alternatively too many would come forward and how would

we decide who would have the opportunity? At this stage it seemed that the process could present a number of ethical dilemmas.

My preliminary work reading recent reports and student evaluations was useful in that this process gave me great confidence that we would face more interest than we had places and not the problem of lack of interest. It was therefore essential to devise a process which would could discriminate but also be fair. The evaluation stage of action research would allow me to review this process and make adjustments but it was essential from the outset to have a transparent process.

We therefore developed a two-step process for applying for a community placement.

#### *First step*

An open email invitation was sent to the whole cohort explaining the limited opportunity and requesting that students responded to the email by a certain date giving reasons why they wanted to take up this opportunity. The email also advised them that they would need to complete certain skills assessments (for example, blood transfusion skill, which is not an opportunity currently available in the home setting) before their final 12 week placement.

#### *Second Step*

If the number interested exceeded the places available we would interview those who had produced a good case for why they wanted to take up the opportunity.

In the event the email elicited a significant response and we therefore reviewed the letters of application. Some gave minimal information or simply said they wanted the opportunity but without responding to the request to specify why. However even after this review stage we were left with 8 applications for 2 places. We therefore conducted an internal interview and chose the two who performed best at interview. As many of the other applicants expressed a wish to work in the

community setting on completion of the programme we offered them all the opportunity of meeting with me on a one to one basis if they wanted to apply for a post in that setting. Our moral reasoning for this was that the student had made a concerted effort to improve their chances of success and the rationing of the opportunity meant we could not offer all candidates but the provision of timely advice may help the application.

As the planning stage unfolded it became easier to see how the objectives would gradually be achieved as set out below in Table 8:

Date	Activity	Data Collection	Contribution to the objective
July 2009-September 2009	Attempted literature review on the “sign off mentor” role and employability of student nurses in the community setting. <i>(in the event the lack of literature at this stage extended this process across the whole timeline of the project)</i> Review of relevant policy documents to provide data for a historical context chapter.	Use of relevant databases Professional body documents	Objective 3
July 2009	Application to university ethics committee ( amended Sept 2009)		
July 2009- November 2009	Selection and preparation of students and community mentors	Learning log detailing processes and researcher insights	Contributing to Objective 1 and 2
November 2009- March 2010	Cycle 1: 12 week placement undertaken by Students A and B	Learning Log Interviews with both students recorded and transcribed	Contributing to Objective 1 and 2
March 2010	Conclusion of Cycle 1 : Meetings with both mentors	Meetings with both mentors recorded in learning log	Contributing to Objective 1 and 2

Table 8: timeline for cycle 1

### 4.3 Ethical Issues

In the planning stage a number of ethical concerns had been articulated. For example:

- Would the students be able to complete all their assessment requirements in the community?
- What if the students chose to work in the hospital on completion? Would undertaking a final placement in the community disadvantage them?
- Would offering this placement lead to excessive work or stress for the practitioners?

On the one hand these concerns could be counterpoised to the view that had emerged at the diagnosing stage namely that *currently* students were being disadvantaged in both obtaining and maintaining a community post by lack of experience at a crucial stage . However I felt it was very important to address the concerns raised and build safeguards into the infrastructure to ensure that students would not be disadvantaged. The preparation stage therefore allowed all the issues listed in the bullet points above to be addressed and we worked to mitigate these concerns for the chosen students by designing work plans which allowed them to be prepared. For the practitioners if concern about workload and stress emerged I would seek to address them as the project unfolded and they would also be addressed in the evaluation.

In addition to these wider ethical concerns, I also had to address the question of research ethics in order to gain the consent of students, practitioners and managers for their contributions to the project to be shared and disseminated.

As mentioned above, I had made an application to the University Ethics Committee of the School of Health and Social Science. The application was considered by the ethics committee and approval to proceed was given in October 2009 (see appendix 2) after I had submitted a Participant Information Sheet and Consent Form (see appendix 3).

#### *4.4 Taking Action: cycle 1*

Once the students had been selected we gave specific preparation to the two students to address the two issues which had been raised as concerns by the university, namely that they might have difficulties achieving all their skills assessment and secondly that they may be disadvantaged if they chose on completion to apply for posts back in the hospital setting. In order to address these ethical concerns both students had an opportunity to review their programme and to make a plan to achieve all the skills which could not be achieved in a community setting. Although both were among those students who had expressed a wish to seek employment in a community setting we explored with them the possibility that they might change their minds and then we gave them a hypothetical interview question which was “what can you bring from what you have learnt in the community to this post?” At this stage of course, the students had not undertaken the placement but we wanted to see if they had any ideas of how to answer such a question and we wanted to “prime” them for the experience.

The students were placed in two clinics – one in the south of the borough and one in the west. The placement period coincided with one of the most severe winters in the past ten years with a significant snowfall and freezing temperatures. Fortunately for the student and the research process, both were able to attend and complete the placement successfully.

As with the students, there was a preparatory phase with the mentors which entailed explaining the NMC expectations of their role (See Table 1 in Chapter 1).

The student and mentor interview format was semi structured and followed a consistent pattern with three elements- participants were asked about their expectations prior to the placement, their actual experience of the placement and finally about their future employment plans.



#### 4.5 Evaluation phase

I transcribed the interviews and analysed them, looking for themes and differences using the phases of thematic coding analysis format (Robson 2007) as set out earlier in Table 7 in the methodology chapter. I also looked at my learning log for the same time period and finally met with a critical reader to explore the emerging themes.

Date	Activity	Data Examined	Objective
March 10-May 10	Transcribing and analysis of interviews from cycle 1. Reading of learning log and integration of insights with data from interviews	Interviews Learning log	Objectives 1 and 2

Table 9: Evaluation phase in Cycle 1

#### 4.6 Dissemination of findings in Cycle 1

This was done locally via existing structures with a verbal report to the quarterly review meetings in the borough where the two students were placed and to the other two boroughs where my institution places students. Internally there was a major meeting in June 2010 of all the community link lecturers and mentors from all boroughs about the new curriculum for Sept 2011 which proved a major opportunity for reporting on findings.

In Sept 2010 together with the clinical practice facilitator from the Trust involved in cycle 1, I had planned to give a presentation about our findings to date at the Networking for Education in Healthcare (NET) conference at Darwin College, Cambridge. The abstract is included in appendix 4. However before the date of the presentation the clinical facilitator had moved to a new post. I could have continued alone but I was very disappointed not to be able to demonstrate and role model the collaborative and participatory aspect of the project. I therefore contacted one of

the students from Cycle 1 who by that stage had been offered employment and fortunately she was able to join me in giving the presentation.

The combination of local and national dissemination from this first cycle meant that I had already made some progress against Objective 4 which focussed on disseminating the learning from Objectives 1-3.

#### *4.7 Cycle 2*

##### Planning Action

As a consequence of the dissemination phase of cycle 1, I found that my mentor participants for cycle 2 were identified by NHS partners. Firstly there was interest in cycle 2 from the original borough as they had employed both participants from cycle 1 and they offered 4 sign off placements for cycle 2. In addition two further London boroughs offered 2 placements each, with the result that the placement opportunities rose from 2 to 8. Stringer (2007: 133) argues that community based action research, if truly adhering to participatory principles, should be able to demonstrate productive working relationships. This was clearly evident at this stage of the process as there was genuine enthusiasm to be involved and therefore not requirement for me to actively recruit participation.

Students were identified using the process outlined in cycle1 and in this cycle, the number of students who met the criteria matched the placements available. In cycle 1 the preparation of mentors had been part of my work as the link lecturer for that area but in cycle 2 this was not the case. However for consistency and as a way of managing the research data I undertook the preparation of the sign off mentors in all three boroughs. As with cycle 1, I kept a learning log of the process of preparation of students and mentors.

#### 4.8 Taking action in cycle 2: November 2010 to March 2011

The format of the student placement was as in cycle 1 and again took place during wintry weather but with slightly less extreme weather than the previous year. All students successfully completed the placement.

The semi structured interviews followed the same format as cycle 1 and in addition to the 8 student interviews; there were 2 mentor interviews and notes taken from routine de-briefing discussions with mentors and 2 interviews with NHS managers. Although the placement period was November 2010 to March 2011, the totality of cycle 2 stretched from July 2010 to July 2011. One additional interview which had been originally scheduled for the summer of 2011, eventually took place in March 2012.

Date	Activity	Data Collection	Objective
July 2010- November 2010	Selection and preparation of students and mentors	Learning log detailing processes and researcher's insights	Objective 1 and 2
Nov 2010 to Feb 2011	12 week placement undertaken by 8 students	Learning Log including record of any communication relating to the placements	Objective 1 and 2
December 2010 to March 2011	Interviews with 8 Students Interviews with 2 mentors	Interview transcripts Learning Log Notes from debriefing meetings with mentors	Objective 1 and 2
May 2011	Validation of the new BSc Curriculum	Learning Log	Objective 1 and 2
July 2011	Interview with NHS Manager	Interview transcript	Objective 1 and 2
March 2012	Interview with NHS Manager	Interview transcript	Objective 1 and 2

Table 10 Timeline for Cycle 2

#### 4.9 Evaluation Phase

This included analysis of data collected and monitoring what happened in terms of employment of students. It also involved reviewing and embedding processes to ensure that the project was fully integrated as mainstream activity. This entailed formalising the process of student selection and discussing a cascade system for preparing future mentors.

The data analysis followed a similar process to cycle 1 with interviews being transcribed verbatim and being re and re-read for themes and following the phases of thematic coding analysis based on Robson (2011) set out in Chapter 3 (Table 7). These themes were then reviewed with reference to the learning log for points of agreement or difference.

In this cycle the processes that had been put in place to ensure rigour and trustworthiness of the data (see section 3.7) were even more important due to the increasing complexity and volume of the data. In this cycle there was triangulation of data across a wider range of stakeholders (students, mentors, manager and HEI Staff) and therefore the process of peer debriefing took two forms: reporting back to student groups and also report backs to practitioners and managers as regular agenda items in existing meetings related to placement. It was useful that there were pre-planned regular meetings between practitioners and the university in relation to the validation of the curriculum occurring in the first two months following the conclusion of cycle 2. The role of my “peer debriefer” (see section 3.7) in assisting with reading and re-reading transcripts and discussing the emerging themes was helpful in gaining another perspective.

#### *4.10 Dissemination of findings in Cycle 2*

This occurred on a number of levels and initially focussed on internal communication within the university. However the fact that both of the students who had undertaken the placements in Cycle 1 and most of the students in Cycle 2 had applied and been successful in gaining a post in a community setting was clearly communicated to the commissioners of our educational programme – the London Strategic Health Authority- and contributed to our positive quality ratings with the authority.

As Cycle 2 progressed academic staff and clinical partners and students were all involved in developing a new curriculum for nurses which was validated in May 2011 and the first cohort commenced in Sept 2011. A major part of this development, and one which was scrutinised by the professional body as part of the

validation process was that there were sufficient places available for students to learn in a variety of settings.

Towards the end of 2011 all London Higher Education institutions had to tender for their contracts for adult nursing. The tender process was intense and competitive and had to be supported by evidence, including evidence of innovation and employability of students. A report that I had prepared for the Framework Management Team on the project became part of the evidence submitted to the strategic health authority to support the tender (Appendix 5). Early in 2012 we learnt that our tender was one of those which had been accepted.

Dissemination was also occurring via the existing structures of the Quarterly Review meetings and in autumn 2011 I was asked to design a new pilot for an inpatient service run by the community trust who had participated in Cycle 1 and 2. This resulted in neuro-rehabilitation unit which had never previously accepted a sign off student offering a placement in conjunction with specialist community services. In this instance the student spends 10 of the 12 weeks in the rehabilitation unit and two weeks with specialist nurses visiting patients in their own homes.

In many ways the dissemination phase proved to have a momentum of its own as I found that colleagues were disseminating my work for me. For example in January 2012 there was a renewed emphasis from central government on recruitment of health visitors and a letter was sent to all child health student nurses who qualified in 2010 and 2011 asking them to consider training for the community role as health visitor (NHS careers service 2013). The university was fortunate in obtaining some additional funding from the strategic authority to spend on placement development. One of the projects involved exploring what would be involved in placing child health students in community settings for the sign off period to reflect the Department of Health initiative to expand health visiting numbers by recruiting newly qualified students (Brown 2012). I was immediately involved in briefing the project worker for this child health initiative. She accessed my report to the Framework Management Team which included the preparation timeline (Appendix 5).

The intensity of in-house curriculum development, validation and implementation of the new curriculum and the subsequent workload associated with the tender had a negative impact on external dissemination. However in May 2012 I was able to host a professional forum at the university with invitations to all the participants and their organisations to formally report back (Appendix 6). In terms of the research process this was an important aspect of authentication of my data (Mc Niff and Whitehead 2010) and was an opportunity for “member checking” (Robson 2011) with all stakeholders including students in the same setting.

#### *4.11 Cycle 3*

Early in 2012 I felt that most of the planned objectives were achieved. The delayed literature review was making some progress, student, mentor and manager experience had been evaluated and there were important outcomes in terms of contribution to curriculum development and the tender for pre-registration nursing. In addition I was now in demand within my own organisation to assist others in preparing placement areas for accepting sign off students (Objective 4). However I felt that in some ways objective 1, namely

*“Design and implement a sustainable structure at my own institution and with stakeholders, to support “sign off” placements in a community setting.”*

was not as complete as I would like and I felt it was timely to refocus internally. I therefore conducted two interviews with key stakeholders in the university practice based learning department- the placement manager (a university administration role) and the Head of Practice Based Learning (the key educational lead).

In discussion with my supervisor I realised that I had devised a third cycle in addition to the two cycles in clinical practice. In effect there had been a “long thin cycle” internal to my own organisation in the educational arena which stretched from the 2009 to 2012.

This cycle could best be illustrated by a chart with some items stretching over long periods interspersed by key dates in the organisation’s calendar.

Date	Activity	Data collection	Objective
July 09- July 12	Planning and implementing processes for students undertaking sign off placements in “non-traditional” areas	Interview data Learning Log	Objective 1 and 2
May 2011	BSc curriculum Validation event	Learning Log	
Autumn 2011	Submission of project report to Framework Management Team	Based on the item above + becomes data in its own right	
Feb 2012	Interviews with 2 managers in the university placement unit	Interview data Learning Log	

Table 11: Timeline for cycle 3

#### 4.12 Conclusion

As set out in the application to the ethics committee (appendix 1) the project timeline in total was meant to run from the autumn of 2009 until the summer of 2012. Although all the data was gathered within the time period, the process of dissemination and report writing has been more prolonged. As will be seen in the next chapter, the process of project implementation led to interest in replicating the activity in other areas such as child health. As an insider researcher I inevitably became drawn into that activity which was in effect another cycle. It became increasingly difficult to define the end point of the project but eventually in summer of 2013 the final iteration of the project report was concluded.

## Chapter 5 – A critical review of the emerging literature on the sign off mentor

### 5.0 Introduction

An objective of the project, agreed with stakeholders, was to “Critically review the emerging literature on the sign off period to identify important issues for the partners in the process, the planned curriculum development and the employability of student nurses in the community setting.” A three month period was specifically set aside in the project plan to conduct this review prior to the beginning of the first cycle of the project activity between July and September 2009.

### 5.1 The Search

The questions informing the literature review are outlined in Box 1 below

Sign off mentor

What are the origins and definition of the topic?

What are the major issues and debates about this topic?

What are the main questions and problems addressed to date?

What do we know about this topic specifically in the community setting?

#### Box 1: Literature review questions

The databases used for the search were the Cumulative Index for Nursing and Allied Health (CINAHL), the British Nursing Index (BNI) and NHS evidence. Keywords used in the search were Mentorship and NMC Standards. Free text searching was also used for the terms “sign off” “sign off mentor” , “sign off student” as this method of searching allows the database to search for exactly the word or phrase entered. Although the phrase “sign off mentor” is now entering the nursing language, it is not a phrase that has meaning beyond the UK and in writing about the topic nursing authors wanting to reach an international audience could therefore have used alternate phrases such as “finalist student”, “third year student”, “immediately prior to qualification” and “at the point of registration”. These alternate phrases were therefore included in the search process.



## *5.2 Inclusion and Exclusion criteria*

As the NMC had only introduced the concept of sign off mentor as part of their standards in 2006(NMC 2006), this date was a useful limiter on any searches using that phrase. Similarly the UK nature of the emerging concept meant that it only occurred in UK articles. The community of practice were interested in the experience of other institutions who had placed students with district nurses for their final placement and therefore a search which combined “community placements” and “district nursing “with all the free text terms related to “sign off” or the alternate phrases used for a student immediately prior to registration with a limiter date of 2000. It was decided to exclude articles about community placements in other countries as the community of practice felt that there were differences in service organisation and community roles.

Early searches retrieved a number of articles related to the midwifery profession which also uses the term “sign off mentor” but in that profession, the role is implemented differently with use of the title across the three years of their professional programme. Articles related to midwifery were reviewed for transferability to the nursing context but the differences in implementation of the process, led to exclusion of these articles.

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## *5.3 Difficulties encountered with the progress of the search*

In the event, apart from the original NMC standards introducing the concept and a subsequent revised version of the NMC standards in 2008 (NMC 2008) with minor amendments, the literature search during the planned search period of July- Sept 2009 was unproductive. Locally there was no shortage of discussion about how to prepare sign off mentors and we were aware anecdotally of similar discussions elsewhere in London and nationally but these processes did not “convert” into published articles until 2010 or much later. Stringer (2007) has argued that in action research that the literature can be reviewed in the light of perspectives emerging from the research process thus emphasizing “the primary relevance of the experience and know-how of people in their everyday lives (2007:186).” This critical review of the emerging literature is therefore presented here following the project

activity as this is where it emerged in the chronology of the project. Some of the literature was available in time to inform the curriculum development but other sources only emerged following the validation of the new curriculum in May 2010.

#### *5.4 The literature review*

The literature review generated articles which were mainly of a descriptive and evaluative nature including several articles describing how particular organisations had prepared the sign off mentors in their setting and several articles describing particular projects which entailed placing students in a community setting. Articles relating specifically to the sign off concept are reviewed first.

#### *5.5 The sign off concept-implementation challenges*

Although the sign off mentor concept had been introduced by the NMC in 2006 the first students to be required to have such a mentor would be those commencing their three year programme in Sept 2007 and therefore their sign off placement would commence in 2010. Therefore publications prior to 2010 which raised the question of sign off were written before the implementation.

Andrews et al (2010) were a group of experienced practitioners and academics in the South East of England who wrote a discussion paper in 2009 prior to implementation. They had taken the lead in implementation of the NMC 2006 standards across a wide area including three acute trusts and three primary care trusts. Their paper explored the complexities of maintaining mentor competence in general and one section of the paper was devoted to their objective of discussing the “challenges for sign off mentors, particularly in relation to student underachievement and the inter professional context” (Andrews et al 2010:252).

All the discussion points in the paper arose from the direct experience of the authors and their contact with local mentors rather than primary research. Several of their points had clear resonance with participants in my community of practice. Firstly there was concern that responsibility for final assessment of practice was

increasingly in the domain of the practitioners (and the associated concern that practitioners would be “on their own” and detached from the university). Secondly there was concern in the authors’ locality that the sign off mentor would be seen as a sort of “super mentor”. The other concerns articulated were:

- Difficulty recruiting sufficient sign off mentors and they reported wide variation in their locality. Anecdotally, the reasons being articulated were that mentors did not want to be seen as “gatekeepers” to the profession.
- Difficulty ensuring that the NMC recommended one hour of protected learning time for mentors and sign off students would be achieved and how would it be monitored.
- Difficulty with ensuring consistency between mentors.

No solutions were offered to the first two concerns. In relation to the concern about consistency a suggested solution was that sign off mentors should spend time together to discuss particular decisions, rather like practice assessment panels do for social work students.

Although Andrews et al (2010) was the only published paper retrieved to comprehensively list concerns with the sign off process, the publication of an NMC circular (NMC 05/2010) indicated that there must have been considerable communication between programme and placement providers and the NMC. The circular (NMC 05/2010) specifically reported:

*“Programme and placement providers of both nursing and midwifery programmes have reported difficulties in meeting the NMC criteria for sign-off mentor, specifically the requirement that:*

*‘... a nurse or midwife designated to sign off proficiency for a particular student at the end of a programme must have been supervised on at least three occasions for signing off proficiency by an existing sign-off mentor or practice teacher.’ (NMC*

*Standards to support learning and assessment in practice, section 2.1.3) (NMC 05/2010:2)*

In response to the reported concerns the circular (05/2010) restated that the requirement for a prospective sign-off mentor to be supervised in signing off students on at least three occasions but that only the final supervision had to be with an actual student and that:

*“First and second such supervisions may now be effected using a range of methods. These include activities which would test the skills required to sign off students safely, including: simulation, role play, objective structured clinical examination (OSCE) and interactive use of electronic resources. “(NMC 05/2010: 2)*

These changes were significant for sign off mentors in a community setting as the original requirement would have entailed at least three visits from an existing sign off mentor to a clinic where a new sign off mentor was being prepared. The alternative suggestions from the NMC opened up the possibility of future sign off mentors at least doing their initial preparation in a group setting without the requirement for one to one visits.

The additional options for obtaining sign off mentor criteria were described by Professor Alan Glasper (2010) who at the time was a member of the NMC. Although mainly a restating of the NMC circular (NMC 05/2010) provisions, he also pointed out that:

*“Mentors who achieve sign-off status are the key professionals in deciding if a student is fit to be a registered nurse.” (Glasper 2010:658)*

This type of statement which emphasised the practitioner’s role in the decision rather than the joint working between the higher education institute and the mentors was relevant to the concerns expressed by Andrews et al (2010) about sign off mentors being “gatekeepers” and “super mentors”.

Rooke (2014) is the first study to directly address how sign off mentors view their role. Unlike Andrews et al (2010) it draws on data from those who have experienced the implementation. Rooke (2014) using an evaluation survey design contacted 114 new sign off mentors, 37 newly qualified mentors and 13 nursing and midwifery lecturers to explore what they saw as benefits and challenges of the sign off mentor role. She highlights as a limitation that her response rate from sign off mentors (95%) was much higher than the other two groups. Her initial findings were that all three sets of respondents view the sign off mentor role positively as both helping to protect the public and offering increased support to students. The challenges were described as the varying levels of support offered to sign off mentors and ensuring that the one hour protected time as recommended by the NMC standards (NMC 2008a) was achieved. She also noted that concern about the level of responsibility placed on sign off mentors was highlighted as challenge but this concern was more likely to be expressed by newly qualified mentors rather than the more experienced mentors undertaking the role.

### *5.6 Approaches to sign off mentor preparation*

Several descriptions of sign off mentor preparation were found in the literature. Two of these (Jones et al 2010 , Barker et al 2011) described the preparation of first wave mentors and two further descriptions (Casey and Clark 2012, Durham et al 2012) describe processes which were developed following the publication of the NMC circular (05/2010) which allowed additional options for sign off mentor preparation. All of the preparation methods listed in the papers discussed below involved some opportunity for group discussion amongst potential sign off mentors. The different approaches described did vary in the intensity of input provided and apart from the final paper (Durham et al 2012) the numbers of sign off mentors prepared were not specified and none of the studies described the cost implications of their approach.

Jones et al (2010) describe the process of how they prepared their first wave of sign off mentors in East London across a range of settings and inclusive of nursing and midwifery sign off mentors. The process was led by staff employed in the role of

practice experience facilitators and entailed assisting sign off mentors to produce a mentor portfolio. This process was supported by an area wide study day and supervision from those employed in practice experience roles. In reviewing the process they highlight the benefits as the opportunity to discuss the responsibility and accountability of being a sign off mentor. They also reported challenges including time release for the study day and ensuring management commitment to the sign off mentor role.

Barker et al (2011) describe how one acute NHS foundation Trust implemented and managed the process of sign off mentorship in one large acute NHS Foundation Trust, with contributions from practice education facilitators, a sign off mentor and a student. They describe an initial implementation of the sign off role and the two measures they put in place to facilitate the role: a three hour workshop , an allocated practice educator contact for each sign off mentor and the presence of one of the practice education facilitators at the final interview . They piloted their approach with two cohorts of “return to practice” students and found that the role was embraced by the senior mentors who volunteered to act as sign off mentors. However from January 2010 when they implemented the process with the mentors for the pre-registration students who would be starting their sign off period in June 2010, they met considerable resistance. They heard objections to the new role including concerns that it would be time consuming and would involve too much responsibility.

Barker et al (2011) were also able to monitor the progress of the first cohort to access all sign off opportunities in their trust which was a sizeable cohort of 68 students of which 9 were found to be struggling. The 9 students required additional help from their course leaders and personal tutors after which 7 were successful but 2 students were intercalated, stepped off the programme and needed to repeat their sign off placement on their return.

Casey and Clark (2012) describe a collaborative citywide approach to sign off mentor preparation in Leeds. They were able to build on a longstanding history of

cooperation between two universities to arrange city wide sign off mentor preparation workshops and set up an initial working group of practice learning facilitators from all three local NHS trusts, the teaching teams of both universities, sign off mentors and managers. Their initiative followed the NMC 2010 circular which allowed for two of the preparation sessions for sign off mentors to take the form of a simulation, role play, OSCE or interactive electronic materials. This initial group agreed objectives and smaller working groups produced learning materials for simulation, and produced a case study for use in role play. The materials were initially piloted and then fifteen subsequent sessions were run on a citywide basis.

Durham et al (2012) also provide a detailed description of a pilot training programme they developed in response to the NMC circular which suggested use of different methods of assessment for sign off mentors. There were six participants in the pilot with only five completing. Preparatory workshops were provided and they describe a three stage assessment approach. Their first assessment is based on three case scenarios based on issues with final placement supervision with a related activity to identify what action they would take to remedy the situation and to complete an action plan as they felt appropriate. These were then marked and moderated by the two authors. The second stage involved an objective structured clinical examination with five stations: a quiz, a case scenario, a role play, a professional discussion and a mock practice documentation book. Durham et al (2012)'s approach to both the preparation and assessment of sign off mentors appears to be more thorough and time intensive than in the other approaches described. As the option of substituting an OSCE or simulation for observed practice had not been available at the start of this project, I had travelled to clinic locations and directly observed practice and had considered that to be a time consuming process but one which had been well received by the individual mentors and others within the community of practice. Although the Durham et al (2012) process allows for six sign off mentors to be gathered in one place, the three stage process and related marking and preparation would be time consuming. For community based staff the travel time of six community staff to one centre is also time consuming

whereas I undertook the preparation on days when I would have been visiting those locations to see students and other staff. None of the papers addressing sign off mentor preparation provided any costing data and it indicates the need for a more systematic evaluation of which method is most effective and for which type of practitioners.

### *5.7 A third year experience in the community*

This section of the literature review explores a number of papers which emerged after 2009 which discussed a third year placement in a community setting. There was little direct reference to the sign off concept as they were reporting on studies undertaken in the years immediately prior to its implementation. However, with the exception of one study focussed on second year students, they did involve placement of third year students in a community setting.

Middleton and Duffy (2009) conducted a qualitative study which described the lived experience of the community nurse when mentoring a final placement student. Three focus groups were convened and the experiences of twelve community nurses working within a large city-based community health practice in Scotland who had mentored a student nurse immediately prior to registration were explored. The analysis suggested that the community nurse mentors required support and development opportunities in relation to mentoring and assessing final placements.

This study was an important part of the diagnostic phase of my own study. It had been conducted prior to the NMC requirement for preparation for sign off mentors and its findings confirmed the NMC view that sign off mentors would need practice based preparation. The study highlighted a high degree of anxiety about becoming a mentor for a student on a final practice experience with issues raised about the accountability of the mentor and how the mentor would cope if the student was not progressing satisfactorily. Another theme of the study revolved around how the mentor managed a student who had his or her own mini caseload. Both of these



topics were to form part of the preparation phase for the sign off mentors in my own study.

Baglin and Rugg (2010) conducted a qualitative study of six second year students who undertook a 12 week community placement at the start of their second year of study. This study was conducted with a convenience sample and the data came from contemporaneous reflective diaries completed by the participants to reflect their “lived experience” whilst on placement which were analysed using a content analysis technique. Participants were asked to record data one week before they went to placement, at the end of week one and again at the end of the twelve weeks. Data about the exact nature of their placements was rather scant and this impacted on the transferability ( Herr and Anderson 2005, Stringer 2007) to other settings. For example one student had expected to spend most of her time with the community gynaecology outreach team but apart from three days, her placement was in an outpatients department. No detail was given of the other five places, although it was possible to surmise that at least one was with a district nursing team as one of the diary quotes related to visiting patients in their own homes. Four key themes emerged from the data: nature of community placements, relationships/teamwork, learning opportunities in practice and gaining confidence in practice. In relation to the nature of community placements, the study authors noted that participants expressed both expectations and anxieties and that better preparation and improved support structures could address the anxieties. The second theme focussed predominantly on the importance of the mentor relationship but also highlighted the positive impact of community placements in assisting students to make relationships with patients. Theme three was focussed on the learning opportunities in relation to practical nursing skills with little mention of other types of learning opportunities in the community setting, possibly reflecting the relative junior nature of these students who were only just moving into their second year. The final theme related to confidence and how the opportunity to practice practical skills was highly influential in developing confidence. This led the authors to recommend further work to explore potential influences on and changes in, pre-registration student nurses’ confidence.

In 2010 Arnott reported on a community focussed pre-registration adult nursing degree pathway which had started in Canterbury Christchurch University in 2008. Under this curriculum model the 16 students were managed as a discreet pathway and whilst they fully engaged alongside their peers across six professional pathways, the nursing element of their pathway was taught by a team of community specialist nurses. This option is not one which could be applied locally as we would not have the placement capacity or the teaching staff expertise to offer this type of model. However at a national level the adoption of this type of model at carefully selected universities could potentially be one of the most comprehensive ways of addressing the concerns about lack of preparedness of pre-registration nurses for community work (Ali et al 2011).

In 2011 Shelton and Harrison reported on a project which had commenced in 2008 when Yorkshire and Humber Strategic Health Authority (SHA) involved local providers, local universities and service users in a project which aimed to provide opportunities to third year students interested in careers in the community at the point of registration and employed a project manager for the scheme. They had sufficient placement capacity to offer 20 community based placements for the whole of the final year- in total twenty two weeks of community placement per student. Prior to commencing the project they surveyed the second and third year students and uncovered a significant number of misconceptions about community placements. These included lack of opportunity for students to develop knowledge, skills and proficiencies and competencies in the community. The preparation phase also uncovered what they described as “entrenched views” from students , and qualified staff in both community and hospital setting that spending a final year in the community might disadvantage a student who subsequently want to work in a hospital (Shelton and Harris 2011: 27). All students were self-selected by declaring an interest in the programme and then the programme leader reviewed the applications and selected those who had demonstrated consistent professional attributes and who had met the criteria for progression to the third year. This selection approach resonated with the approach adopted for our study as set out in Chapter 4 section 4.2.

In 2012, Marshal and Shelton reported on the implementation phase of the same initiative from the students' perspective using a mixed method approach. Data was collected using a series of questionnaires and focus groups. They monitored the progress of 31 students who went out in two phases, 11 in phase one and twenty in phase two. Of the total 31 students, 77% (24) completed the year. The reasons the other 23% (7) students withdrew included academic difficulties, not being a car driver and anxiety about skills development during the second placement of the year. No breakdown is given as to how many students opted out of the project for which reason. Of the 24 students who completed the year 14(58%) went on to work in a community setting, 6 (25%) went to work in acute settings whilst four had not secured employment at the data capture point.

The focus group data highlighted three key themes: confidence, placement diversity and knowledge, skills and learning objectives. The majority of students highlighted an increased confidence in professional practice and particularly highlighted undertaking lone autonomous working in their final twelve weeks as contributing to that confidence growth. In practice the need to have access to a car limited the ability of students in some areas to conduct independent visits. In the second theme students highlighted how the placement diversity across the year had led to development of knowledge, and skills. The final theme illustrated how on the one hand students had achieved the expected NMC competencies but also that this had relied on a very proactive approach on the part of the student and that the assessment documentation was hospital orientated. Advantages of community placement were seen as the opportunity to have more access to a mentor on a one to one basis.

Brooks and Rojahn (2011) reported on a framework developed in Leicester to enable adult branch students to undertake delegated care activities independently whilst working with district nurses. Their undergraduate curriculum allows all students to typically undertake 16 weeks of placement in a community setting during their second year with an option of returning to undertake their final twelve week placement in the community. Their framework highlighted the need for

careful preparation of students prior to taking any independent visits, access to a source of support whilst visiting on their own and careful supervision of a student after the visit to ensure patient safety and appropriate documentation. It also stressed the importance of documentation of any untoward events.

The importance of guidance for independent visits and careful documentation of progress are also points argued by Cooper (2014) in a discussion article highlighting the role of the sign off mentor in the community. Cooper (2014) draws on a number of the articles cited above such as Middleton and Duffy (2009) and Shelton and Harrison (2011) to argue the case for community sign off placements promoting recruitment to district nursing upon qualification.

### *5.8 Impact of placement patterns on employability*

Ali et al (2011) conducted a series of 14 telephone interviews with qualified nurses working in a variety of primary care roles exploring the question “Are qualified English novice nurses prepared to work in a primary care setting?” Their key findings were that pre-registration nurses typically lacked an appreciation of the range of roles in a community setting. However there was a range of views about how adequately the pre-registration curriculum prepared nurses to work in the community setting with a range from well to not at all. A common perception was that the pre-registration curriculum is generally acute focussed and does not educate nurses about the structure of the primary care setting. The respondents made several recommendations including a recommendation that there should be more placements in a community setting especially in the final year of the programme. In contrast some practitioners recommended that the pre-registration curriculum could focus on primary care as a starting point and proceed to the acute care setting.

In 2012 Betony published a survey which explored the pattern of placements in community settings in undergraduate nursing programmes in England. Questionnaires were sent to the 48 universities offering the nursing programme

and 18 were returned (39% response rate). The low response rate is acknowledged as a limitation.

The survey indicated that Year 2 of the programme was the most common time for students to be placed in the community and the typical placement length was 4-8 weeks. These findings very accurately reflected the situation at my own institution prior to the project commencement and in our case; we were at the 4 week end of the continuum. Superficially these results would at least indicate some increase in community placement compared to the variation noted by Thomson et al (1996) as outlined in the historical context of this project in Chapter 2. Thomson et al (1996) reported a variation of between 5 days and 105 days. However the non responders to Betony's (2012) survey did constitute 64% of her sample and it is possible that little has changed since 1996, and as with Thomson (1996), she concludes that there were no explanations for the wide variation other than the difficulties in centres accessing placements. However other possible explanations could relate to the perceived importance of such placements as seen by local educators or practitioners and maybe even the enthusiasm and motivation of those stakeholders.

Overall the survey showed inconsistency between universities in the number, timing and length of primary care placements. Unfortunately it was not possible to ascertain how many or indeed, whether any, of the 18 universities who supplied data were in the London area. It was not possible to ascertain how many universities, if any, offered the opportunity of undertaking a final placement in the community although it was possible to ascertain that a minority did offer year 3 placements.

However there were other findings which had relevance to my project. The respondents were asked about what they perceived to be significant issues and it was found that:

*“25% (n = 5) of statements highlighted ‘organising primary care placements’, with 16% (n = 2) highlighting that organising the primary care placements was particularly complex, and one commented that it was harder to manage than secondary care placements.(Betony 2012:22).”*

Nearly a quarter of the respondents stated that their university wanted to offer more primary care experience but were controlled by placement availability (Betony 2012:22).

In her discussion Betony (2012) came to a rather similar conclusion to the manager who suggested the intervention for my project, namely that the current arrangements were not leading to students having confidence to nurse in a community setting. Commenting on the observed pattern of relatively short placements in Year 2 Betony (2012) observes that this demand could be taking precedence over the need for substantive placements which are needed to build confidence in the community setting. She concludes by arguing that current NMC requirement for “home nursing experience” needs to be broadened to include more diverse primary care placements as a means of expanding community placement availability. This strategy would provide more capacity in district nursing placements for those senior students with an explicit wish to work in that setting.

### *5.9 Conclusion*

This review has sought to address the objective “Critically review the emerging literature on the “sign off” period to identify important issues for the partners in the process, the planned curriculum development and the employability of student nurses in the community setting.”

In summary the emerging literature on the sign off concept has been largely descriptive with an emphasis on approaches to preparation of sign off mentors and some anxiety about the responsibility associated with the role. The different methods of preparation have been shared with the participants in the community

of practice and will be used to inform the future preparation of sign off mentors in our local setting.

Anxiety in relation to responsibility of the role was a discussion point in the literature and the opportunity for group discussion seemed to be a helpful way of addressing this, however it was noted that in the more recent review by Rooke (2014) that anxiety was less marked in actual sign off mentors than in newly qualified mentors indicating that preparation strategies may be able to address that anxiety.

The second section of the review included a range of descriptive and evaluative articles which have explored different approaches to third year placements in the community. A consistent theme of this section of the review has been the impact of the placements on the confidence of students to seek employment in this setting following qualification and the richness of the learning opportunities which are themes relevant to this project and which are developed in the next chapter.

## Chapter 6 Project findings and discussion

### 6.0 Introduction

This chapter will report and discuss the findings of the three cycles which form this action research project. Two of those cycles were undertaken with practitioners and students in practice and the third cycle is, in effect, the cycle in my own workplace which predated the first cycle in the practice area and continued through to July 2012.

The tables from Chapter 4 which indicated the timeline, the activity and which project objective was being addressed are replicated below, so that project findings can be clearly linked to the activity and objectives.

As Coghlan and Brannick (2005) have argued it is very important in writing an action research report to distinguish between the factual report of events and the researcher's reflections or "sense making":

*By separating the story from the sense-making, and by clearly stating which is story and which is sense-making, you are demonstrating how you are applying methodological rigour to your approach." (Coghlan and Brannick 2005:129)*

They suggest a useful technique of inserting a box at periodic intervals for the researcher's reflections as this provides a mechanism for having accounts of your own reactions and interpretations as the story goes along but does not confuse the two. As cycle 1 unfolded, I increasingly adopted the technique in my learning log to differentiate the data collection element of the log and my reflections. For this report I have evolved this technique and from the end of cycle 1, I have inserted my reflections in boxes to assist the reader with their sense making of the whole.

All of the students, practitioners and managers who have participated in this study have been given fictitious first names in this report. In the first draft of the report



they were given codes which were used in some quotations used in the report to the Pre-registration Nursing Framework Team (appendix 5) but it was felt that the use of names would aid readability in the final report.

### 6.1 The learning from cycle 1

Tables 1 and 2 from the project activity chapter are reproduced below and activity will be reported against each section of the timeline with the exception of the first item as the literature review has already been discussed in chapter 5.

Date	Activity	Data Collection	Contribution to the objective
July 2009-September 2009	Attempted literature review on the sign off mentor role and employability of student nurses in the community setting. <i>(in the event the lack of literature at this stage extended this process across the whole timeline of the project)</i> Review of relevant policy documents to provide data for a historical context chapter.	Use of relevant databases Professional body documents	Objective 3
July 2009	<i>Application to university ethics committee</i>		
July 2009-November 2009	Selection and preparation of students and community mentors	Learning log detailing processes and researcher insights	Contributing to Objective 1 and 2
November 2009-March 2010	Cycle 1: 12 week placement undertaken by Students Patricia and Emily	Learning Log Interviews with both students recorded and transcribed.	Contributing to Objective 1 and 2
March 2010	Conclusion of Cycle 1 : Meetings with both mentors	Meetings with both mentors recorded in learning log.	Contributing to Objective 1 and 2

Table 12: Timeline for cycle 1

Date	Activity	Data Examined	Objective
March 2010-May 2010	Transcribing and analysis of interviews from cycle 1. Reading of learning log and integration of insights with data from interviews	Interviews Learning log	Objectives 1 and 2

Table 13: Evaluation of Cycle 1

It is appropriate that this chapter should begin with a discussion of ethical issues. As stated on the timeline an application was made to the university ethics committee in July 2009. Progress of that application was unremarkable apart from early feedback from the ethics committee suggesting minor alterations to the participant information sheet and the consent form. Aspects of the research ethics such as the student choosing to be engaged in the project and gaining their consent to contribute to the project were straightforward. However the project intervention did entail a change to the usual placement pattern of the students and there were concerns at the university that this could disadvantage the students. The early sections of my learning log convey a mixture of excitement about the commencement of the project and concerns about disadvantage.

The following extract explains how my institution originally intended to place all the students in a hospital setting:

*“... The places where “sign off placements” were going to take place were all going to be general wards as this was seen to be the easiest areas for students to achieve any outstanding skills. However as was said today this will have a strong psychological impact on where students see as an “appropriate or safe” place to start their career. The NMC requirement for sign off placements is a necessity from 2010. If we achieve this pilot of two students from November 2009 to March 2010, we will have prepared two sign off mentors in a District Nursing team and we will have established the principle that a community sign off experience is possible at \*\*\*\*\*. (Of course that only applies if it goes well!) This will be a first in London.*

*If it goes well, then \*\* is sure that other Trusts will be interested. So it really is unfolding: cycle 1 with a possibility of cycle 2. Must discuss with \*\* ”.*  
*(Learning Log July 2009)*

This optimistic extract is quickly followed by another anxiety laden extract which summarises the worries in the university setting which had been articulated to me by a key member of university staff:

*“ \*\* is worried that students will enter their last 12 weeks with outstanding skills incomplete and there are a range which cannot be achieved in the community. Another worry is that students will undertake the placement in the community but then decide it’s not for them- are they going to be disadvantaged? I do have confidence that they will get great experience which will stand them in good stead wherever they work but this is all a bit nerve-wracking. Also some staff are saying that students will be reluctant to come forward. I am confident that this will be good management experience but when I say this, colleagues look at me in a quizzical way which is unsettling.*

*However feel better now as have agreed the following with \*\*:*

- A process for informing students of the opportunity and a selection process if we get more applicants than the two places.*
- A process for ensuring skills such as blood transfusion is completed before they come to the community.*
- A number of key “messages” to give students to make sure they really know what they are letting themselves in for.”*

*(Learning Log July 2009)*

In combination the two extracts set the scene for the preparatory period and provide an insight into how the preparation phase came to be managed. In particular the concerns about whether students would be disadvantaged in any way by “the experiment”, as it was seen by some colleagues prompted the planning of written process for how students would be selected. These safeguards took the

form of planning a selection process for the two students in the pilot in conjunction with the Head of Practice Based learning. In the event we had many more applicants for the two places and therefore had to select two from the eight applicants. Our initial plan to select based on the student's written statement of interest, immediately ran into difficulties as we found ourselves unable to distinguish between the four best. We therefore called the four to interview and we conducted this in two stages. Initially we met all four and discussed what was involved and in particular we talked through the process of addressing certain skills in ward environments prior to their community experience and secondly we discussed what I came to call the "what if" question. That is "What if they decided they did not want to work in community afterwards, how they would ensure that undertaking this placement could assist rather than hinder an application in a hospital environment?" Although we did not know it at the time, the same "what if" question was exercising researchers in Leeds (Marshall and Shelton 2012) who had the placement capacity to allow their third year students to undertake the whole of the final year in the community setting and who were able to demonstrate that 25% (6) of their sample were able to successfully gaining employment back in an acute hospital setting. As with this study, their sample was small and to gain a fuller picture of the impact of community placements on employment a study with a quantitative and longitudinal design would be necessary.

The other part of this initial preparation related to ensuring that the student would be ready for the practical implications of working in the community environment. This included discussion of practicalities such as bad weather, accessing patient information systems in the community and travel claims.

The other key phase of the preparation in cycle 1 (July 2009- November 2009 in the timeline) was the preparation of the two practitioners who would support the students. It is interesting to note from my learning log that this aspect of cycle 1 did not really receive much consideration until one month before the placement was due to start. I had made several comments about the anxiety of colleagues regarding students and it seems that this anxiety had "pushed out" anxieties about

practitioners. However in October 2009 before going to meet Meg (Practitioner) who was going to mentor one of the students, I noted the following in my log:

*“I do hope Meg is OK about undertaking this role. In terms of AR the voluntary participation and engagement is important. Both Meg and Doris (practitioners in cycle 1) have in effect been “volunteered for this” by \*\*\*\*\* (manager who had originally met with myself and Head of Practice based learning).”*  
*(Learning Log Oct 2009)*

Fortunately for the smooth running of the project when I actually met with Meg and Doris, both viewed the intervention in a positive light. As required by the NMC sign off mentors should be “experienced” and this meant they had been in post for several years and this gave them important insights. After visiting Meg I noted the following in my log:

*“Meg, without prompting from me, mentioned two newly qualified staff in her team who had started but who had left in less than 6 months. She said several times “this (meaning the intervention) is good, students will know a bit about what they are letting themselves in for.” At the time I thought, “Good, Meg is on board” and was really pleased. Reading this written down, now makes me worried for the students- what are they letting themselves in for? On the other hand I know that most students really enjoy working in that patch except for the ones who complain about “too much walking”.*  
*(Learning Log October 2009)*

The preparation phase with the two mentors did not prove difficult. It involved providing explanation of what was then the new concept of sign off mentor (NMC 2008a). I explained to both practitioners that it would be a professional body requirement for students completing from the next cohort and that it was not a formal requirement for this cycle. However the NMC (2008a) had provided advice that the first wave of sign off mentors should be identified locally and thereafter the subsequent waves of sign off mentors should be prepared by existing sign off

mentors on at least three occasions. Following discussion within the community of practice the decision was taken I would offer preparation and support on three occasions as suggested in the guidance.

At the time there was considerable anxiety about the sign off concept in the local acute settings and many of those anxieties were subsequently highlighted in the literature (Andrews et al 2010; Jones et al 2010). Although conducted prior to the introduction of the sign off concept Middleton and Duffy (2009) had also reported some anxiety about supporting third year finalist students in their study based on the experiences of twelve community nurses working within a large city-based community health practice in Scotland who had mentored a student nurse immediately prior to registration. Their study highlighted a high degree of anxiety about becoming a mentor for a student on a final practice experience with issues raised about the accountability of the mentor and how the mentor would cope if the student was not progressing satisfactorily.

In contrast, the two practitioners in the first cycle of this study did not express those concerns and explanations for this could have included their perception of being supported in the project, or their concerns being outweighed by perceived benefits. Andrews et al (2010) were reporting the views of those who had been very actively involved in educational aspects in practice and it may be that the relative isolation of community clinics from some practice networks may simply mean they were not exposed to discussions and anxieties.

### *Placement Period November 2009-March 2010*

Data from this phase was due to be collected from three main sources: student interviews, mentor interviews and my on-going learning log. In the event only one of the practitioner research interviews took place but because I was required to support them in becoming sign off mentors, I had formal contact with them on two occasions in the 12 weeks and noted their observations. They could have contacted me at any stage in the 12 weeks but did not choose to do so.

As the project had chosen to follow the professional body requirements for future sign off mentors, it meant that I had to meet with each practitioner on three occasions to prepare them for the sign off role, once prior to the placement commencement and twice whilst the placement was in progress. Both practitioners expressed the view that they had “said what they wanted to say” during those encounters and fortunately I had noted most of this in my learning log. I did manage to meet Doris for a research interview and although Meg agreed to do so, practical work considerations meant that this was postponed twice and then the practitioner felt it was too long after the event. I did however interview both students and this data is reported below.

### *The Interviews*

Both students and one mentor were interviewed towards the end of their 12 week placements: one at 10 weeks and one at 11 weeks and both interviews were subsequently transcribed. As outlined in Chapter 4 the interviews with all participants would cover three major areas: their expectations of the placement, the actual experience of the placement and finally the question of student employment in the community. In the analysis I looked for significant learning in relation to objectives 1 and 2. In relation to objective 1 which was about developing a sustainable process, I was keen to hear the students’ views about the ethical issues which had troubled my colleagues for example. In terms of the question about expectations there was a significant “negative” finding, in that neither student highlighted any examples of feeling unprepared for the placements in terms of information given related to aspects such as their assessment and likely learning opportunities. This was significant for my objective of designing a sustainable process (Objective 1) and reassuring in terms of the anxiety about disadvantaged which I had noted in the learning log. Both students in this first cycle had had the opportunity of undertaking a community placement in their second year and had undertaken some visits independently and this experience may have been significant in relieving anxiety. In addition Middlesex University has long standing written guidance for both students and mentors in relation to these visits. Brooks and Rojahn (2011) reported on a similar guidance developed in Leicester to

enable adult branch students to undertake delegated care activities independently whilst working with district nurses. When in 2012 I was asked to develop a sign off placement for child health students with Health Visitors (Brown 2012) the importance of adapting such guidance to the context of care was an important consideration.

As with the students, there was an important “negative” finding in the mentor data in that they did not highlight difficulties with the process or concerns about being able to assess the student. It was important to the objective of a sustainable process that they were expressing confidence about completing the final paperwork which would allow the student to join the professional register. One unexpected finding in terms of sustainability was that one of the mentors highlighted that having a third year student was in some ways less stressful than a second year:

*Doris said that having a finalist student was “a serious responsibility” but “less stressful in some ways” than second year students. When I asked in what way less stressful she said, “Good to have time to get to know them, they help out and contribute” (Learning Log: February 2010)*

The comment made by Doris that her student could “help out and contribute” could be significant. It is possible that in a community setting the demands placed on practitioners of having a sign off student might be balanced or outweighed by the view that the third years make a contribution. In her survey of UK universities Betony (2012) found that most universities only offered one compulsory community placement and that this typically happened in the second year. This had been the typical pattern in our locality prior to the project and although second year students do undertake some independent visits towards the end of their placement period; their ability to take some share of the workload is probably insignificant. Jones and Akehurst (2000) highlighted that placements led to a cost for community providers whereas they were a benefit for acute providers. An area for further research would be to explore in financial terms the impact of a third



year student on the workload of a community team over a twelve week period with proper accounting of the NMC requirement of one hour protected time and other supervision for that student balanced against the time and costs saved in terms of visits and other work undertaken.

Objective 2 had involved evaluating the process and the student placement experience and identifying the implications for students, provider organisations and Higher Education. Even though there were only three interviews to transcribe and evaluate, they did provide a lot of information and I therefore transcribed both verbatim and then read and re-read them to generate initial codes following Robson's (2011) thematic coding analysis. Once the initial coding had been undertaken I analysed them for key themes. Three important themes emerged: the impact of practical considerations, opportunity for skill development and future employment in the community.

### *The impact of practical considerations*

This theme was generated by collapsing a number of initial codes including the impact of the severe weather on the placement, access to mobile phones and access to the electronic information system.

When I asked the students about expectations the first thing they talked about was that they had not expected the severity of the weather- but to be fair, neither had the Met office! Although considerations in relation to the weather had formed part of my preparation for practice discussions with both students, I had not anticipated them featuring as an issue in my findings. In the event I chose students from March cohorts (students who commenced and conclude their three year programme in the month of March) for both cycles of my project. On the one hand I now regret this as such students are atypical as most nursing students in England, since the move to degree only programme from September 2011, now only commence and end their programmes in September. On the other hand the significance of weather cannot be ignored in community nursing and although the weather was significant

for both cycles of my project it did not deter them from considering a career in this type of nursing. In addition the experience of this project would suggest that anyone wishing to pursue a career in this area should give careful consideration to the impact of weather.

In December 2009 London saw more snow and ice than it had seen for some years. Some permanent staff had difficulty reaching their workplaces- in particular Student Emily's workplace was affected. In Student Patricia's workplace, one of the senior staff members slept over at work one occasion. Both students saw dealing with the snow a challenge:

*"It was a struggle getting in but once you were there, all you could think about was reaching the patients who were anxious." (Patricia- Student)*

Emily also rose to the challenge but found this had some longer term impact:

*"I managed to get in everyday and we just had to divide the work between who were there... Some of our support workers did not get in and some qualified staff didn't either...I just got on with it. The bad thing about that was even when the weather was better, people just expected me to do those visits, even though they were not the most appropriate ones for me." (Emily- student)*

In my learning log I noted that post snow Patricia felt immediately "back on track". However in Emily's case my learning log notes that she continued to be given the health care assistants visits and it required the Trust clinical facilitator to intervene to break this pattern by speaking to the clinic manager.

In terms of my objective of developing a sustainable process, my own institution now only has September cohort students and therefore all final placements will be in the summer months. Whilst there can be adverse summer weather, it is unlikely to prevent staff reaching their workplace in the same way. The learning I have taken from this is that student preparation should emphasise weather considerations and

mentally prepare students that if they are considering community nursing as career option, they need to be mentally and practically prepared for the potential of severe weather.

The other practical consideration which impacted on the student experience was access to workplace mobile phones and the electronic information system. Full access to the electronic system entails an individual practitioner attending a half day training before getting a personal identification number ( PIN) and this was managed quite quickly for Patricia and took much longer for Emily.

*“Getting on to the RIO system was a great help as I could do my own recordkeeping with my mentor checking. My manager got it sorted by week 3” (Patricia-student)*  
*“It wasn’t until I was in my last six weeks of placement that I had my own RIO card. It made a big difference to how independent I felt.” (Emily-student)*

In terms of learning for cycle 2, I noted that early access to the electronic systems is vital, as recordkeeping is seen as integral to nursing care, and therefore anything which blocks a student from fully engaging in the process is a handicap. Preparing workplaces to make provision for this early in the 12 weeks is now a key part of local planning.

Access to a workplace mobile phone was more problematic. In the event a pragmatic solution was arrived at with the students using their own mobile devices and sending a text to their mentor asking the mentor to ring them.

In the Yorkshire and Humberside study (Shelton and Harrison 2011; Marshall and Shelton 2012) one of the reasons given by students who withdrew from their year long community placement project was the fact that they were “not car drivers” indicating that practical considerations need to be very carefully considered. The built up nature of the inner London borough in cycle one meant that many staff undertook visits on foot and therefore the student would not be seen as unusual and there would be no expectation that a student was a car driver. In some senses,

the concentration of patients in a given locality in London could be seen as advantageous to community placements compared to students working in more rural locations where car ownership would become a practical consideration.

### *Opportunity for skill development*

This theme was generated by collapsing a number of initial codes about learning clinical skills, assessment skills and developing managerial skills.

One of the anxieties prior to Cycle 1 was whether the placement would in some way disadvantage the students compared to a ward based placement. Some of this concern had focussed on the importance of achieving certain technical skills before this final placement and this was achieved without difficulty by both students and was not commented upon by either but this negative finding is significant.

Without specific prompting both students volunteered a lot of information about skills learnt and specifically about developing their management skills. This is exemplified by this quote Patricia:

*“I have learnt such a lot here, lots of skills ...wounds of course, there is so much about wound management as a student you only just start ...but also PEG tubes, and catheters. I had done my catheterisation skill in the hospital but the practice I have had here, I really feel confident in it now but the main thing my mentor keeps saying is “assessment”.....assess the situation and consider the situation holistically.” (Patricia-student)*

A companion quote from Emily highlights how the bad weather interrupted her skill acquisition:

*“I have learnt loads of skills...early on I did such a lot with wounds, nutrition, bowel management..then the snow and ice came and I did learn stuff then ..stuff on how to manage...but I know I lost the momentum on skills which is why I had to say something and I feel I am back on track” ( Emily- student).*

It is interesting to contrast the students reports of skill development with the anxiety expressed prior to their placement about skill development. The perceived lack of opportunity for skill development was also a feature of the second and third year students in Shelton and Harris's (2011) study and they have described these concerns as pervasive "community placement myths" affecting not only students but also some acute practitioners and university staff . However studies like this one which directly interview students on district nursing placements find that the opportunity for skill acquisition is a strong finding (Middleton and Duffy 2009; Baglin and Rugg 2010; Marshal and Shelton 2012). In a survey evaluating undergraduate nursing experience in one Higher Education institution in Wales ( Murphy et al 2012), District Nursing was highly valued as a placement opportunity to practice and master clinical skills, whereas health visiting placements were not and therefore it may be important not to generalise from District Nursing placements to other types of community placements.

In addition to clinical skills, the interviews of both student s and the mentor contained many references to the opportunity for developing managerial skills. The NMC has significant expectations about how a student at the point of qualification can manage care and care processes (NMC 2010). The original decision of my institution to only provide sign off experiences in the hospital setting possibly reflected the institutional view of what constituted a good management experience. I was quietly confident that District Nursing would provide a different but equally good management experience but my notes from the learning log showed that I did spend some time exploring this:

*"Discussed NMC expectations in relation to student's ability to manage care and Meg (mentor) assured me on this account...she provided lots of examples of how she could address this ..."*

*(Learning Log: November 2009)*

In the event both students without prompting described in some detail how their management skills developed as the placement progressed. In student Emily's case her account was mirrored in what her mentor subsequently said and serves as good example of the role of the mentor as a person who can help structure learning. This was how Emily described her management skill development:

*"My mentor really steered me to get the management experience. First she said think about the management of your patient, assess and re-assess...it's on-going. Then think about managing your own workload and that is different to the ward but the same in some ways, it's about planning and then think about managing a caseload and she told me about all the different things you have to consider but she did let me at the end, plan the work for the day and finally she said about "risk management" which is about thinking about the whole thing, all the things which affect your decisions" (Emily-student).*

This is how the mentor described how she "taught management" in her role:

*"The way I did it was to focus initially on management of the individual patient, then we looked at how to manage your workload on a specific morning ...from there I gradually introduced her to caseload management and how we allocate patients to particular members of the team and so on, then I brought it all together and talked about how you manage the risks in this job, it's like layers of an onion and a staff nurse needs to know how to operate in all the layers...." (Interview with Doris Practitioner/Mentor March 2010).*

The learning from this interview was distilled to improve the preparation of students and mentors for Cycle 2 as the management opportunities above could be linked to the "organisational competencies" expected from a nurse about to join the register as now outlined in the NMC Standards (NMC 2010).

### *Future employment in the community*

Although it would not have been appropriate for me to have an objective that Students Patricia and Emily should apply for community posts as this would be their personal decision, in fact this was what happened. In March 2010 both students applied for community staff nurse posts and were successful. It was interesting to note that in the research interview they had rather different perspectives:

Patricia: *"I really think this what I want to do long term, I like dealing with patients one at a time, and I like looking at their needs holistically. I think I want to do this ....."*

In contrast Emily:

*"I am definitely going to apply as I really like this sort of work, although my long term goal is to do midwifery and I think this will be really useful".*

In my learning log I note the students' success but what I really notice is the wider impact:

*"Everybody seems to know about the community sign offs getting jobs. Students from the next cohort have mentioned it, \*\*\*\* from practice based learning has mentioned, my Director of Programmes mentioned it. Apparently it was reported to everyone at Framework Management Team meeting. I wonder who told them as I did not send any form of report. The big news is that I hear there is now interest for Cycle 2 from the other two Trusts." (Learning Log March 2010).*

### *Conclusion of Cycle 1*

Each cycle in action research requires clarity about how the learning from cycle 1 informs cycle 2 (Coghlan and Brannick 2010). In some ways the most important learning was that the anxiety that students would somehow be disadvantaged had not been realised. In fact the data from the students highlighted how appropriate

the placement was as a “management experience”. In addition the initial evidence showed that the measures taken by the HEI prior to the placement appeared to be an adequate preparation for both students and mentors. One device which emerged in my reflective diary at this stage was that I reviewed anxieties which others had expressed about the project and wrote my answers down. See Box 2 for an example which also acts as summary of learning from cycle 1.

**•Would the students be able to complete all their assessment requirements in the community?**

*The preparation phase has meant that this was not an issue. Indeed the data from this cycle is pointing to the fact that the opportunity for “management skills” a focus of the final placement was particularly rich. Area for more exploration in cycle 2.*

**• What if the students chose to work in the hospital on completion? Would undertaking a final placement in the community disadvantage them?**

*There was no data emerging to address this issue as both students applied and successfully obtained community posts.*

**•Would offering this placement lead to excessive work or stress for the practitioners?**

*Unexpected data emerged in response to this question in that the students’ determination to reach and complete their placement despite the bad weather has meant that, in a very practical way; they had contributed to the team effort and had actively reduced the workload and stress for the team over a two week period. However it was also clear that the sign off mentors as required by the NMC had spent time with students but they did not view this as “excessive” compared to other students. One mentor in particular pointed out that longer placements were “in some ways less stressful”. When I had explored this, she pointed out that the beginning of a placement period with a student is often the most demanding and therefore multiple shorter placements demand more energy than a longer placement.*

I would now recommend this technique of keeping a log of questions asked and answering them as the data emerges as a very useful device for the Action Researcher.

Box 2: Reflecting on progress in cycle 1



Other significant learning from cycle 1 related to a range of practical considerations which emerged such as the importance of student access to the electronic information system or the impact of weather conditions which needed to be factored into the preparation for cycle 2.

The outcome of both students finding employment in the community setting was significant for them as individuals but it provided a wider “legitimacy” for the project and willingness from stakeholders to participate in cycle 2.

### Dissemination of cycle 1

Informal dissemination of cycle 1 proceeded without any active intervention on my part as word “got round” that the students had found community posts and I found that I was being approached by stakeholders from other boroughs offering to be involved in cycle 2. In the HEI setting I also had the advantage that I was chairing the group which was looking at the philosophy for the new BSc Nursing programme which was due to commence in September 2011 and this meant I had frequent contact with practitioners and managers from different NHS Trusts. Simultaneously the practice based learning department were reviewing the practice learning opportunities for the new programme and they took the view that even on the basis of cycle 1 we should continue the opportunity. In many ways this was an enviable position to be in terms of cycle 2 in that I had very active participation from stakeholders.

As cycle 1 was underway I took the initiative of jointly submitting an abstract for a conference presentation with the local practice facilitator for the Networking for nurse education conference (NET) in September 2010. The abstract (appendix 4) was accepted and we were duly invited to present. As mentioned in Chapter 4, the facilitator changed jobs before the September presentation dates and one of the students (by then a newly qualified registered nurse) was given the time off work by her employer and therefore the planned collaboration was able to continue.



(NET Conference Cambridge Sept 2010)

This presentation which was about dissemination to a wider audience produced some interesting, and for me disconcerting, findings. On the one hand the audience were very struck by the former student's account of her experience and learning. Whilst I was pleased to see this very positive feedback for a student from my institution, it made me consider whether this student in cycle 1 had been "exceptional" in some way and made me consider whether the success of this stage could be attributed solely to the individuals involved.

The other disconcerting thing about the conference was that several people said that they had a history of placing students for their final 12 weeks in the community. The useful thing about this was that it gave me the opportunity in a public forum to ask whether any of those from London based institutions were doing so and the answer was negative. I also told the audience that apart from Duffy (2009) I had not found other published accounts about other areas placing

students in the community in the final 12 weeks. I will never know whether this public remark played any part in subsequent publications by (Baglin and Rugg 2010; Arnott 2010; Shelton and Harrison 2011; Brooks and Rojahn 2011 and Marshall and Shelton 2012) which I included in my literature review retrospectively.

This conference really underlined the importance of what I called “evaluating in public” stage of the research cycle. In my work role, cycle 1 was seen as a success by colleagues because the process went off smoothly and the students obtained community posts. The conference propelled me back into the research role as it made me realise that I had been influenced by the positivity in my workplace about the outcome to cycle 1 and had been in danger of taking cycle 2 for granted. The reflecting on action (Schon 1983) with other experienced practitioners problematised the data again. The dialogue with the wider audience led me to be very self-aware of what would be different in cycle 2. It would be a real opportunity to see whether outcomes in cycle 1 were dependent on “exceptional” students and my own familiarity with the location and staff. Although I was making minor modifications to the preparation of students and mentors for cycle 2, based on the learning of cycle 1, many elements of the intervention were unchanged. However I was now moving outside my own link area to geographical areas which were less well known to me and with 8 students instead of 2.

**Box 3: Reflecting on conference presentation**

## *6.2 Cycle 2 July 2010 to March 2011*

### *The interview data*

As in cycle 1, I explored three areas in each student, mentor and manager interview. The three areas were their expectations prior to the placement, the experience of the placement and their thoughts about future employment. Findings from each of these broad areas will be explored in turn with reference to the relevant objectives.

Date	Activity	Data Collection	Objective
July 2010- November 2010	Selection and preparation of students and mentors	Learning log detailing processes and researcher's insights	Objective 1 and 2
November 2010 to February 2011	12 week placement undertaken by 8 students	Learning Log including record of any communication relating to the placements	Objective 1 and 2
December 2010 to March 2011	Interviews with 8 Students Interviews with 2 mentors	Interview transcripts Learning Log Notes from debriefing meetings with mentors	Objective 1 and 2
March 2011 – May 2011	Interviews with NHS Manager	Interview transcript	Objective 1 and 2
May 2011	Validation of the new BSc Curriculum	Learning Log	Objective 1 and 2
May 2012 ( originally planned for late 2011)	Presentation at the university to review data with students.	Peer debriefer to take notes	Objective 1, 2 and 4

Table 14: Timeline for Cycle 2

In this cycle there were four key themes which emerged from the data: Differences between hospital and community working, organisational competence, employment in the community and the process of sign off. One of these themes “employment in the community” had been a feature of cycle 1 but in this cycle the triangulation of views from students, mentors and managers enhanced the understanding. The theme of “organisational competence” had some overlap with the “opportunity for skill development” in cycle one but it was more focussed on the managerial skills and how those skills had to be adapted to the community setting. Initial codings for this theme had included time management in the community and discharge planning.

The theme related to differences between hospital and community working arose largely from the student data. Employment in the community was a theme which arose from students, mentors and managers. The final theme about the process of sign off was a theme from mentors and managers only.

### *Differences between hospital and community working*

As in cycle 1, there was a significant “negative” finding in that no student described themselves as “unprepared” for what they found. Likewise there was no expression of complaint that they wished they had been told x or y. Therefore in terms of my objectives of designing a sustainable process and evaluating a process, the fact that students did not refer to unrealised expectations or express concerns was significant.

In this cycle I was aware that six out of the eight students had spent one month in the community in the second year of the programme. The other two students had no second year community experience and had originally been allocated to a six week placement early in their third year. However the necessity of achieving their acute skills meant that they had to access an inpatient area instead and therefore their 12 week experience was their first non- hospital based adult placement in their three year programme. In the preparation phase I had been so focussed on ensuring that all the students were able to be assessed on their acute hospital skills, the significance of this difference had not occurred to me. With no previous experience to draw upon, the two students who were attending a community placement for the first time had in effect taken a “leap in the dark” by choosing to do their final placement in – for them- an entirely new setting. This meant that when I began the interview with a question about how they had found the placement compared to their expectations these two students provided some of the richest data about the distinctiveness of community work. Presumably the novelty of the experience had heightened their sense of difference from hospital work. However they were not the only students to speak about differences and two students used the phrase “the other side” when speaking about community in contrast to the hospital setting. Other initial codings for this theme included comments about shift patterns, car drivers and non car drivers, and differences in supervision and support between hospital and community settings.

Interestingly the two students, who were prepared to take the “risk” of doing their sign off in an environment where they had not worked before, were both mature students who had done other people orientated jobs before- one had been a store manager and the other had worked in a bank.

In the following extract with Hema, I am exploring the differences and she emphasises:

*“Yes very different. All my previous placements had been in hospital so compared to a ward surrounding, it’s completely different.”*

*(Hema- student)*

I ask her to explain what was so different. I interviewed Hema after she had started to undertake some independent (lone visits without the direct support of her mentor) visits.

*Hema: ... managing your bay of 4 patients compared to managing 8-9 patients in a community setting, very different.*

*KB Can you articulate what’s so different?*

*Hema: Support I think is the biggest thing .....in a ward setting you have got the comfort of everyone being around you, not that you haven’t got the support in the community – you do. But they are not next you. You have to be decisive. You have got to make certain decisions, there and then. You have got to be proactive. Much more than you need to be on the ward.”*

*(Hema- student)*

When I started to interview the two students who had not had previous community experience in their second year I felt concerned that I had not given this distinction more thought in the preparation phase. I felt that I had been so focussed on my work role that I had lost sight of my research role and ignored this important distinction. However out of this “error” I derived important learning in that it made me think about the significance of the second year experience on student choices, their actual experience and employability.

In addition the two students who came to the setting with complete freshness also provided detail which helped to illustrate the uniqueness of the community experience. I did however become very aware of the characteristics of these two students, that is that both were mature with previous work experience which involved managing processes. I had to acknowledge that a younger less experienced student might not have coped so well.

**Box 4: Reflecting on researcher role**

In contrast to the two students with no previous experience, Susan had been on a one month community placement in her second year and was emphatic in describing how her second year experience had led to her decision to put herself forward:

*“The main reason that I chose to do community ...I had my initial taste in year 2 when I did a four week introduction to community and that ...If I go back ....it is often said that you will often have in your nursing training because of the variety of placements, one will be the one that you REALLY want to do, when I did the community in year 2 I just loved it, I enjoyed the interaction with the patients, I enjoyed nursing patients in their own homes, that was the main reason when the opportunity came up I just jumped at the chance.....”*

*(Susan - Student)*

Aileen also stated that she chose to apply for the opportunity because of her second year experience and when I asked if she would have applied in the absence of previous experience she replied:

*"I doubt it for the 12 weeks.....it would be a long time not to know whether I would enjoy it" (Aileen-Student)*

Currently in my institution there are insufficient placement opportunities to offer all second years an opportunity to nurse patients in their own home; some always have to have that opportunity in the third year. However if that student wants to do their sign off placement in the community then they need to undertake their other third year placements in an inpatient environment. This means that there must be a small subgroup of students who, if they had the same reservation as Aileen, would not take the risk of applying for this opportunity. In the new curriculum there is a new opportunity for students to undertake a "taster" unassessed placement of one week in their second year. It might be that some of the community placement provision should be reserved for this type of placement to allow all second years some opportunity to experience community nursing prior to making decisions about the location of their sign off placement.

The whole area of placement patterns and how they impact on student confidence in different settings and their employability characteristics deserves wider debate. Betony (2012) argued that we need to expose undergraduate healthcare staff to the *variety* of primary care settings as a crucial first step to preparing the next generation. Currently the limited resource of District Nursing placements is stretched thinly as the NMC 2010 continues to contain a stipulation for "home nursing experience". Betony (2012) argues for the NMC to broaden that stipulation to "further encapsulate the primary care placement opportunities within PCT owned hospitals, clinics and services who offer minimal home nursing but are the epitome of primary healthcare delivery" (Betony 2012:25). This arrangement would free up District Nursing placements for those students with a particular interest in home nursing and might allow institutions such as my own to offer the type of



placement patterns offered outside of London (Arnott 2010; Shelton and Harrison 2011). Ali et al (2011) reporting on the views of existing staff in the north of England about the preparedness of English novice nurses to work in the primary care setting found a mixed response with a range of views from staff who believed the existing curriculum prepared students adequately to others who found novice nurses completely unprepared and a common perception that the curriculum remains acute focussed.

### Organisational Competence

The second key theme which emerged from the data was organisational competence. This theme was generated by collapsing a number of initial codes such as “dealing with the unexpected”, time management” and “discharge planning”. This theme had a direct link to the first theme in that the ability to cope with the differences between the hospital and community setting is a key organisational competence.

The naming of the theme as “organisational competence” is a direct reference to one of the five essential skills clusters, “organisational aspects of care”, which form part of the guidance in the NMC standards for pre-registration nurse education (NMC2010). Many older nurses still refer to the final twelve weeks placement as the students “management placement” as this was how this placement used to be termed in some hospitals.

When my own institution had originally placed students in ward areas only for their final twelve weeks, one rationale had been that it would be easier for them to gain those organisational skills in a ward setting. Cycle 2 provided detailed data about how the students gained organisational competence in the community setting. In particular three aspects of organisational competence were highlighted; the skill of dealing with the unexpected in the environment, time management and coping with the process of discharge planning. The latter was not a new skill to the students but rather they highlighted what they had learnt from their experience of

being on the “other side” as usually they were in hospital doing the discharging, rather than in the community receiving the discharge.

Several students referred to the importance of expecting the unexpected. This is Susan describing how she adapted in her first three weeks and how she gained organisational skills in her new environment and when I listen to the transcript I have a sense of being with her on street corners as she checks her bearings:

*“Oh yes! (laughter) week one, first day was the transport strike, subsequently the snow. However the team have been very welcoming and they have all had real regard for my learning .....we have the walkers and the drivers in the team...so whoever I am with I am getting used to ..with the walkers I am getting used to certain landmarks...I know this area. It is quite good...I am familiar with here, I can walk to here. Even different routes to coming into work to help me to navigate around here ... (Susan- student)*

And this is Meredith talking about the skill of working in the home environment:

*“You obviously come across homes which are not pleasantly clean so you have to think about yourself and where you stuff is...because sometimes where you actually are in the room you have got patients who are sitting in chairs and you have to kneel on the floor so I always tend to bring extra aprons just to lay on the floor so that I don’t get on me what’s on their floor (laughs)”. (Meredith- student)*

This was Angela talking about making time for the unexpected:

*“making sure ...knowing you can afford to leave 5 minutes, just in case you need to do something else with that patient the holistic side, not just going there, here is your medication, goodbye! E.g. even though you may be administering insulin , you may notice that the patient seems short of breath , they may need to see their GP and or a change of medication and so on...” (Angela- student)*

A similar point was made by Susan in her “thinking aloud” style which might also have been an echo of her mentor’s advice:

*...you want to think of your patient from head to toe. Every patient from head to toe is covered in the community. (Susan- Student)*

For those who had never previously undertaken a community placement, everything struck them as different rather than unexpected. When I asked Hema about her expectations, she referred to her experience as “completely different”:

*Hema: “Yes very different. All my previous placements had been in hospital so compared to a ward surrounding, it’s completely different. Being in the community, what was I expecting? Firstly there is a change, you have got your 8.30 to 5pm, that’s a big change in itself, you haven’t got your long days and nights. So that’s one big thing..”*

KB *“So for you was that a pleasant change?”*

*Hema: “for me, yes because I have commitments at home and I like being home at a reasonable hour 6pm so I can give time to my family as well. I actually like that change.” (Hema – student)*

In cycle 1 a mentor had eloquently described how she introduced management to her student beginning with the management of self, then management of the individual patient, then the management of the group of patients on that day, management of the caseload and management of risk. In cycle 2 it seemed that the student voices supplied examples for “layers of the onion” that the mentor had mentioned in cycle 1.

Firstly student Sarita talks about managing herself:

Sarita:” *You have got your management of yourself, you as a student as a learner, management within a team because you are working in a team and then management wider than that because .....if I go back to me, how I manage my time, how I prioritise the care of the patient, how I am able to pass on information in the team and then the overall management of providing a good and effective service..”* (Sarita- Student)

Then Angela talking about the juggling involved in managing the individual patient and she wasn’t the only one to mention “logistics”:

Angela: *“Knowing in a hospital setting you need to get to some patients (have medicines) at 8 and some at 10..in the community it is about the logistics of that situation to make sure you have enough time to see them, that they have had the medication they have been authorised, it’s working ...it’s a lot of management ...”* (Angela-student)

Then the next layer, this is Hema talking about prioritising your day:

Hema: *“time management ...on the ward, it is also possible that your mentor is also there looking over you, possibly saying “this needed to be done by this time”, pushing you. Community you are on your own. You have to manage your time...for example there may be a patient who needs prompting re morning medication, and then there is a wound care case which you are close to but it doesn’t matter you have to go and do the medication first. So it just organising and managing your day, your own load.”* (Hema – student)

Here is Susan thinking about workload allocation and the logistics of delivering care in an inner city area. The laughter associated with “drivers and walkers” reflected an informal discussion we had before the interview started which mentioned adjusting to community life and needing to be very clear about “drivers and walkers” as they had to be treated as “separate breeds”!

Susan: *"I have had insight into that...in the team, the wider team...For example how to prioritise, which patient to go to first e.g. a patient with insulin, you go there first – it is important you know. All those things come into play. Looking at the patient, looking at the staff mix, looking at the location of each patient, drivers and walkers (laughs)...that IS important, you do have to consider London transport, we waited 20 mins for a bus, that's real, you know you have to consider that..."* (Susan-student)

In addition several of the students commented on how their mentor managed the caseload as a whole and were somewhat awestruck. Angela explained how she was affected by her mentor's management style:

*"... knowing she does it so well. Managing the time, managing the load..."*  
(Angela-student)

And then went on to discuss how if she qualified she might treat herself to a satellite navigator in order to emulate that efficiency.

The findings from the theme of organisational competence are in stark contrast to the findings of an earlier study. In 2001 Carr had undertaken a study to compare the difference in understanding and approach between student nurses and the more experienced nurses who were undertaking the further training to become a community specialist practice (CSP) nurse in District Nursing. She found that the students did not appear to understand the importance of the community context and had a task driven approach whereas the CSPs identified a lack of routine, managing the unexpected, autonomous working, managing risk and uncertainty as key components of community nursing. All of the aspects identified by the more experienced nurses in Carr's (2001) study were clearly articulated by the students in the current study. This served as important feedback to the mentor's on their own efficacy in preparing their students for the demands of the setting.

All the students had received theoretical content at university about safe discharge of patients to their own home but the power of learning about the discharge process from what the students referred to as “the other side” cannot be underestimated . In the extracts below Sarita reflects on this:

*Sarita: “Well I have found it very interesting because when you are in hospital, you don’t think too deeply about what is going to happen next with the patients, you know you are doing the discharge and you know you might be involved in a referral for District Nursing but coming out here and seeing that side of it, what happens when you get the referral.”*

KB: “Yes”

*Sarita: “ I have also managed to spend two days with the continuing care team so I have sat in on panels and gone to a couple of hospitals to see cases for continuing care. So that is the other side. You are still caring, the role is still there but you are seeing the other side- what happens when the patient is discharged...”*

*KB “Hypothetically...If you were back in a ward. Is there something you might do differently if you were back in the ward?”*

*Sarita: “Yes there is. I think I would really go into the social aspects of the patients. We often get a report from the OT who has been to the home...possibly think a bit more along the lines of the discharge planning, how to support the patient more once they are home.”*

Another student was very profoundly affected by returning to the hospital where she usually worked but this time she was returning with a District Nurse to review a palliative care patient who had school age children and needed to be assessed before returning home to die. She said that she had nursed younger patients who were dying before but there was something different about this situation. In the interview she was still grappling to make sense of her feelings:

Angela: *"I left the hospital not knowing what my feelings were.....One of the visits I found a bit different."*

She still couldn't put her finger on what was so different and at the point of the interview the patient was still in hospital. It was not clear whether the impact was because she had been much more aware of the patient's family and social circumstance.

When I first read the transcripts of the student interviews, I had a sense of data overload. It all seemed to be very interesting but I did not seem to be able to come to any useful synthesis. However I took encouragement from Williamson et al (2012) exhortation to action researchers not to be overcome and to keep an eye to the outcomes. Firstly the fact that the students' minds were focussed on what they had learnt meant that Objective 1 of developing a sustainable process was progressing from their perspective. They chose to focus on their learning rather than negatives in the learning experience. Secondly, the way that cycle 2 reinforced the evidence from cycle 1 that community nursing was an excellent setting to develop organisational competence was an important one. It answered those early critics who were sceptical about the final 12 week placement being undertaken in the community. The importance of District Nursing as a placement for gaining practical clinical skills is well documented (Murphy et al 2012; Marshall and Shelton 2012) but its role in developing organisational competence needs to be highlighted. Finally the intense thought processes and "streams of consciousness" type contributions made by the students gave some insight indirectly into why students who chose to work in the community for their first post without having this experience as a student, might struggle. Experienced nurses who work in the community often speak about having a "community head" - may be the student who saw the dying patient in hospital was not disconcerted by the environment (she was used to hospitals), rather she was affected by having her "community head" which made her much more aware of the patient as a person and as a mother.

Box 5: Reflecting on managing data overload

Although the mentor interviews did not contribute significant data to this theme, one aspect which did emerge was the time commitment involved in teaching about managing in the community.

*“I think the reason I spent more time was because it was management and you need to spend more time discussing management styles and observing and giving her the opportunity.”* (Deirdre- Mentor in Cycle 2)

The NMC requirements for sign off mentorship (NMC 2008) do require that mentors have one hour of protected time with their students and the importance of this in relation to developing organisational competence was something which now informs our mentor preparation.

### Employment in the community

This theme was one which emerged in cycle one but which was much enhanced by data from mentors and managers in cycle 2. The data clearly showed that the experience of being on community had altered career decisions. Of the 8 students involved in cycle 2, 6 applied for posts and 5 obtained posts. The two students who did not apply for posts in the community wanted to apply but there was a local vacancy freeze.

This is Hema who was one of the students with no previous experience in a community setting:

*“... prior to actually coming into the community it was all hearsay , colleagues talking ...I have spoken to a few staff nurses who have actually worked in the community ..it was only what I had heard so it wasn't that I wanted to apply here. I thought it would be something I would enjoy because you know in the morning you have your patients to see; you have your handover, possibly do your administration*



*you have to do for your patients. So I thought OK I like that the day is divided, I had that idea in my head because my background is very much in admin prior to nursing. So I thought "that's good, that's two things I enjoy doing. I enjoy that side and I enjoy nursing so it was in my head but it was only when I came here and did the work that I thought I would REALLY like to apply for this". (Hema-student)*

In contrast Susan was already inclined to working in the community. I interviewed her before the six week point in the placement and she was already keen to obtain a post in the community. She maintained her view throughout and took up a community post:

*KB: "I think you were someone who came in with an interest in working in this area-how do you feel three weeks in?"*

*Susan: "Oh I have found my niche! (laughs warmly) I have found what I want to do, be community based and I think you do make adjustments, You are having to ....say around infection control, the principles of infection control, it is quite different to the hospital, getting used to not having readily available patient notes, that's something I am having to adjust to ..it's not like you just walked over to the nurses' station, pick and read and everything's there. It's just...coming into the community, especially as more patients with long term conditions will be managed in the community...this is the way that it is going". (Susan-student)*

Both students at site 2 went on to obtain community posts but were originally employed as local "bank" staff until posts were advertised. This is how one of them described the placement:

*Aileen: "I believe we were kind of treated as a Band 5 to an extent. We were not let loose doing everything but we did take on a lot more responsibility than we did in our second year and we thought it was a real EYE OPENER to what we would be once we were qualified at Band 5 if we were to get a job here." (Aileen- student)*

Rather contrasting views emerged about the topic of employment from the mentor data. Deirdre was very positive and although she was not the mentor for Aileen quote above, continuity can be seen:

*KB: "Do you think it will make a difference if these third year students spend time with your service?"*

*Deirdre: "Definitely, Definitely. I think from the employers point of view, you have got the student with you for a longer period of time than we are used to so we you will able to try before you buy almost....because you can see their performance and you are also involved in their development and there should be job opportunities and rather purely basing it on interview and references...this way could be a much better way of securing quality staff." (Deirdre- Mentor in Cycle2)*

The second interview was with Helen who had been involved as a co-mentor in cycle 1 and had been a sign off mentor in cycle 2. In contrast to Deirdre her tone does not express the same enthusiasm but in many ways it reflects the same potential for the "try before you buy" – be that from a student or employer perspective:

*Helen: "I think some choose DN because after the placement there is opportunity to find employment because we recruit quite heavily and people think maybe if I come into my final placement I will find employment and that's the fix and maybe they are not that suitable for a community placement or maybe they do not enjoy working in wards and they think perhaps the community placement will be a softer option but it is a very dynamic area, it is very hard work and the onus is on you to make decisions and you have to make very quick decisions sometimes and students do find that difficult to cope with because you feel in those final weeks when you are out on your own and you are doing small tasks.....when you tell them this in the beginning stages they can be really very worried." (Helen-Mentor in Cycle 2)*

This mentor perspective also contains important learning in relation to student preparation as it highlights what students might find stressful. It also resonates with

the student view in the first theme about differences between hospital and community and the sense of having to make decisions “on your own”.

The theme of employment in the community was a strong feature in both manager interviews however there were significant differences in the expectations of the two managers. Geraldine had a striking dual focus: she wanted to talk about the benefits to the service as well as how the student could be useful to the student. In contrast Diane was predominantly focussed on what the student could gain from the learning opportunity, with benefits to staff and the service being a secondary consideration.

These managers ( Geraldine and Diane) both worked in the practice development area of their organisations with a brief which included responsibility for managing student placements but their main responsibility was managing the educational commissioning process to meet the learning needs of their employees which had been identified in practice. In their interviews both managers also relayed the feedback they had received from clinical managers. Geraldine was particularly exercised by the difficulty in recruiting and retaining staff nurses in the district nursing service and had been the person who was instrumental in changing the focus of the project to one which particularly focussed on students in their final placement prior to qualification.

This is how Geraldine outlined her expectations from the project:

*“The reason I wanted it was that I had worked at (name of area outside of London) before and had worked as a clinical placements facilitator and doing that realised how precious third year students were to good services. It is a really good relationship. If you have a good service and they put the time into the third year student ...the third year students really like being there ..then we can recruit them...but equally service really benefits from having third year students who have a bit of nouse about them and can question them and push up standards.”*

*(Geraldine-Manager)*

The interview with Geraldine was also useful in confirming data which had been largely anecdotal in the diagnostic phase of the project, namely that the lack of community experience had an impact on student's ability to apply for and retain posts in the community setting. She clearly outlined why the previous pattern of one month placements did not make the necessary difference:

*"I was a bit shocked that all our placements in community services were for one month.....for me – to be selfish about it- what do the services get out of it? Giving students one month placements and there was the issues of transforming community services ...students should be able to work in the community direct on qualification. Actually our Band 5s were showing that was not the case...so actually there were lots of reasons for wanting to get third year students. And finally we had an adult community nursing service at the time which was struggling to recruit, so I thought if we could get third year students in there and really give them a good placement, they would choose us to come and work, we would recruit them and it would be a real morale booster for the service."* (Geraldine-Manager)

Whilst Diane's expectations of the project had likewise been positive, her focus was much more on the student experience and why that was beneficial:

*"I thought it was a wonderful opportunity for the students to get a much better idea about what is happening in the community because care is now moving into the home much more...I think it is for them to understand that you have still got the acute element but also that a lot of the "acute parts" can happen in a client's home ..you can bring most of it, almost all of it into the client's home and that's what people want, they want to be at home...some people don't they want to be in hospital, they feel safer may be but a lot of people want to be at home with their family and their carers so I think for the students it is a wonderful opportunity to understand that it can all happen in the community and also they see the multidisciplinary working. You have got people like the OT; you have got the physio,*

*the chiropodist etc. THAT's what I thought was a great opportunity...so yes I was personally really looking forward to having that..." (Diane-Manager)*

Although the student, mentor and manager contributions on the employment in the community theme had different points of emphasis, there was one very strong point of agreement that the placement played a part in the confidence of both the student *and* the service that a community post would be suitable.

The actual process of recruiting students to staff nurses posts formed part of the data from both managers but local circumstances impacted on their perspectives. However from a project standpoint the differences contributed to our learning. Geraldine had been involved in Cycle 1 and Cycle 2 and therefore not surprisingly had plenty to say about employment. Her organisation had employed both students from Cycle 1 and they had just interviewed for new staff the week before I conducted the interview and they had employed three students from Cycle 2.

KB: *"Have you, in your role, had any feedback from individual managers of the services?"*

Geraldine: *"X (overall manager of DN services) has fed back because she is absolutely delighted because of the recruitment of course...because it is an ideal thing you are recruiting people that you know are good." (Geraldine-Manager)*

This section of the interview also revisited the theme of the service's previous difficulties with retention and recruitment:

Geraldine *"... but for the service as a whole in terms of recruitment it has been fantastic and the confidence they can take third year students. It has been a successful project, really successful. The other reason I was really keen on it was in the past we were getting BAND 5 nurses and sending them out there and expecting them to deal with End of life care and they were not ready for it...so it was part of that retention thing too...it's that sort of thing that they have the support*

*mechanisms in place and then they are not going to burn out in the first six months.”*

KB: *“Yes that is an important element.”*

Geraldine: *“...and they know what job they are coming into!” (Geraldine-Manager)*

As I knew from the interviews with students, the situation in Diane’s organisation was very different because of the vacancy freeze. I knew that neither student from her area had obtained a job locally. This is how Diane reflected on the situation:

*Diane: “No one has gone on which is a real shame. There hasn’t been the posts available, they haven’t been linked with their placement...I don’t know whether the students said anything to you about whether they would come back into the service?..... my understanding is that both of them are local and would want to ..I know that one of them got a post at X (a rehabilitation centre) and may come back. I think the other has a place in the community but not with us...I think it is a real shame, we have gone back and asked the manager...it just hasn’t happened. It is not because they haven’t got the experience...maybe we need to think about that. Maybe I need to go back to the manger and say “is there anything else we could do to support the student if they would like to get a job” because obviously the mentors have put in a lot of time and investment into the student and they get to know a particular area...and enjoy it and they have chosen to come , they have been interviewed by the university and they want to do it, they have chosen to do it.....so maybe from the trust point of view we need to relook at it...” (Diane-Manager)*

The important point about this section was the tone of Diane's comments. The repeated reference to it being a "shame" that the students were not employed hints at this but it comes across more strongly on the tape. I remember feeling rather uncomfortable at this stage of the interview because I sensed that the manager felt that she had somehow "failed" in not doing more to help the students gain employment. However I knew that it was not within her gift to influence NHS funding and I knew that her organisation had been merged with a much larger trust just as the cycle 2 concluded and therefore it was not surprising that this had been associated with a vacancy freeze. I was conscious that even if Diane had argued the case for the students, it was unlikely that the much larger organisation would have made an exception for District Nursing which would have been one of many service lines.

In terms of the project objectives the immediate importance of her data, was that it indicated that even those students in cycle 2 who did not immediately gain community employment, were keen to do so and possibly had done so after the project period.

**Box 6: Making sense of feelings in the interview process**

In summary the employment and employability theme of this project and the mentor, student and manager testimony about how the placement built confidence to work in the community setting is a theme echoed in other descriptions of third year placements with District Nursing teams (Middleton and Duffy, Arnott 2010, Marshall and Shelton 2012) and in particular the confidence arising from undertaking delegated visits independently (Brooks and Rohjahn 2011) is well documented. However which placement pattern is the most effective and how best to manage that placement pattern to maximize the benefit to patients and the profession are bigger questions which deserve further study. Equally evident from this study is that whilst the aspiration of the government in their last major document on the nursing workforce (DH 2006) is that nursing profession would begin their working careers in the community, unless undergraduate nurses are exposed to home nursing, they will lack both competence and confidence in the setting.

### *The process of sign off*

This final theme from cycle 2 was most pronounced in data from my learning log and from interviews with mentors. Originally I had concluded that this theme would be called “anxieties about the sign off process” as the initial codings did include refer to anxiety or uncertainty about the process. However after reading and re-reading the data, it became apparent that although there was a degree of anxiety about sign off, there was also good evidence of the services adjusting to the concept.

Although the time line for cycle 2 had indicated that the preparation for mentors would take place from July 2010 to November 2010, the evidence from my learning log shows that this preparation actually took place in the two months from September to October. Some of the diary entries relate to the importance of ensuring that learning about logistical issues such as ensuring students could access IT systems which emerged in cycle 1 were acted upon in cycle 2. However the most striking feature of the entries is my comments about the contrast between the areas where I was well known and the two new areas. In total there were 8 mentors involved in cycle 2, of whom four came from the borough where I was well known and two each from the other two boroughs.

I made an assumption that I would find it harder to access staff in the new areas. This proved to be completely wrong as the following two extracts from my learning log demonstrate:

*“Got a call from x (manager in Site 3) and she says she has booked a room for my meeting with the two mentors and she is going to be there too! Normally it is me doing all the arranging and finding a space to “perch” somewhere with the telephones ringing and patient calls coming through.” (Learning log Sept 2010)*

*“All set up for Site 2 now- again both mentors will be there. I am so used to whizzing around on my bike and “fitting in”, this is really good.” (Learning log Oct 2010)*



Not surprisingly both these meetings led to quite a lot of questions about the project and the sign off mentor role. In particular in Site 3 the involvement of the manager at the meeting meant that I was asked to give a detailed explanation of NMC requirements and this is reflected in the learning log:

*“I was really cross examined about the sign off concept and NMC requirements. It was a bit intense and there does seem to be a higher anxiety level than in Site 1. However it is first time for this site and although they know that cycle 1 was “successful” that might be contributing to their anxiety. For example, what if it doesn’t work out here, would they see that as reflecting on them. The good thing about this anxiety is that it does make the organising much easier! I have got dates in the diary for the two subsequent meetings and for an interview with one of the mentors after the placement has ended.” (Learning Log September 2010)*

Cycle 2 introduced a new dimension to the insider/outsider concept. An interesting dimension of cycle 2 was that I was much less of an insider in the two additional boroughs who joined the project. I was known to the staff but the relationship was more formal. Several of the mentors had attended a session at the university where I was discussing the new curriculum for BSc Nursing (which was validated in May 2011) and therefore knew my face but unlike in cycle1 where I was a “known quantity” as their link lecturer, I was a comparative outsider for half the mentors in cycle 2. I had anticipated that this would increase the challenge of engagement but in reality found the opposite applied as the little extra formality meant they also timetabled carefully for the research contact time.

This contrasted with the area where I was well known, where they were more relaxed about postponing a research related meeting.

**Box 7: Reflecting on insider/outsider concept**

As often is the case in action research it was in writing the research report (Williamson et al 2012) that I really “noticed” the importance of the sections in the learning log about practitioner anxiety. The learning log entries were focussed on

the pragmatics of dealing with the anxiety, providing information and so on. However in reflecting on action (Schon 1983) some time afterwards, I appreciated that if the anxiety about the sign off role at sites 2 and 3 was generalised, then this could impact on the sustainability of the process (Objective 1). I therefore tried to unpick this further in one of the mentor interviews (Deirdre) after the placement had ended.

The opening section of the interview with Deirdre (Mentor to Angela in Cycle 2) where I explore her expectations was one of the most confusing sequences of all the interviews that I transcribed. It is worth showing in full because it provides some insight into how new the concept of sign off mentor was to this practitioner and also gives some insight into how her community colleagues viewed the role with some trepidation:

*Deirdre: "I was a bit apprehensive to begin. I wasn't sure what the whole process would involve. I thought it would be something quite different to what it actually was and I don't know what I expected."*

*I think the only thing I found with it was that I worked harder with this student than I would do normally. I spent more time with her and she was very enthusiastic anyway. And from the expectations anyway ...It was easier than expected...It wasn't totally unknown territory though... I felt quite comfortable."*

*KB: "And when you say "easier" can you pin point what you expected?"*

*Deirdre: "I don't know Kate, when you listen to other people...they say "sign off mentor, Oh No" ....and I say "what does this mean then? After all teaching is part of our whole role, what is different with students and being sign off mentor...as I say it was easier than I had anticipated....I thought there was some hidden agenda that I did not know about. But there wasn't." (Deirdre- Mentor in Cycle 2)*

I decided that this was a very significant section for my report in that Deirdre is clearly voicing concerns from colleagues about undertaking the sign off role and had clearly formed an impression that there was a hidden agenda and that the role would be very hard. In the event she did find that the role entailed more work than with a more junior student but the anticipated difficulty in being a sign off mentor did not materialise. Later in the interview she talks about the significant benefits for the service of having finalist students. This would seem to be key message for preparing sign off mentors in the community- be prepared for some additional workload but the work in itself is a natural extension of what you already do as a mentor and although there is additional work, this carries benefits to the service. Deirdre was reflecting anxieties that existed amongst her colleagues but she was indicating that she had personally had “found a way through” and reached a conclusion that the role was manageable but did entail some additional workload. In terms of objective 1 about the sustainability of the process, the importance of acknowledging the anxieties and implications for mentors is also significant.

**Box 8: Reflecting on sustainability of the process**

In 2010 Andrews et al used the phrase “a type of super mentor” to illustrate how some of their contacts viewed the sign off role and, as in Deirdre’s quote above, they described a wariness amongst practitioners of a “hidden agenda” in relation to the sign off role. Although Deirdre did not use the term “super mentor” she did reflect similar anxieties. Andrews et al (2010) also reported on “unease amongst practitioners and educationists that mentors may not always have the time to mentor students to an appropriate standard” (Andrews et al 2010: 252). The literature which has emerged since the project activity (Baker et al 2011, Casey and Clark 2012) provide descriptions of whole trust or city wide preparation strategies for preparation of mentors . It is clear that group preparation would provide practitioners like Deirdre with the opportunity to share her concerns with other sign off mentors. In the early stages the wide geographical spread of the individual community sign off mentors made group preparation difficult but once each community trust has a critical mass of sign off mentors in place, an annual

workshop for community sign off mentors might be a useful strategy for sustaining the process in the longer term.

The manager interviews presented contrasting pictures of the sign off process. For Geraldine it was cycle 2 and she reported a fairly smooth process.

*"I didn't hear anything from X ...there was an issue about can they get RIO cards and can they use Rio or not. That was the only thing which came across my radar and I heard that they got employed. I think you did a lot of work to make sure that it worked and I think that worked....." (Geraldine-Manager)*

When I transcribed this part of the interview I noticed for the first time her emphasis on how my own work and its importance to the process but in the same section Geraldine noted:

*"X ( one of her own team) probably did less "hand-holding" than they got last time but it still obviously worked...which means there is something in the service . They are doing it for themselves now really."(Geraldine-Manager)*

In contrast in Diane's contribution there was evidence of possible fragility in the system when she explained how they selected their mentors:

*".....if I am honest we hand-picked who we were going to use because there are some staff who are really happy with students ...so I think you go to those staff first and they were fine with it." (Diane- Manager)*

Likewise her description of my role below could be interpreted in two ways. It could be indicative of dependence, but as she outlines the actual contact with me was very limited- the actual day to day actions of practitioners had not involved very much contact with me at all:

*"...the fact that we had you taking the lead and they knew they could ring you about any problem etc. which they have done and they have occasionally come to me but I*

*think they have come to you more as you are dealing with the 12 week students. They may not have rung you up but they KNEW there was someone in the background and the fact that if they contact you, that they would always come back to them. Sometimes you ring someone and they may not come back for a couple of days or a week but with your good self you come back. So they get good response, and they feel confident then that you are there to support them....” (Diane-Manager)*

Although I had originally viewed it as a negative that I could not interview Diane until four months after Cycle 2 had ended, it transpired that the delay was useful in that her organisation had by that time accepted three further students for a sign off experience. Therefore although I was interviewing her about Cycle 2 I knew that the process of accepting more students had proceeded without significant intervention on my part. Although I had prepared the mentors as part of my routine work, I knew that I had only had brief telephone contact with the mentors subsequently. I therefore checked with Diane if this had deflected work on to her? However this had not occurred:

*“No I don’t think so. I don’t know if I should have been more greatly involved but they are all experienced mentors and normally if there is a problem they will ring me up or they email me.” (Diane-Manager)*

This section of the interview therefore provided useful evidence for my objective of developing a sustainable system for community sign off students. Nevertheless it would need to be highlighted as a limitation of the study that the success of the initiative could be in part due to individual commitment. In Yorkshire and Humberside their community placement final year model ( Marshall and Shelton 2012) was set up with Rosemary Shelton employed in the role of project manager and they specifically highlight as a limitation the fact the success of the project relied on individual effort:

*“the success of this innovative approach, at least in part, was a result of the tireless motivation of a project manager and champions (Marshall and Shelton 2012: 628).*

As with this project, they go on to report that the placement circuit is now embedded in the adult nursing programmes and hope that the success will be maintained. When Robinson et al ( 2012) studied the sustainability of student nurse mentorship as a whole they highlighted how relationships between key university staff and managers like Diane and Geraldine were the “glue which held the system together” and were based on detailed local knowledge of practice settings and circumstances.

#### *Dissemination in Cycle 2*

In the project plan the intention had been to present findings to participants some time shortly after cycle 2 had concluded and there had been time to process the data. The original plan had been to present findings to participants in 2011 shortly after the validation of the new curriculum in May 2011. In the event this was highly optimistic as the month immediately after validation required changes to be made to meet the validation conditions and, in addition, work which had been displaced due to validation needed to be attended to. In Sept 2011 I took responsibility for a new programme at the university and somehow the pressures of the academic year mounted and the event took place in May 2012. I was fortunate to get attendance from mentors and managers in sites 1 and 3, senior staff from the university placements department and colleagues who were community link lecturers in all three sites. I was also fortunate that my colleagues who had acted as a peer debriefer throughout the period of data analysis took detailed notes of the session which lasted nearly two hours. My presentation took approximately 30 minutes and therefore there was considerable questioning and commenting.

The key points from the notes of the meeting were that those who had contributed to the research could relate to the presentation and this contributes to the

participation validation (Boulton and Hammersley cited in Sapsford and Jupp 2006) of the data. Importantly they contributed further examples to illustrate the points that I was making. An important section of the discussion related to the participants discussing earlier problems with recruitment and retention. The issues of previous students applying for posts but then not being retained were raised by two of the participants. Again this was important confirming data.

The discussion at the end of the presentation diverged from nursing education to the wider discussion about the future of community nursing. In terms of the objectives this discussion was relevant to objective 2 about the implications for service providers. One of the practitioners and one of the managers commented how unusual it was that someone was interested in what happened to community nursing and that the research had been positive in that it “felt as if someone cared about us”. This particular remark resonated with the comment made by Deirdre when said at the conclusion of her interview:

*“One more thing I must add is that this whole experience has brought the university closer to the clinical environment.” (Deirdre-Mentor)*

This feedback from practitioners about feeling “cared for” in some way by the project was important. The section of the historical context chapter in relation to the reduction in District Nursing numbers (QNI 2009; RCN 2010) had originally been driven by the Higher Education representatives in the community of practice as they sought to understand what was happening to District Nursing. This dissemination phase highlighted one of the positive impacts for the practitioners as they sensed how the wider community of practice appreciated what was happening to their role. The knowledge obtained proved important for the dissemination phase in cycle two as it gave a context to the views of mentors who felt that their profession was being neglected by policymakers. The “glue” of relationships which Robinson et al (2012) describe as sustaining mentorship in the UK was strengthened by the increase in local knowledge and contact.

Herr and Anderson (2005) argue that a collaborative approach to methodology truly develops where the observer and the observed develop a reciprocal learning relationship. They argue that the dialogue between researchers and research participants enhances the authenticity and utility of the research findings. My attitude throughout this project was that all the stakeholders had knowledge and valuable expertise to contribute to the research and therefore I did not view them as the “observed” but I do agree with Herr and Anderson (2005) that it is about a reciprocal relationship. The remark made in the presentation about the project making the practitioner feel as if someone “cared for” them, made me in turn reflect about the positive commitment of the practitioners to the project despite working in a specialist field of nursing which has seen the been under severe pressure in recent years ( RCN 2013a).

Patricia Maguire in her foreword to Herr and Anderson( 2005) says that action research projects

*“...are not neat, individualized academic exercises with correct answers, but messy work best done in collaboration, reflection, and conversation. New insights and knowledge are arrived at through action and research done in relationship with others.” ( Herr and Anderson 2005:xiii)*

Many of the key words of my experience are in that quote: “messy”, “collaboration”, “reflection”, “conversation”. And probably most significantly, long standing relationships were strengthened and new ones developed.

**Box 9: Reflecting on the collaborative approach**

### *6.3 Cycle 3-the “long thin cycle”*

In my earliest version of this report I focussed on writing about the intervention and documenting the findings from cycle 1 and cycle 2. However as I continued to explore the implications for my own workplace – the HEI- I decided in conjunction with my supervisor that there was, in effect, a long thin cycle underpinning the whole project. This cycle did include the work within my organisation to prepare for cycles 1 and 2 but it also predated and post-dated the interventions. The work



related to preparation of students and mentors has been reported above, and therefore this section reports on two new elements: the two interviews with colleagues in the Practice Based Learning Department and particular written outputs which have been requested from me by the organisation as a result of this project. Key events in the cycle 3 timeline which covers a three year period are outlined in the Table 15.

Date	Activity	Data collection	Objective
July 2009- July 2012	Planning and implementing processes for students undertaking sign off placements in “non-traditional” areas	Interview data Learning Log	Objective 1 and 2
May 2011	BSc curriculum Validation event	Learning Log	
Sept 2011	Interview 1 with Senior HEI staff member with administrative responsibility for placements	Interview transcript	
Sept 2011	Interview 2 with Senior HEI staff member with overall curriculum responsibility for placements	Interview transcript	
Autumn 2011	Submission of report to Framework Management Team		
July 2012	Briefing project worker regarding development of sign off placements for Child Health Students in non-ward areas		

Table 15: Timeline for cycle 3

### The HEI perspective

In my research design I had envisaged that I would gain my understanding of the implications for the HEI via my insider work role and careful reflection on that role via my learning log. I would also have access to student evaluations and discussions. However I thought it would be important for objective 1 and 2 to formally evaluate with practice based learning colleagues whether they thought the process was sustainable and to identify whether they thought they were implications which I may have missed due to my closeness to the data. I therefore planned to interview

two colleagues shortly after the conclusion of cycle 2. In the event this proved unrealistic as they were very involved in the curriculum planning for the new curriculum in May 2011 and the subsequent amendments before the summer holiday period. My original conception had been they would be easy to access because they were in my immediate work environment but this was not the case. I therefore planned to interview them in September. I identified two people who I thought could provide useful data namely Leila, the lead academic with responsibility for practice based learning and Peter who had overall administrative responsibility. The interview with Peter confirmed existing data about the general difficulty involved in accessing community placements. However whenever I asked follow up questions, he suggested that I spoke to Leila and therefore in this final report I quote from Leila.

The interview with the lead academic for practice based learning (Leila) in Feb 2012 was a very strategic interview in that it helped place the project in a wider context and in particular spurred me to think about the recommendations that would arise from the project. However the first important piece of learning from the interview was historical rather than future orientated. When I started the project the focus had been about changing our systems from one month placements to some longer placements which could impact on employment. Despite working for the same organisation I had forgotten how we had arrived at that point and this interview reminded me:

*Leila: "When we developed this curriculum it was to try and get students a six or eight week placement in the community ...even though the curriculum from the beginning was meant to develop students for hospital and community equally we knew there were fewer community placements and that was a practical goal to get them a minimum of six or eight weeks with a district nurse type of placement if possible. Over the years that became very difficult with the changes happening in the community and we had to reduce it to 4 weeks because they couldn't provide the placements for the students with all the reconfigurations and reductions in health centres and everything else that led to so we were then more or less forced*

*to reduce to a minimum of a four week experience.....However one of the negative aspects coming back from the community team AND the students is that 4 weeks isn't really long enough to help the student get a proper experience but that is what has been maintained to date..”(Leila –HEI Practice Based learning)*

In some ways the report of previous students was important data to support the intervention but I was disconcerted that I had not seen this concern in any written evaluation prior to the commencement of cycle1 as it would have confirmed the anecdotal concerns.

Another section of the interview which contained important historical data is set out below. In this section Leila is recalling the original meeting with Geraldine when the suggestion was first made to place students in the community for the “sign off” period:

*Leila: The discussion then led on to the fact that they would really like to employ the students in the future and what was the possibility of having an end of programme placement for students and the issue of the 12 weeks came up which Geraldine ( Manager involved in Cycle 1 and 2) at the time was quite excited about and we were quite excited about because from my perspective I hadn't really thought of the students going for a final 12 week placement in the community at that stage because I was unsure whether students could be employed directly into the community and so did not think it was such a viable option .....*

*(Leila- HEI practice based learning)*

The key sentence in this section was her admission that she had not been aware that prior to the project students had been applying for first posts in the community and was a local example of someone believing “community myths” (Shelton and Harrison 2011). She did not seem to be aware that students had been employed in the past and as Geraldine had reported, some had not been retained as they had found it too stressful.

Of all the interviews that I undertook for this project this was the one which made me reflect most about my role as an insider researcher as I think I should have conducted this interview much earlier. I chose to time this interview towards the end of the project for two reasons. Firstly I thought I had sufficient data about her role because of regular interaction, notes in my learning log etc. to inform my preunderstanding in the early part of the project. Secondly I thought to myself “concentrate on gaining access to other staff in clinical practice, who are harder to access, you will be able to access this colleague at any stage.” This was the senior member of staff who had been present when Geraldine suggested the intervention which I studied in this project. I had regular contact with her in my role as link lecturer and would see her at least weekly. However this interview completed after the intervention did produce important information about the HEI view which must have been having an impact on services and also this member of staff had insights into student views which had not emerged from written evaluations. Despite my immersion in the process, I had not been fully briefed in student views and I also found out that a key member of staff was making wrong assumptions about community employment. Although these views emerged late in the project, they added weight to the decision to choose the intervention. However they really should have been part of the preunderstanding.

In future action research studies, I would now choose to interview close colleagues at an early stage in the process as there is something about putting the participant in “research mode” as opposed to “work mode” which is just as important as the duality of role that is experienced by the researcher. In “research mode” colleagues say different things to “work mode”.

**Box 10: Reflecting on role as insider researcher**

### The future and sustainability of the process

Two further key sections from this interview related to objective 1 and 2. This was largely positive in terms of describing how the process was working effectively. However as with the NHS, funding uncertainty in Higher Education is also impacting on nurse education (Willis 2012). Although the process of contacting students had

been developed efficiently and working effectively it did entail some administrative support from the practice based learning unit and in February 2012 this HEI manager was concerned about how the review of administrative staff in the university might impact on our process:

*Leila: "We have looked at the student's profiles, contacted the students, set up appointments with the students and I have done that with the support of \*(name of administrator) doing that for me and that is one of my concerns for this type of work in the future with the way the university is moving forward with the mass reduction of administrative work..with this type of work which is becoming even more important of the different types of placements that students will be going into in the future that people will want a selection process of some kind to know that they are getting students who are motivated e.g. foundation trusts, independent/private sector..... they don't have to take students (note: different to NHS) so it is important for them to get the right student so it may be difficult. So it is resource intensive and it does need administrative support. (Leila- HEI Practice based learning)*

I pressed her to say what she meant by resource intensive and she said:

*"... it is probably a day for each cohort."*

This could be looked at two ways: on the one hand as "resource intensive". On the other hand if the results of cycle 2 were maintained with future cohorts, and 5 out of 8 students successfully obtain a community staff nurse post then this might be rather cost efficient. An investment of one day to ensure better retention in community staff nurse positions could be viewed as very worthwhile expenditure. The HEI budget is quite separate from that of the NHS provider, but in the wider picture; they are part of the same public expenditure. This indicates that there is an urgent need to update the work of Jones and Akehurst (2000) on the cost and benefit implications of placements in different settings.

## Outcomes in the workplace

As all HEIs in the London area had to tender to deliver Pre-registration nursing programmes in 2011 I was asked to prepare a report for the Pre-Registration Nursing Framework Management Team (appendix 5). Unlike some other institutions my own was successful in obtaining a contract in January 2012. However it was not until I conducted the interview with practice based learning colleagues that I understood how frequently the project had formed part of the on-going report to the strategic health authority:

*Leila: "We presented it as an example of good practice in reports such as annual monitoring reports and track monitoring report with NHS London because of their focus with preparing students and preparing students for community. So for those reports or for any NMC visits we have flagged the project as an example of effective practice that we are pleased with/proud of to demonstrate these students being prepared for the community and data for these students being successfully employed. And when we had the initial data we did present to NHS London of the number of students who had been through and the number of students who had been employed and a number of the trusts were represented there at that meeting – at the annual meeting. NHS London were very pleased with the initiative and felt that it was a very sound initiative to move forward with. So because it is important initiative we have made sure that Head of Institute, Dean and all of the external bodies have been made aware of it at different stages. So the report also that was presented at FMT was appended to our tender process to give an example of innovative practice and also show ways we are preparing the nurse for the future....." (Leila- HEI practice based learning)*

The other important development was the way the project acted as a catalyst to the development of sign off placements in a whole range of areas where they had not been previously considered. Several of these related to a different field of nursing – child health. In this instance my institution employed a practitioner on a short term contract to arrange these. I played a key role in inducting her and

describing the processes developed in the project. These sign off placements will take place in 2013. See appendix 6 for an article (Brown 2013) that I wrote describing the development of a sign off placement pilot with the health visiting service.

#### *6.4 Conclusion*

This chapter has outlined how the planned project activity was implemented and has presented the data and findings which resulted. The themes as identified by the students, mentors, managers and higher education colleagues are highlighted and, using the mechanism of boxed comment as introduced at the beginning of this chapter, my reflections on action (Schon 1983) are presented alongside those findings to assist the reader in making sense of the data. The next chapter will present the conclusion and recommendations arising from the action cycles.

## Chapter 7 Conclusion and recommendations

### *7.0 Introduction*

This chapter will summarise and reach conclusions in relation to each of the objectives for this project. In addition important findings which were not part of the original objectives, such as the employability and employment of students, will also be addressed. Likewise there will be reference to the development of learning opportunities in community areas which were not part of the original project but which have unfolded during the dissemination phase. Finally recommendations will be made for the local context and the wider educational and service context.

### *7.1 Design and implement a sustainable structure to support sign off mentorship in the community*

The intention was to design a sustainable structure in my own workplace and this has been described in the Chapter 4 as part of the project activity. There is now a well understood timeline whereby students with an interest in undertaking their final weeks of practice in a community setting, express an interest towards the end of their second year of their three year programme, and then those students are interviewed in a process conducted via the practice learning unit at the university.

The other side of the “sustainable process” is the availability of qualified community sign off mentors. At the start of this project there were none available and now there are 16 such mentors on the live registers held by the local service providers who provide the learning opportunities for the institutions students. I have personally played a role in the development of all of those individuals but there is an NMC expectation that the process of developing sign off mentors will proceed by a cascade system with existing mentors preparing others within their own organisation. One positive resulting from the delay in producing the final



version of this report has been the opportunity in 2013 to observe the involvement of existing sign off mentors in preparing new sign off mentors.

The other important evidence that the structure has truly become embedded in the workplace is that the timeline and process for student preparation has now been adapted for the preparation of students in areas which were not originally planned as “sign off” areas in my institution such as operating departments and accident and emergency departments. The development has now influenced other fields of nursing with child health colleagues in particular utilising my timeline and approach. One of the child health areas is also community based in the health visiting service and I have been able to publicise this development (Brown 2012). This article in turn has sparked interest outside our local area and I have been able to advise other institutions on our processes.

Although there is no intention in action research to claim that findings are generalisable, there is a requirement for “transferability” (Herr and Anderson 2005) which entails providing sufficient detail about the context and processes so that others can replicate the process. Likewise the requirement to disseminate is a vital stage of the action research cycle and ensures that the learning is shared. In this report Chapter 4 has aimed to give sufficient detail of processes such as our method of student selection and mentor preparation to allow others to replicate our processes and study them in their own context. In addition the description of the processes involved in this project and the learning and outcomes arising, have been formally reported to London Strategic Health Authority as part of a tender submitted by my organisation and in articles arising from the project (Brown 2012, 2013).

## *7.2 Sustainability – the wider context*

The literature review involved a re-reading of the NMC 2010 standards for pre-registration nursing. These standards contain a statement

*“Adult nurses must also be able to carry out accurate health, clinical and nursing assessments across all ages and show the right diagnostic and decision making skills. They must have confidence to provided effective adult nursing care in the home, the community and in hospital settings to individuals and communities”*  
(NMC 2010: 17)

Evidence quoted from participants in this project indicates that confidence in the home setting arises from a period of prolonged contact in that setting in the latter stages of the educational programme. In our community of practice realistically that opportunity for prolonged contact in the foreseeable future will only be accessible to a minority of student nurses and therefore confidence in that setting will not be achieved by all. The NMC competency statement above should be formally challenged and it is a view that I have shared with the Head of the Institute of Nursing, Midwifery and Social Work at my institution as she is official correspondence for my organisation with the NMC. This point is also articulated by participants in the recent survey of placements in primary care settings (Betony 2012) described in the literature review.

The NMC 2010 standards should be modified to reflect the importance of all nurses having some experience and awareness of nursing in the home setting. This will be challenging as currently there are multiple community placements which are inaccessible to student nurses as GPs are reluctant to provide placements without financial reimbursement (Willis 2012). The provision of community services by private contractors as has already in occurred in Hampshire where community services are provided by Virgin health care may also impact on practice experience provision in the future. The Willis Commission on the Future of Nursing education noted that although nursing education issues were not a focus of the controversial Health and Community Care Act 2012, they predict that the 2012 Act and other health care reforms are having “a major, as yet unquantifiable impact on nursing and nurse education.” (Willis 2012:19).

Even though it will be challenging to find all student nurse a practice experience in home nursing, it will be vital for all areas of the country to ensure that *some* students do have the opportunity as demonstrated in this study to access this opportunity as the literature review clearly indicates an urgent need for this area of nursing to be rejuvenated and replenished with a younger workforce. The number of students accessing this opportunity must be compatible with the number of sign off mentors available to offer a quality placement.

### *7.3 Evaluation of the student experience and the process- the implications from the perspective of student, provider organisations and higher education.*

The following sections will summarise the key findings in relation to the student experience from the perspectives of the different stakeholders and will explore the implications for them. The triangulation of data from students, NHS service providers and Higher Education produced considerable agreement on the benefits of the intervention. However the intervention does have implications for the Higher Education infrastructure and demands a time and workload commitment from front line practitioners which should be acknowledged and recognised in workload allocation.

#### The student experience – key outcomes

The most significant finding in terms of evaluation was the strong link between the experience of undertaking a final placement in a community setting and applying for, and obtaining a post in that setting. Of the total number of students (10) involved in the two cycles, seven obtained a community post as their first destination upon qualifying. I subsequently learnt that two of the remaining three have also applied and gained roles in the community within two years of qualifying. As a result of my insider role I have access to on-going evaluative data and I am aware that one of cycle 2 students has already gained a promotion. However the question of whether they continue to have a career in the community in the longer term is unanswered and would require a longitudinal study.

The project found that the process of selection of students for the community setting had also served the dual role of preparing them for learning in that setting. The opening part of my interview with each student had been about their expectations prior to placement and then moving to their actual experience. This did not elicit any complaint from the student that they were unprepared. Nevertheless there was an important part of the biographical data of the students that I had not highlighted in the project activity which was significant in that two out of the students in cycle 2 were students who had not undertaken any experience prior to their final 12 weeks. Inevitably those two students experienced more significant reality shock and spoke in more dramatic terms about their actual experience. It is well known that student nurses in general find the transition from student to staff nurse to be a difficult transition (DH 2010) and the experience of these two students doubly underlines the importance of experiences as a senior student in a community setting. An incidental finding was that the process of selection for undertaking a community sign off placement had also helped prepare students for actual job interviews.

Some of the students who had undertaken a second year experience, highlighted that they would not have “risked” applying to undertake their final placement in the community without that experience. It would therefore appear that the availability of second year experience complements third year experience. However the success of one of the students in obtaining a post upon qualification based only on third year experience would indicate that lack of second year experience should not be a deterrent to applying for a post in the community setting.

Prior to the project , concerns had been raised at the university that students might in some way be disadvantaged by undertaking the placement and this concern had led to specific interventions including preparing students about how to “use” their community experience in applying for jobs back in the hospital setting. In the event the evaluation did not demonstrate any disadvantage experienced by students. Of course, two students were adversely affected by a vacancy freeze in the

organisation at the point they qualified which meant that they could not apply locally. These two students applied successfully for roles in inpatient settings initially and again as a result of my work role, I have heard since completion of the project that they have both moved into a community role.

In more general terms the student data highlighted that the community setting was a particularly rich learning environment with description of a wide range of learning opportunities particularly in relation to wound care and management and the management of other long term conditions. In some ways this was an unremarkable conclusion as this is the main workload of District Nursing teams. Nevertheless it needs to be stated because the initial plan of the university was not to use this setting at all in the final 12 week period.

Traditionally the final 12 weeks prior to qualification has been referred to as the student's "management experience" and the HEI documentation included a formal skill "managing a group of patients in the hospital setting" which had to be amended to "managing a group of patients in the community setting" for cycle 1 and subsequently for cycle 2. This project demonstrated clearly that nursing management skills could be easily assessed in the community setting and perhaps more significantly, that a placement with a District Nursing team was in many ways, an exceptionally rich opportunity, for learning managerial skills. Students and mentors provided detailed illustrations of how they learnt and conceptualised management in this setting. In particular both mentors and students gave descriptions which I dubbed as "layers of the onion" management models. This took the form of students describing to the researcher how they initially concentrated on learning how to manage aspects of care for an individual patient, then learning about managing how to deliver care to their assigned group of patients, then learning about how the team manager managed the total caseload of that particular clinic.

## The student experience: practical considerations

The project highlighted a number of practical considerations which impacted on student learning and whilst these were addressed at the time, they do warrant mention in the conclusion. In both cycles of this project students commenced their practice experience in November and concluded in early February and in both cycles, students' encountered adverse weather. Unlike their counterparts in the hospital setting who can be oblivious to weather conditions for the duration of the now typical 12 hour shift in the NHS, community nurses have to be outside in all weathers and highly sensitive to the impact of the weather on their patients. In both cycles, the students were very quick to tell me about the challenges of the weather conditions and their satisfaction in – as they saw it- triumphing over the adverse conditions. However one of the students' learning was thrown off course as she was deflected into doing the work of care assistants during the poor weather and found her learning neglected subsequently. The situation with this student was rectified with some support from the local clinical learning facilitator and overall, the adverse weather conditions gave the students' a very realistic insight into community nursing at the most challenging time of the year.

Since the completion of the cycle 2, circumstances at the HEI have changed at the request of the strategic health authority with all students commencing and concluding their programmes in September as per the conventional academic year. This pattern is now the typical pattern in UK universities and means that most future students undertaking their final 12 week practice experience prior to qualification will do so in high summer and they will not have the experience of coping in adverse winter conditions. However once in a staff nurse post, they will have to work through a winter. I would therefore suggest that universities make explicit reference in learning materials to this aspect of community nursing to at least prompt students to give consideration to this aspect before applying for work in the community.

The other practical issue which students faced was difficulty in accessing electronic record keeping systems. The local NHS trusts information governance procedures had rules about staff attending a workshop prior to being given a PIN code and for students on shorter placements, custom and practice was that they entered records under the direct observation of a mentor via the mentor's access. However for senior students it is essential that they have independent access and the information governance rules are clear that staff should not share their PINs with anyone including the student. Equally the NMC recordkeeping guidance (NMC 2009) is very clear that recordkeeping is "integral" to giving care and not some additional activity. What was observed in this project was variable practice with some students gaining their own PIN very early in the 12 week period and others much later. It appeared that this process was reliant on the initiative of the local manager and the student's individual mentor was not easily able to affect the process. Although delays are now less likely, there continues to be variable practice and this is one area of my objective of developing a sustainable structure which is not satisfactory. At my instigation this topic is being formally addressed at the Pre-Registration Nursing Framework meeting at my own institution.

#### The service provider experience

This section summarises the key findings from the collaboration with the service providers— all NHS community trusts- who offered the sign off experiences for the students in this project. The data was gathered directly from the practitioners who acted as sign off mentors and two managers who had overall responsibility for student learning in the organisation.

Some conclusions relating to practitioners have been reported above, in that the plan to recruit sufficient sign off mentors proceeded without complication or resistance. One concern expressed before the project was that there might be anxiety or resistance from practitioners about taking on the role of sign off mentor. This concern was not entirely without justification as one mentor did clearly express

the view that colleagues had made her anxious about taking on the role but in the event she had not found it daunting.

All practitioners also expressed the view that the time commitment involved in supporting a sign off student should be acknowledged. The NMC (2008) explicitly requires a sign off mentor to spend one hour a week with their student in addition to the time spent in direct or indirect supervision of their work. As expressed by one of the mentors, it might be that this professional body requirement is slightly easier to arrange/manage in a community setting than in the ward environment as there are designated periods of time when there are no patients present. In addition one mentor, who did a lot of her work on foot, discussed what she called her “mobile classroom” in that she used the time at the conclusion of a day’s visits when she was returning to the clinic to discuss the student’s learning and meet the professional body time requirement. However this method was only really suitable in the early weeks as when the student began to do more independent visits, the mentor and student would not be attending the same visits.

An important incidental finding from the project was that the increased contact between practitioners and the university was viewed positively and as expressed by Deirdre it brought the university and service “closer together”. This positive view was also echoed in the managers’ data. Although it was never explicitly stated I think that the practitioners were very sensitive to the concern about the decline in district nursing numbers (RCN 2013a , RCN 2013b ) and the fact that someone was undertaking a research project in their area was viewed positively as both an expression of interest and concern/ support. This aspect of the project is explored more fully in my final reflexive chapter.

The main conclusion from the managers was that they viewed the project as successful for themselves as an organisation and they would have been very happy to recruit the students as the output was a highly employable student. In two sites this was followed through with actual employment of the students but unfortunately in third site the reconfiguration of NHS services meant that there was



a vacancy freeze. This made for an apologetic and disappointed manager but for the practitioner who had actually supervised the student, this was a cause of significant distress. In my preparation I had been very concerned for the student who might have to apply for a job elsewhere and in the event, the students were confident in seeking out work. I had not considered the upset and hurt felt by the practitioner who had invested her time and energy in the student, only to find that the student could not join the organisation because of a vacancy freeze. Since cycle 2 I have prepared mentors with this cautionary tale, advising them that vacancies are not always available in order for them to be more protected from the disappointment that this mentor experienced.

### The Higher Education Experience

The most striking conclusion about the Higher Education experience was that the whole of the preparation period was focussed on how to ensure that the students would not be disadvantaged and then the actual outcome was that the majority obtained employment and those who did not, was as a result of a vacancy freeze, rather than any adverse effect of the project. However I do not regret any of the early “angst” as it contributed to objective 1 and the sustainable process. There could be some impact associated with the research that meant these students had high input/high visibility and therefore were encouraged to apply for posts and obtained them. If so, this would not apply hence forward. The early “angst” and the measures put in place to ensure that students would not be disadvantaged if they had to return to the hospital environment and apply for work, may well be needed in the future. Indeed the current trend of foundation hospitals to run both inpatient and community services may well see more hybrid posts developing with newly qualified nurses expected to rotate to both environments (Marini and Miraldo 2009).

The other important aspect of the Higher Education experience was the extent of the timeline required to achieve a sustainable process. The reality is that only a minority of students will be able to access a sign off placement in the home or

community setting. It is therefore important that this opportunity is offered in an equitable way to the student body and from the perspective of sustainability of services, in a manner which means that those with an interest of working in that environment can access the opportunity. This project has demonstrated that this process needs to begin early with student knowledge of the opportunity in the second year and a selection process early in the third year.

#### *7.4 Limitations of this study*

Action research does not make a claim for generalizability but it should provide sufficient context for others to consider whether the learning can be transferable (Herr and Andersen 2005). To date there have been no published reports of other HEIs in the London area offering a sign off opportunity with district nursing services. This study does not claim that this type of practice experience is feasible in other environments although it is significant that I could update my literature review with reports of this opportunity in Yorkshire and Humberside and Leicester (Arnott 2010, Brooks and Rojahn 2010, Baglin and Rugg 2010, Shelton and Harrison 2011, Marshal and Shelton 2012, and Betony 2012, Cooper 2014). The fact that cycle 2 included services in one inner London borough and two outer London boroughs suggests that this practice experience could be offered elsewhere in London.

In this study the majority of students obtained immediate employment in District Nursing teams following their practice experiences. This could be an effect of the research process and selection and is not an indicator of the longevity of any of the students in a District Nursing role. A longitudinal study following the careers of students who undertake a sign off period in the community would be recommended. However a snap shot survey of such students at three years post qualification could also yield useful information about whether they have stayed in work outside of the hospital setting and what their long term career aspiration might be.

The NHS recommends that all health care professionals experience a period of structured preceptorship in their first post following qualification (DH 2010). This entails targeted non managerial support for the staff member to assist their on-going continuing personal and professional development. This recommendation is not followed in all organisations and the experience of newly qualified staff is highly variable. The availability of preceptorship in a community setting may be more influential in terms of longevity in role than sign off experience and therefore the availability of preceptorship would be an important variable to be considered in any snap shot survey or longitudinal study.

Objective	Outcome
1. Design and implement a sustainable structure at my own institution and with stakeholders to support “sign off” placements in a community setting.	Sustainable structure in place which is understood and utilised by the students and service providers.
2. Evaluate the process and the student placement experience and identify the implications for students, provider organisations and Higher Education Institutions and utilise this information to inform the process of curriculum development for the new graduate programme of September 2011.	<p>Process has been evaluated from perspective of all key stakeholders and the process was used as an example of innovation in the May 2011 validation of the new curriculum.</p> <p>There is no evidence that students are disadvantaged by undertaking a community placement as their final placement.</p> <p>The workload and practical implications for stakeholders have been explored.</p> <p>Although not listed as an objective at the outset, the student participants have been</p>

	successful in gaining and sustaining employment in the community setting.
3. Critically review the emerging literature on the “sign off” period to identify important issues for the partners in the process, the planned curriculum development and the employability of student nurses in the community setting.	The literature review was conducted and has been drawn upon in subsequent articles and conference presentations.
4. Disseminate the learning from Objectives 1-3 and contribute this learning to the understanding of the factors that impact on employability of student nurses in community settings , the process of curriculum development and the development of “sign off “ placements in other new areas .	The learning from the project has been shared with participants as part of the process of validating the data. This has taken the form of seminar at the university open to partners (Appendix 6 is one example) and internal research seminars where information is shared with colleagues. In addition there has been one national conference presentation (Appendix 4) and two publications in practice journals (Brown 2012, Brown 2013). In terms of my institution the ability to use the project as an exemplar in the competitive tendering bid for the pre-registration education contract and in regular reports to educational commissioners (Appendix 5 is one example) is an important aspect of the dissemination.

Table 16: Summary of Outcomes in relation to the objectives

### *7.5 Recommendations for the local context*

1. That the current process at Middlesex University for identifying adult nursing students who wish to undertake a sign off period in the community should be continued.

2. That a pilot of other areas of community practice (e.g. health visiting) which have not taken sign off students be identified with a view to rolling out a number of other sign off practice experiences.
3. That Middlesex University in conjunction with stakeholders in local community nursing services identify best practice in preceptorship programmes with a view to increasing support for newly qualified nurses in their first post

### *7.6 Recommendations for the wider context*

1. That the findings of this study be shared widely across the newly established Local Education and Training boards for London with a view to increasing the number of sign off experiences in the home setting.
2. That a follow up study be designed which would explore whether the provision of a sign off experience in the home setting had any bearing on whether the student continued to work in that setting. This could take the form of snap shot survey or a longitudinal study.
3. That the Nursing and Midwifery Council review the requirement of the NMC Standards for Pre-registration nursing 2010 that all adult nursing students “.....must have confidence to provided effective adult nursing care in the home, the community and in hospital settings to individuals and communities” (NMC 2010: 17) in the light of the practical difficulties of ensuring that all students have sufficient opportunity to achieve that confidence in the “home setting” and limit this requirement to the more generic community setting as defined in the glossary of the 2010 standards.

## Chapter 8: Reflection and Learning

### 8.0 Introduction

This chapter will explore my personal and professional development as it unfolded during this project. In my experience, undertaking a professional doctorate entails being in the workplace with “new antennae”. It evokes sensitivity to what is happening around you and a questioning approach. For someone like myself who has worked in nursing for 34 years and in nursing education for over 20 of those years, undertaking a work based doctorate has had the effect of making me see the workplace afresh.

In addition to my own personal and professional development, this chapter will also explore the incidental learning which emerged during the project. In combination, these insights make for a rich and eclectic mix and cover topics such as the research process, the nursing policy context and the challenges and pitfalls of a nursing academic career. This chapter contains what I would describe as five areas of insight and each has been given its own subheading.

### 8.1 Research can do good as well as harm

It is only in retrospect and after reflection *on action* (Schon 1983) that I can see how concerned I was about the possibility about research “doing harm”. The chances of research “doing good” did not figure in my project activity. It does warrant a mention in the findings but the real significance has only emerged in the dissemination and post research period.

In the early stages of my DProf studies there was a heightened awareness about the risks associated with research following the Northwick Park Hospital drug trial disaster which had left six healthy volunteers hospitalised in intensive care (Boseley 2006). As this was a local hospital and it was medical students involved, I was very conscious about how research in the health field could “do harm”. Although my

project had no involvement with harmful substances, I was very conscious ( and worried) that an intervention during the last 12 weeks of their professional programme could have a negative impact on their career choices and disadvantage them in some way. This concern, combined with colleagues' scepticism that a community placement could offer students the opportunity they needed, meant that strategies to avoid "doing harm" were a significant feature of the project activity.

The fear of doing harm forced out any precontemplation of research doing good despite references in action research literature to that possibility (McNiff and Whitehead 2010) , and therefore for me, an important aspect of my personal and professional development has been a refocusing on the potential of research to "do good" and thinking about what to do with that learning . My proudest moment in the data collection phase was when, with the interview effectively concluded in terms of exploring the three key areas that I had outlined to her, Deirdre in cycle 2 said:

*"One more thing I must add is that this whole experience has brought the university closer to the clinical environment."*

Following the presentation in my own workplace and my recent publications (Brown 2012, Brown 2013), colleagues ask me about the action research process and I can now genuinely say that the process (even when it might be difficult to negotiate) has the potential *of itself* to produce tangible benefits to the individual and the organisation.

In addition, from the student perspective, there was also a sense of pride of being part of the project. In early 2012 in my work role as link lecturer I was facilitating a mentor update and Patricia, now a staff nurse and qualified mentor attended. She had undertaken the mentorship preparation programme (NMC 2008) at the earliest opportunity in her clinical career and had begun mentoring learners herself. When

the question of sign off mentoring arose in discussion, she contributed her pride in being part of the cycle 1 and how it had helped her learn about research in practice.

## *8.2 Valuing of District Nursing*

Another important part of my learning on the research process was the importance of being able to see how others viewed the research. It was only when I wrote the words of a mentor in my learning log in 2011 and realised that I had written the nearly identical quote in 2010 that I got a sense of how you as the researcher can have a particular view of a researcher's significance and a participant can attribute an entirely different emphasis. The words which appeared in my learning log on two occasions were "at least you care about District Nursing."

Interestingly, although the students in the project were placed with District Nursing teams my view of the project was about how to best prepare students for working in that environment and an exploration of the implications for the stakeholders in the process. My perception was not therefore one of a study about District Nursing per se and their clinical role. However from those who worked in the District Nursing teams their focus was that there was someone from the university who cared about whether their specialism lived or died. I do not write those last words lightly as the workforce dilemmas that I outlined in Chapter 2 are critical. Smith (2010) and Meehan (2010) both referred to District Nursing as an "endangered species". The month before this final chapter was written the Coalition Government published what they described as a "New vision and model for district nursing" (DH 2013) which at least acknowledged the importance of district nursing. It states that the need for "high quality care delivered in people's homes is self-evident" (DH 2013:8). There is no reference in the forward or introduction to the recent erosion in District Nursing numbers and no mention of any funding to support the community and district nursing programme it advocates. Nevertheless a public acknowledgement of the importance of home nursing is a first step. When I started the project I was aware that District Nursing had an aging workforce but I was not apprised of all the workforce statistics. In particular I did not have



insight into the fact that the numbers of qualified district nurses had reduced from 1990 to 2009 by over 20% (QNI 2009). I therefore did not have the same experience as the mentors who had lived through that reduction but I came to realise that for them, the fact that someone was researching a topic which touched District Nursing and, even more importantly, someone was interested in bringing a new generation into their specialism was very important.

When the project commenced there was no shortage of government rhetoric about developing primary care and indeed the buzz phrase as the project progressed was that of “transforming community services” (DH 2009). However the actual experience of nurses on the ground was quite different. I then realised that we as educationalists were caught in a pincer movement between the policy rhetoric about primary care and our lived experience of accessing community placements, namely that availability was limited and access therefore limited. This professional understanding has given my project a sense of urgency which rises above that of just using action research to address a problem encountered in the workplace. The literature and the policy understanding have grounded my study in an interesting historical context.

Prior to the project I had not appreciated that for District Nursing as a specialism in nursing it was a case of “condition critical” with a reduction in staff number and a growing number of the remaining practitioners being over 50 years of age (RCN 2011). As this chapter is being written I know that in the inner London borough where I conducted the project the service currently has a 20% vacancy rate, now exacerbated by rising house prices and rent costs in London which means that as staff come across vacancies in outer London and further afield, they move out of the capital to work in areas where they can more easily afford the living costs.

Ensuring there are sufficient applicants to apply for community nursing posts is an ever more urgent consideration. As the project progressed I found that it was being mentioned by my organisation in reports to NHS London and this led to a request to write a more formal short report for the Pre-Registration Framework Management

Team. This subsequently became part of the evidence for the competitive tender to continue our provision of nursing education.

### *8.3 The research objectives: should I have set an objective about employability/employment?*

One of the pleasures of exploring action research methodology has been its close fit with the Nursing Process. As far back as 1996 Hart had noted that the spiral or cyclical AR method was attractive for nurses because it mirrored the nursing process steps of assess, plan, diagnose, implement and evaluate.

As I began to make notes in my learning log for this final chapter a new textbook (Williamson et al 2012) was published which includes a short history of action research in nursing. It highlighted why nurses were attracted to the methodology and also noted the limitations and difficulties encountered. They pointed out that typically action research projects had a long diagnostic phase (in my case I had been concerned about the difficulties of community placement for over a decade) and that practitioners were dealing with complex problems and issues. They cite Waterman et al (2001) who say that the complexity is a source of strength but it also can mean that projects can be time consuming and frustrating. Action research is a good approach for highlighting the mismatch between operational policies and the reality of day to day life. In the case of this project the mismatch was between government rhetoric around developing care closer to home and the ability of the university and its partner trusts to easily provide that experience for students.

The history of nursing involvement with action research has not always been positive. Indeed the systematic review of action research that Waterman et al (2001) had conducted in 2001 criticised nursing projects arguing that they were “difficult to assess” due to the lack of precision in defining outcome measures. Reviewing my own project I believe that I did set clear objectives but I would be self-critical on two counts: did I do enough to provide sufficient evidence of the

“sustainable process” as outlined in objective 1? More importantly could I have put in an objective which would have been more easily subject to quantitative analysis? Firstly I will offer some evidence for a sustainable process. In the project I have provided small items such as the report to NHS London which includes a timeline for the process (appendix 5). Equally important, rather like a plant which has set down roots, the fact that sign off placements are being developed in other areas where they were not established previously (appendix 6) is a better demonstration that the initiative is truly embedded. However extending into new areas can of itself challenge sustainability as resources may become stretched to cover them.

The more substantial self-criticism that I would now make of myself is why did I not at the outset of the project set myself the easily measurable objective of tracking the students who participated in the pilot and their first destination employment? In practice I have been able to do this as I have access to this data in my work role and this data is in the public domain as it has to be presented to NHS London. I therefore know that of the 10 students who were carefully tracked through cycles 1 and 2 that eight applied to work in the community as their first destination following registration and seven were appointed. Additionally, although my official research period has ended, I know that the two students who wanted to apply but were unable to apply locally due to the vacancy freeze are now working in a community posts. Although this data did appear in my findings, I was left puzzled as to why I had not formally set myself the objective of following up students to see how many were appointed?

On reflection I think the explanation is that another aspect of nursing practice cross fertilised with my research practice. In nursing care plans we always aim to agree goals with patients/clients which as SMART (specific, measurable, attainable, realistic and timely) and at the outset I wondered if it would be realistic to expect a twelve week placement to ensure a student’s career direction? It is obvious that in research terms, if no students continued into a community post, this would be significant data. Also in research terms that fact alone would not have meant the intervention had “failed”. Readers would need to review that particular outcome

against other data, including what I had told them about the context at that historical time. Indeed given what did emerge in one of my locations, it is conceivable that there could have been vacancy freezes in all three locations.

With the benefit of hindsight I now suspect that a certain lack of self-belief contributed to the decision to omit the “goal” of the students progressing to employment in the setting. The other possible explanation is after a period of over 10 years of obsessive target setting in the health sector (for example, the 4 hour wait in Accident and Emergency being an example) that I have developed an aversion to anything which might assume the nature of a “target”.

One colleague has suggested that the title of my project could be changed to:

“How can we enhance the *employability* of student nurses undertaking community based practice placements in their final twelve weeks prior to registration?”

However I would not have been as comfortable sharing that title with the student participants as I would have been concerned those students would have perceived my role as “preparing” them for a community post rather than them having the autonomy to choose to work in the community setting. I would have felt that the title was “value laden” in the sense that it might have suggested that I wanted them to work in the community and that I would have been imposing my choices on them. Although the Higher Education sector is currently placing great emphasis on “employability skills”, the term does not always sit easily with those university students who are on a programme preparing them for specific employment. When nursing students hear academic staff talking about their “employability skills”, it is not unusual for them to ask questions such “are you saying I am not employable?” and hear the term as some sort of criticism of their level of clinical skills.

#### *8.4 The fragile system*

In November 2012 as I began to consider the contents of this final chapter, NHS London published a report on sustaining and managing the delivery of student nurse mentorship (Robinson et al 2012). They noted that enabling mentorship to be delivered entails a range of resources, activities and the interaction of complex systems in practice and higher education. As mentioned in Chapter 1 they coined the term “hinterland”:

*“This ‘hinterland’ to the delivery of mentorship has been the subject of much less research than the experience of mentors and mentees and yet it is this hinterland that enables delivery to take place.” (Robinson et al 2012:2)*

Their study explored this hinterland and their specific objectives were to look at capacity in relation to providing sufficient numbers of placements, mentors and sign off mentors to match student numbers, capacity in terms of educational preparation to enable mentors and sign off mentors to fulfil their roles and capacity in relation to factors influencing delivery of practice. The main conclusion of the report was that:

*“HEI and trust participants, in the main, reported fulfilling their remits for enabling mentorship to be delivered.” (Robinson et al 2012:3)*

Having drawn this conclusion that “in the main” all was well, the rest of the report went on to describe the fragility of the system. It acknowledges that much effort has been expended in “sustaining and enhancing placement capacity” including “innovative strategies to bring a much wider range of community settings into the placement circuit” (Robinson et al 2012:4) and this would include the work of our project. However when it describes the considerable effort expended by both educationalists and services in maintaining placement availability, it says:

*“Considerable achievements were perceived in enabling mentorship to be delivered. At the same time, throughout participants’ accounts there was a sense of the*

*system just holding together and that it was under considerable pressure and facing a diverse range of challenges.” (Robinson et al 2012:6)”*

When I read their use of the word ‘hinterland’ and subsequently their description of the system as “just holding together” it triggered a series of insights into my own work which are worthy of review.

Firstly I realised that my project is about that “hinterland” which they describe as under researched and thus my project helps paint a picture of a particular part of that hinterland. In particular Robinson et al (2012) report that creating a sustainable placement circuit is resource intensive. My project provides detail of what was involved in starting up a new placement opportunity and what is involved in preparing and selecting students and preparing and sustaining mentors.

However what really struck me about Robinson et al (2012) was the particular way they had presented their conclusion. Their overall conclusion that “in the main” things were OK but when they really spoke to people they found a “system just holding together”. This provoked the question: as nurses do we feel that we have to be seen to be coping? I reconnected with the early thoughts which started me out on the path of this project: namely that placements are a real problem but it is not really permissible to express this openly. This in turn provoked a second question: why is it not OK to say that placements are problem and what does it do to the whole debate?

Having undertaken this project, and having been immersed in both my work and research roles in the hinterland, I think I know some of the answers. One of the difficulties is that the way that nursing student numbers are decided is as follows: services tell the Local Education and Training Boards (LETBs -formerly the Strategic Health Authority) how many students are required to meet workforce needs and a total number of places are commissioned at educational institutions. Those institutions in turn ask the services to guarantee the placements which will be a prerequisite of the professional body validation of the educational programme.

However in real life, there are many service changes in the validation cycle of five years but to even hint at these real life difficulties could jeopardise validation and therefore these difficulties are minimised. As programmes unfold, the difficulties get worse but by then the students are there and there is a moral imperative to cope. Even more worryingly, in the London area with multiple educational institutions, any admission of not having sufficient placements, risks exposure of weakness in your programme overall and transfer of students to another provider. This sequence of events makes it taboo to admit to difficulty. So this may be why the overall conclusion of the respondents interviewed by Robinson et al (2012) is that “in main” the system is coping despite their subsequent comments failing to support that conclusion. This leads to the next question: what does this do for the whole debate? My experience in this project could be illustrative.

In 2009 I was determined to look at the problem of community placements but because I was so enmeshed in the organizational culture of the system which was just holding together, my original thinking had been about increasing the number of community placements. On the one hand, I wanted to break the taboo but the pressure of working in the system, led me down a particular path. Luckily the collaborative approach introduced a whole new way of looking at the situation. I would therefore contend that one side effect of working in a system that is just holding together, is narrow thinking and a failure to question assumptions. It sometimes feels that in nursing education we teach about reflection but don't have the time to “indulge” in it ourselves. I have often wondered why the manager's suggestion had not been made via the existing forums such the Pre-Registration Nursing Framework or the more strategic Partnership Board between the university and service providers. Maybe it was a case of not getting around to it but maybe a research project makes the space to say that something is not going right. In Robinson et al (2012) there were plenty of voices also who said that things had to change but who had to simultaneously say “we are coping”.

In their conclusion Robinson et al (2012) specifically avoid making any recommendations and say their report “identified the challenges that mentorship

faces and the debates that need to be addressed". I hope to participate in that debate in the form of an opinion article for publication based on the concerns expressed above arising from my personal learning in this project.

### *8.5 The journey without an end point?*

One of the most significant challenges I have experienced in undertaking action research, has been to be decisive about the end point. In writing this report I have been guided by the ethical approval which was timed to end with cycle 2 which placed the proposed end date as June 2012. The difficulty has been that the research cycles inevitably led to work cycles which almost felt like a continuation of the project. In particular I was drawn into important but time consuming work sharing my learning with colleagues in my own institution as they introduced sign off experiences in other new areas such as Accident and Emergency and Operating Theatres. I then engaged in the same work in a different field of nursing as I worked with child health colleagues. Inevitably these experiences informed my own learning further but eroded the time available for finalising the report. On the other hand they were important examples of dissemination.

As Mc Niff and Whitehead (2009) have suggested action research reports undergo many iterations and therefore my report was constantly in draft form and it seemed never to be finalised. My supervisor did her best to encourage submission chapter by chapter but progress was slow. My work roles as link lecturer continued as did all of my other insider roles. Inevitably I found that I had access to evaluation information which informed my research data , for example hearing about the promotion of one of the students in cycle 2 to senior staff nurse, hearing that one of the students who could not apply for a post due to the vacancy freeze had now obtained a post in the local patch. Inadvertently it appeared I was collecting data but feeling uncomfortable that I was in research mode but not within the period on the ethical permission.



Still struggling to complete the report I was then in demand by academic colleagues in child health who had received a small grant to assist in placement development. At that point in 2012, all of their sign off placements were in acute units as had been the case for adult students in 2009. Although they were able to employ a project worker to assist with their development, I found myself spending many hours sharing my learning with the project worker. As a result one of the unexpected outcomes was that my first publication (Brown 2012) arising from my own project was about extending the process that I had devised to another service namely health visiting. Fortunately the irony of writing about the sequel before the substantive report acted as the final spur to complete this report.

It seems the reality of being a practitioner researcher is that the allotted time to finalise the report is often eroded as the practitioner element always seems to outweigh the researcher. I was too busy playing my part in the system which was “just holding together” (Robinson et al 2012). On the surface there appeared to be an obvious way to achieve that end point of a final draft, namely arrange a sabbatical. In reality the injunction in my own institution’s policy of the need for the applicant to identify others able to do their work in their absence proved a significant deterrent. How can someone playing a part in a system which is just holding together, duck out of that system and leave others unsupported. In retrospect I see the importance of appearing to cope with everything is fairly pervasive in nursing.

### *8.6 Summary*

This final chapter has been an opportunity to review my own learning and in addition to acknowledge that the future of District Nursing as a specialism within nursing continues to be uncertain and that the student nurse mentorship system is also precarious.

In my own institution there is now a process which can enhance the learning of third year students with District Nursing teams and which gives them confidence to

apply for permanent employment in those teams. I have shared the learning with other areas of adult nursing and with colleagues in the child field and seen what started as a research intervention become accepted practice. We have moved from a position of sign off placement experiences being based in hospital wards to sign off experiences in diverse settings.

On a personal level, the acknowledgement of clinical colleagues in my three local boroughs that the “community sign offs” has become their “grow your own” approach to recruitment to district nursing teams is the most important outcome.

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## Appendix 1: Application to research ethics

MIDDLESEX UNIVERSITY  
SCHOOL OF HEALTH AND SOCIAL SCIENCES

Health STUDIES ethics SUB-committee

### APPLICATION FOR ETHICAL APPROVAL OF CATEGORY A PROPOSALS

This form must be completed for all research projects carried out by staff or students of the School that conform to the Category A definitions.

#### Title of proposed study:

The implications for students, higher education institutions and practitioners of placing student nurses in a community setting for their final 12 week "sign off" placement.

#### Name(s) and qualifications of supervisor(s) / principal investigator (s):

Barbara Workman DProf, MSc, BSc, RGN, RNT, RCNT, Dip N ( Lond), FHEA ( Supervisor)

Prof Daniel Kelly - PhD (Goldsmiths, London), MSc (Surrey), BSc (Edinburgh), RN, NDN Cert, PGCE, FRSA

#### Name(s) and qualifications of researcher(s):

Kate Brown RGN RHV RNT BA MSc, PGCHE, PGCHEM

#### Is the proposal linked to a programme of study? If so, please identify:

Work Based Learning D Prof

#### Indicate the start and end date for the proposed study:

December 09- June 12

#### Is the proposal externally funded? If so, name the source of the funding:

No

Identify under which of the criteria in Category A of the guidelines this proposal can be classified:

For information only

A1

A2 Yes

A3 Yes

A4

A5

A6

**NB: If A6 is ticked you will also need to tick A2, A3, A4 or A5 as appropriate**

You should submit one hard copy (signed by the research supervisor in the case of a student submission) and an electronic copy to Mrs Christine Constantinou, HSESC secretary, at the Archway Campus ([c.constantinou@mdx.ac.uk](mailto:c.constantinou@mdx.ac.uk)). This should be submitted at least **two weeks** before the date of the HSESC meeting.

Students must remember to keep a copy of this form for inclusion in their project/dissertation report.

Declaration:

- As supervisor or principal investigator for this research study I understand that it is my responsibility to ensure that researchers/students under my supervision undertake a risk assessment to ensure that health and safety of themselves, participants and others is not jeopardised during the course of this study.
- I confirm that I have seen and signed a risk assessment for this research study using standard university forms and to the best of my knowledge appropriate action has been taken to minimise any identified risks or hazards.
- I understand that, where applicable, it is my responsibility to ensure that the study is conducted in a manner that is consistent with the World Medical Association Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects (see <http://www.wma.net/e/policy/b3.htm>).
- I confirm that I have reviewed all of the information submitted as part of this research ethics application.
- I agree to participate in committee's auditing procedures for research studies if requested.

Kate Brown.....

**Signature of Supervisor or Principal Investigator**

**Supervisor: Barbara Workman**

**Date 7/9/09**

## Appendix 2: approval from Research Ethics Sub-Committee



School of Health and  
Social Sciences  
The Archway Campus  
Furnival Building  
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London N19 5LW

Tel: +44 (0)20 8411 5000  
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To: Kate Brown  
DProf Work Based Learning

Date: 12<sup>th</sup> Oct 2009

Dear Kate

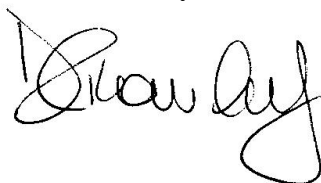
Re: Kate Brown (572). The implications for students, higher education institutions and practitioners of placing student nurses in a community setting for their final 12 week “sign off” placement. Category A2 & A3 – Supervisor, Barbara Workman

Thank you for the response which adequately answers the ethics committee's queries. On behalf of the committee, I am pleased to give your project its final approval. Please note that the committee must be informed if any changes in the protocol need to be made at any stage.

I wish you all the very best with your project.

Yours sincerely

Yours sincerely

A handwritten signature in black ink, appearing to read 'Dympna Crowley'.

**Ms Dympna Crowley**  
**Chair of Ethics Sub-committee (Health Studies)**

## Appendix 3: Participant Information Sheet and consent form

### MIDDLESEX UNIVERSITY SCHOOL OF HEALTH AND SOCIAL SCIENCES

health STUDIES ethics SUB-committee

### GUIDELINES AND TEMPLATES FOR A PARTICIPANT INFORMATION SHEET (PIS) AND CONSENT FORM

#### 1. Study title

The implications for students, higher education institutions and practitioners of placing student nurses in a community setting for their final 12 week “sign off” placement.

#### 2. Invitation paragraph

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

#### 3. What is the purpose of the study?

The Nursing and Midwifery Council (NMC) require that students in their final year undertake a 12 week “sign off” placement (NMC 2008).

To date student nurses in the North London area have typically been placed in a hospital setting for their final 12 week placement. This study is exploring the implications for students, higher education institutions and practitioners of placing student nurses in a *community setting* for their final “sign off” placement. Eight students, eight practitioners who are supervising those students, 4- 6 lecturing staff and up to six stakeholders (managers or community placement facilitators) from the participating NHS organisations will be invited to take part.

#### 4. Why have I been chosen?

You have been chosen either because you are a student undertaking your “sign off” placement in a community setting or you are a practitioner supporting the student or you are an employee of Middlesex University who has a responsibility in relation to community placement or you are a manager/placement facilitator in an NHS provider providing placements

- I will be conducting interviews with students on sign off placements, practice based mentors and other relevant stakeholders ( e.g. nursing managers or placement facilitators)
- I will also be conducting a focus group with community link lecturers

## **5. Do I have to take part?**

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. If you decide not to take part in this study it will not affect your course/ placement in any way.

## **6. What will happen to me if I take part?**

You will need to give up 30-40 minutes of your time for an individual interview which will be tape-recorded with your permission.

If you are invited to be part of a focus group, you will need to give up approximately one hour of your time. The focus group will be tape-recorded and is likely to take place at the Archway Campus of Middlesex University.

## **7. What do I have to do?**

Please indicate on the reply slip or by email if you are interested in taking part in this study. The return address and email is given on the reply slip. Before taking part in an interview or focus group you will be asked to sign a consent form.

## **8. What are the possible disadvantages and risks of taking part?**

There are no anticipated disadvantages in taking part. Every endeavour will be made to ensure that you are put at as little inconvenience as possible and that the interviews and focus groups do not overrun.

## **9. What are the possible benefits of taking part?**

You will have an opportunity to influence the curriculum for current and future students.

**10. Will my taking part in this study be kept confidential?**

All data will be stored in compliance with the Data Protection Legislation. All tapes and transcripts will be kept in a locked drawer when not in use. The tapes and transcripts will be destroyed after they have been written up in the study. Your name will not be used in the write up of the study.

**11. What will happen to the results of the research study?**

The study is part of professional doctorate and the results from the study will be used to improve the preparation of students and mentors for community “sign off placements” and will be reported back to the Framework Management Team for Pre-Registration Nursing and used to improve the curriculum in the University and in practice. I hope to publish the study in order to reach a wider audience and benefit students at other institutions. If you would like to receive a summary of the report when it is completed please let me know.

**12. Who has reviewed the study?**

The Health Studies Ethics sub Committee of the Middlesex University has reviewed this study.

**13. Contact for further information**

Kate Brown Researcher  
Work address: Furnival Building  
The Archway Campus, London N19 5LW  
Tel 0208 411 6930  
Email [k.brown@mdx.ac.uk](mailto:k.brown@mdx.ac.uk)

Barbara Workman Supervisor  
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Tel 020 8411 6929/4901  
Email [b.workman@mdx.ac.uk](mailto:b.workman@mdx.ac.uk)

Thank you for reading this and for all those who are participating in the study.



**Middlesex  
University**

Participant Identification Number:

**CONSENT FORM**

**Title of Project:** The implications for students, higher education institutions and practitioners of placing student nurses in a community setting for their final 12 week “sign off” placement.

**Name of Researcher: Kate Brown**

**Please initial box**

- 1. I confirm that I have read and understand the information sheet dated .....for the above study and have had the opportunity to ask questions.
- 2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.
- 3. I understand that my interview/focus group may be taped and subsequently transcribed
- 4. I agree to take part in the above study.
- 5. I agree that this form that bears my name and signature may be seen by a designated auditor

Name of participant	Date	Signature



Name of person taking consent  
(if different from researcher)      Signature

Date

\_\_\_\_\_

\_\_\_\_\_

Researcher

\_\_\_\_\_ Date

Signature

1 copy for participant; 1 copy for researcher;

## Appendix 4: Abstract from NET conference 2010

**Title: Undertaking a final pre-registration placement in a community setting: implications for students, health care services and higher education institutions**

**Presenters' details:**

Kate Brown  
Principal Lecturer  
Middlesex University  
London UK

Sally XXXXXXX  
Senior Clinical Practice Facilitator  
XXXXXNHS Provider Services  
Practice Development Unit

**Conference Theme:** Effective Partnership Working (and also relevant to Enhancing the student experience)

**Contact details:**

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N19 5LW

**Telephone:** 0208 411 6930 (Work)  
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**Abstract Information** (for theme paper)

Since the Nursing and Midwifery council published their standards to support learning and assessment in practice in 2006 it has been a requirement that pre-registration students in the UK are required to have a "sign off mentor" in their final placement (NMC 2008). The same standards identify a range of requirements for those who act as sign off mentors "Sign off" mentors are required to have an "in depth understanding of their accountability to the NMC for the decision they must make to pass or fail a student when assessing proficiency requirements at the end of the programme"( NMC 2008 p21).

In many parts of the UK, final placements, and therefore sign off mentors, have tended to be concentrated in in-patient environments. However in the recent consultation on the future of pre-registration nursing considerable emphasis has been placed on how students are to be prepared to work in a variety of settings (NMC 2009). In addition, UK government policy places considerable emphasis on shift of health care from in-patient to community settings (Department of health 2006 Department of Health 2008).

This presentation will describe a pilot study where two adult branch students were placed with Community District Nursing teams for their final 12 week placement. Ethical consent to interview the students was sought from the University ethics committee and the local NHS research committee gave permission to interview practitioners as part of educational evaluation.

Students were interviewed before commencement and during their placements and researchers had access to their written evaluations. Practitioners were interviewed during the placement and feedback was also sought from District Nursing managers. One of the presenters was directly involved in supporting the practice mentors achieve their “sign off” status. The presentation will explore the preparation phase for the pilot in both the Higher Education setting and in the placement area. It will examine the student and practitioner perceptions of the placement prior to the placement commencement, during the placement and at conclusion. The process of preparing “sign off” mentors in a community health setting will be explored.

The study has yielded significant information about how students and practitioners can best be prepared, including practical information ( e.g. introducing the students to the electronic patient information systems used in community settings) to how community placements can be utilised to teach students the skills of management of patients, workload and risk management. The interviews with students yielded rich data about their learning opportunities and the nature of the learning process on these placements. The possibility that undertaking a final placement in a community setting could disadvantage a student who subsequently wanted to apply for a first post in an in-patient setting was directly addressed in the project and a number of safeguards were put in place to address this concern which was initially raised by academic staff.

The pilot has already led to interest from a number of other provider services who are keen to provide end of programme placements in community settings. Another finding is that both of the students who participated in the pilot have applied for community posts at the conclusion of their programme.

## **Bibliography**

Department of Health 2006 Our health, our care, our say: a new direction for community services London: Department of Health

Department of Health 2008 NHS next stage review: Our vision for primary and community services London: Department of Health  
Nursing and Midwifery Council (NMC) 2008 Standards to support learning and assessment in practice London 2<sup>nd</sup> edition London: NMC  
Nursing and Midwifery Council (NMC) 2009 Consultation on the future of Pre-registration nursing London: NMC

## **Appendix 5: Report to Framework management Team with identifying names of people and services redacted.**

### **Report to Framework Management Team- Sign off Mentor in the Community project**

#### **Introduction**

For cohorts who commenced after September 2007 it has been an NMC requirement that students have a “sign off” mentor for their final twelve weeks of practice before registration. When planning for this began at Middlesex University it was envisaged that all adult branch students would undertake the sign off placement in an in-patient setting. The option of offering a sign off placement in a community setting was not initially considered because of the challenge of finding sufficient community placements to meet the existing requirement of offering some community experience to all students. However when a local manager was approached to review availability of community placements for students in general, she raised the concern that because students did not have exposure to community placements in their final three months that this had an adverse impact on recruitment of newly qualified students to community posts as they lacked the confidence to apply. Furthermore the few who did apply and were successful, often found the first year very stressful.

The Trust offered to make available 12 week placements in addition to the existing placement capacity. It was therefore decided to pilot this in November 2009 with two students. In 2010 the project was expanded to include all our local community providers with the placement of eight students. The project has now been mainstreamed - see the annual timeline as the end of this document.

This short report will outline the process for all the stakeholders and examine the outcomes. The most significant outcome is that the placement has significantly enhanced the employability of our students in a community setting.

Finally recommendations will be made to ensure the sustainability of the process for the long term.

This project had been undertaken as part of a work based learning doctorate and interviews have been undertaken with participants and therefore some short quotes have been included to illustrate stakeholder views.

#### **The Pilot - November 2009 - March 2010**

Although it was not an NMC requirement for March 07 cohort students to have a sign off mentor, it was agreed that when two March 07 students were placed xxxxxx Provider Services, we would use this as an opportunity to prepare sign off mentors. Thanks are owed to xxxxxx for putting themselves forward and working jointly to make the pilot a success.

### **The main project - November 2010 to March 2011**

For the main project eight students from the March 2008 cohort were placed. Four students were placed with xxxxxxxx Provider Services (now with xxxxxxxxTrust) and two were placed with xxxxx (now xxxxxxxx) and two were placed with xxxxx Community Services (now xxxxxx Trust). Again thanks are owed to all the participating organisations, especially the mentors and to the clinical facilitators who assisted the process.

### **The Student Preparation Process**

As the pilot offered only two opportunities for students to have a community sign off placement it was necessary to devise a mechanism for selecting appropriate students. We therefore devised an internal process which we continue to use. In the first instance an email goes to the whole cohort asking for expression of interest and asking the student to write a short account about why they would like to access the placement. To date we have always received more requests to place students than there are places available. These accounts are then reviewed jointly by myself, Kate Brown (as a community link lecturer) and xxxxxxxx Head of Practice Based Learning and exclude any who have not been able to articulate why they want to access the placement. We then jointly interview the students and use this as an opportunity to assess the suitability of the student but also to ensure that the student is prepared (for example it is essential that some of the third year skills such as Advanced Life support are undertaken prior to community and therefore we help the student plan their workload to ensure this occurs). We also confer with the programme leader to ascertain whether the student has any outstanding assignments or resits as we decided that such a student might experience extra difficulty on the community without easy access to library or tutorial support, and therefore would not be selected.

### **The Mentor Preparation Process**

As it had not been envisaged that we would be placing sign off students in the community there had not been any particular initiative to prepare community nurses for the role and therefore an in-house cascade of expertise was not possible. It was therefore decided to target four mentors per Trust. The role of preparing the sign off mentors was mainly undertaken by Kate Brown with some assistance from xxxxx and other community link staff. This was quite labour intensive and involved many clinic visits across the patch.

The preparation focussed on the NMC requirements and familiarity with Middlesex processes to ensure the efficacy of the sign off process. Although the process was labour intensive there were benefits for the whole process of student learning in the community as the spot light on sign off students raised wider questions about student learning in this setting and led to a productive discussion about team expectations of students at the three points that we now place students - second year, early third year for those not placed in this environment in their second year and now sign off.

This was reflected in the following unprompted observation by a mentor in a follow up interview:

*“One more thing I must add is that this whole experience has brought the university closer to the clinical environment.” ( Code:M1)*

### **Outcomes from the Pilot**

Both students successfully completed the sign off placement and both applied and were appointed to community staff nurse posts. The project is still in touch with one of these students who has recently returned to Middlesex to undertake the mentorship preparation programme and is now a qualified mentor herself supporting students in community placements.

A number of practical issues emerged:

1. The pilot highlighted the importance of placement areas making early arrangements for the students to attend RIO training for the patient information system.
- 2 The best travel option for students is the purchase of a weekly oyster card which means any visits taken within the area are covered by the card.
3. In the preparation we had highlighted to students the importance of being prepared for adverse weather conditions. This proved prescient as London had some of the worst weather for a decade with snow and ice. In the longer term with Sept only cohorts this will not be an issue.

### **Outcomes from the Main Project**

In the main project in 2010 all students successfully completed and to our knowledge 5 out of 8 obtained community staff nurse posts. One of the difficulties at the time (March 2011) was that because of NHS restructuring recruitment processes had been halted at one of the employers and two more of the students would have liked to apply for a community post but had to apply elsewhere. (We know that one of the students obtained a post at Stoke Mandeville and the other was still seeking community employment.)

Here is one of the mentors responding to whether the sign off placement makes a difference to employability:

*“Definitely, Definitely . I think from the employers point of view , you have got the student with you for a longer period of time than we are used to so we will be able to try before you buy almost....because you can see their performance and you are also involved in their development and there*

*should be job opportunities and rather purely basing it on interview and references...this way could be a much better way of securing quality staff.”(code M1)*

And here is a manager reflecting on the difference:

*“...for the service as a whole in terms of recruitment it has been fantastic and the confidence they can take third year students .It has been a successful project, really successful. The other reason I was really keen on it was in the past we were getting BAND 5 nurses and sending them out there and expecting them to deal with End of life care and they were not ready for it ..so it was part of that retention thing too...it’s that sort of thing that they have the support mechanisms in place and then they are not going to burn out in the first six months.” (code Ma2)*

And finally a student commenting:

*“We were not let loose doing everything but we did take on a lot more responsibility than we did in our second year and we thought it was a real EYE OPENER ( strong emphasis) to what we would be once we were qualified at Band 5 if we were to get a job here..” (code S3)*

### **Sustainability of the process**

Since the project preparation phase in 2010 we have sustained a steady flow of sign off students to the community and now with Sept only cohorts there will be a clear annual timeline for how this should be managed:

### **Annual TimeLine**

Time	Activity	Key personnel involved
Sept - Nov	Email to cohort from Programme Leader calling for expressions of interest in undertaking a sign off placement in a community setting	xx + KB
Sept -Nov	Email to community practice facilitators asking them to confirm number of sign off placements available for the following May	xx and programme leader
December	Interview students for community placements	Students xx + KB
Dec - May	Preparation of any new sign off mentors	KB but there is now in-house expertise and capacity to support new mentors. Community link lecturers.
May - July	Sign off Placement in progress	Students, Mentors, Link Lecturers and Community facilitators
July - Sept	Feedback from Students and placement facilitators and managers in relation to posts	Students, Managers and Community facilitators



In many ways this project has developed in an organic way building on existing relationships between the university and partners trusts. However it might be useful to now take time to look in a more structured way at the community workforce identifying how many Band 5 posts are likely to be available in any one year and seeking to match this more systematically to sign off opportunities available.

The project has already inspired other areas who have not traditionally taken sign off students to consider developing their learning opportunities. An innovative new sign off placement is being developed in xxxx which involves in patient neuro-rehab with a spoke placement with the outreach team who supports patients in their own homes. The student will spend ten weeks in the inpatient setting and two weeks with the community team. This pilot will run in Nov 11.

Kate Brown Principal Lecturer in Primary Care and Child Health Oct 2011

## Appendix 6: Advertising flyer for local dissemination meeting

### Undertaking a “sign off” placement in the community: implications for Students, Mentors, Community Services and Higher Education.

The Department of Health places great emphasis on effective care delivery in a community setting and the Nursing and Midwifery Council expects nursing students to be able to work in a range of settings. In reality finding community based placements to meet the demand and supporting learning in those settings can provide a number of challenges for all involved.

You are invited to come and discuss findings from this Action Research project which Kate Brown Principal Lecturer in Primary Care undertook between 2009 and 2012. This collaborative project entailed data collection from adult branch students, community nursing mentors, and other key stakeholders in community services and the university.

**Where: Middlesex University, Furnival  
Building, Fifth Floor, Room 517  
Archway Campus  
London N19 3UA**

**When: Thursday 24<sup>th</sup> May**

**Time: 3-4.30pm**



**Tea, Coffee and proper cake provided!**

**RSVP: [k.nichols@mdx.ac.uk](mailto:k.nichols@mdx.ac.uk)**

## Appendix 7: Interview with Hema 7th Jan 2011 Site 1

KB How has your first six weeks been?

H: Yes very different. All my previous placements had been in hospital so compared to a ward surrounding , it's completely different. Being in the community, what was I expecting? Firstly there is a change, you have got your 8.30 to 5pm, that's a big change in itself, you haven't got your long days and nights. So that's one big thing (Code:Differences)

KB So for you was that a pleasant change?

H: for me, yes because I have commitments at home and I like being home at a reasonable hour 6pm so I can give time to my family as well. I actually like that change (Code:Differences) and in terms of what I was expecting, being a final year student my main thing was getting my skills done on this placement but I had discussed it prior to coming here with other students and my professional development tutor as well as I wasn't quite sure what skills I WOULD be able to do here but I had a good idea of what I wouldn't be able to do , so I tried to do them in my previous placements. So I knew my learning objectives for this placement would be management because being a 12 week placement and the other one was administration of medication. Now in both...I practiced management of patients in a ward setting, not that I had the skill signed off but I did practice it

KB yes

H so ...that again very different, managing your bay of 4 patients to managing 8-9 patients in a community setting, very different (Code:Differences)

KB Can you articulate what so different?

H Support I think is the biggest thing ....in a ward setting you have got the comfort of everyone being around you , not that you haven't got the support in the community – you do . But they are not next you. You have to be decisive. You have got to make certain decisions, there and then . You have got to be proactive. Much more than you need to be on the ward.(code Differences)

KB right...

H time management ...on the ward, it is also possible that your mentor is also there looking over you, possibly saying “ this needed to be done by this time”, pushing you . Community you are on your own. You have to manage your time ..for example there may be a patient who needs prompting re AM medication, and then there is a wound care case which you are close to but it doesn't matter you have to go and do the medication first. So it just organising and managing your day, your own load. (code Time management) But I think the biggest difference was support and being able to think and be proactive ( Code: Differences)

KB um um

H that was the biggest difference I found . Administration of medication again. **Very different what you get to do on the ward and what you do in the community . You do get to practice more administration on the ward, you do get to see more things happening in terms of IV fluids ..but there are opportunities in the community ..and being proactive and asking for opportunities .** I have had really good support here. Whenever I have said “ I need to witness so and so or be a part of this “they have helped me out.

KB What sort of things have you asked to witness

H: **Catheterisation. Again I had my skills signed off but it is about keeping up with the practice so you do not lose that skill. Catheterisation, the antibiotics, PIC line which I did not see much of in the wards either and seeing wound care. You have so much opportunity here for seeing wound care and those were my main objectives. That is what I have asked for in my first six weeks (code: Clinical Skills)**

KB Anything else in terms of your expectations. You have said : “ adjusting to the shift times, the support – the immediate availability of the mentor . Anything about the community which has disconcerted you or made you think that’s interesting or different ?

H **Well I have found it very interesting because when you are in hospital , you don’t think too deeply about what is going to happen next with the patients , you know you are doing the discharge and you know you might be involved in a referral for District Nursing but coming out here and seeing that side of it, what happens when you get the referral (Code: discharge or “other side”)**

KB Yes

H: **I have also managed to spend two days with the continuing care team so I have sat in on panels and gone to a couple of hospitals to see cases for continuing care. So that is the other side . You are still caring, the role is still there but you are seeing the other side- what happens when the patient is discharged .. (Code: discharge or “other side”)**

KB Hypothetically ..IF you were back in a ward. Is there something you might do differently if you were back in the ward

SG **Yes there is. I think I would really go into the social aspects of the patients. We often get a report from the OT who has been to the home ..possibly think a bit more along the lines of the discharge planning , how to support the patient more once they are home ( code discharge or “other side)**

## Appendix 8: An example of a published output demonstrating on going developments

### FEATURE

# Can a 'sign-off' experience with the health visiting service benefit students?

The provision of a final placement before qualification – often referred to as a 'sign-off' placement – in the child field of practice can prepare students for their transition into health visiting

**Kate Brown**  
BA MSc RGN RHV RNT  
Principal Lecturer  
Middlesex University

In the push to achieve the Health Visitor Implementation Plan target of 4 200 extra health visitors by 2015 (Department of Health (DH), 2011a) a range of measures are being directed at student nurses to recruit them on to specialist practice health visiting programmes, including a 'myth buster' document from the Nursing and Midwifery Council (NMC, 2011) and targeted mail to the home address of recently and newly qualified students.

One route to health visiting offered by some universities is the 2+1 programmes, where a graduate with a degree in a health-related subject claims accreditation of prior learning and achieves first registration after two years and then immediately commences their specialist community public health nursing (SCPHN)/HV programme (NMC, 2011). Another option being taken by a growing number of students is to complete the three-year nursing pre-registration programme and then join the health visitor (HV) programme (NMC, 2011).

#### Student nurse to health visitor

The NMC has argued that the current pre-registration programmes 'have greater opportunities for practice learning in primary care ... facilitating the graduate

#### Box 1. NMC expectations of the sign off mentor covered in the preparation period

- An understanding of the NMC registration requirements and the contribution they make to the achievement of these requirements
- An in-depth understanding of mentor accountability to the NMC for the decision they must make to pass or fail a student when assessing proficiency requirements at the end of a programme
- A working knowledge of current programme requirements, practice assessment strategies and relevant changes in the education and practice for the student they are assessing

to move onto a SCPHN/HV programme without any requirement of post-registration experience in primary care' (NMC, 2011). In practice, the amount of primary care experience in a pre-registration nursing programme may vary as some universities have found identifying placements in primary care to be a challenge (Dean, 2010).

In relation to adult nursing, several universities have documented how a more structured approach to placements in the community setting has made it more likely that students will apply and be successful appointed to community posts (Shelton and Harrison, 2011; Brooks and Rojahn, 2010).

Offering final year 12-week placements to adult branch students within district nursing at Middlesex University has made a difference to the confidence of students in applying and remaining in community posts in adult nursing services. Therefore, the university has decided to see whether this can be replicated for health visiting with students from the child field of practice. It is too early to assess how many of the newly qualified

nurses who join the HV programme will have longevity in health visiting at a national level, but it is possible that an important variable will be the amount of exposure to the service which occurred as part of their pre-registration programme.

Students can join health visiting from any field of nursing or midwifery. An important starting point for reviewing how the current pre-registration educational programmes inform health visiting practice are the NMC standards for pre-registration nursing (NMC, 2010) or midwifery (NMC, 2009). While student nurses in any field must gain generic competencies there are also individual field competencies to be achieved for adult, child, mental health and learning disability. Arguably, each field has something to offer health visiting.

The decision to offer child field of practice students this opportunity was partly a pragmatic one, in that they can build on existing learning opportunities in child health community services. However, the BSc in Child Health programme provides an