Purple, Green and Blue:

exploring mental health student nurses' narration of their own professional identity

Fiona Elizabeth Grace Bowring-Lossock

August 2024

This thesis is submitted in partial fulfilment of the requirements of Cardiff University for the Doctor of Education Award

Cardiff University, School of Social Sciences

Abstract

Defining mental health nursing is challenging. For nursing students this can be frustrating, fuelling uncertainties of identity, affecting a sense of belonging. This may contribute to attrition, currently around 25% in the UK. Determining students' narration of professional identity might help understand how they become mental health nursing students, potentially useful in addressing issues of attrition.

The COVID-19 pandemic completely changed the education of nursing students UK-wide. It is reasonable to suppose such changes would affect students' sense of identity.

Using a case study approach, underpinned by an interpretive-constructivist framework, I employed Wenger's (1998) Social Theory of Learning to analyse data from two pre-pandemic focus groups, and from two mid-pandemic interviews. These were conducted with undergraduate mental health nursing students at one university, post university-based Interprofessional Education (IPE). The interviews were conducted during their National Health Service COVID-19 deployment. Further data gathering was curtailed by the pandemic.

Focus group findings indicated that students narrated their identities through practice, on the peripheries of mental health nursing communities, as they learnt to become and belong, managing the unpredictability of mental health nursing. Innately held qualities and attributes supported this, often strengthened by previous care work experience. Resilience and a high tolerance threshold was important, notably, when experiencing incivility from staff. IPE encouraged learning with, from and about other professional groups and facilitated reflection on self-identity.

The interviews revealed the distress students experienced before deployment, feeling isolated and unprepared. Once deployed, they felt superfluous, uncertain of their status as student/employee. Although there were some positives, such as developing fortitude and managing uncertainty, on balance, they would have preferred to retain full student status.

Research conclusions are fourfold. Students should be supported to define their identities through their developing mental health nursing skills and knowledge. Issues of staff incivility towards students must be addressed. IPE can facilitate understanding of self and others. Students must be prepared for deployment in public health crises.

Statements/ Declaration

Statement 1

This thesis is being submitted in partial fulfilment of the requirements for the degree of Doctor of Education.

Signed: FEG Bowring-Lossock

Dated: 26th August 2024

Statement 2

This work has not been submitted in substance for any other degree or award at this or any other university or place of learning, nor is it being submitted concurrently for any other degree or award (outside of any formal collaboration agreement between the University and a partner organisation).

Signed: FEG Bowring-Lossock

Dated: 26th August 2024

Statement 3

I hereby give consent for my thesis, if accepted, to be available in the University's Open Access repository (or, where approved, to be available in the University's library and for inter-library loan), and for the title and summary to be made available to outside organisations, subject to the expiry of a University-approved bar on access if applicable.

Signed: FEG Bowring-Lossock

Dated: 26th August 2024

Declaration

This thesis is the result of my own independent work, except where otherwise stated, and the views expressed are my own. Other sources are acknowledged by explicit references. The thesis has not been edited by a third party beyond what is permitted by Cardiff University's Use of Third Party Editors by Research Degree Students Procedure.

Signed: FEG Bowring-Lossock

Date: 26th August 2024

Word Count: 50,385

(Excluding summary, acknowledgements, declarations, contents pages, appendices, tables, diagrams and figures, references, bibliography, footnotes and endnotes).

Acknowledgements

Thank you to my family, friends and colleagues who have supported me and made the navigation of this long journey possible. I am especially thankful to my husband Neil, to my friend Alicia, and to my brother John. Thank you also to my supervisors, Professor Alison Bullock and Dr Jamie Lewis, for your guidance and encouragement.

Thank you to the students who took part in the study, I wish you all the best in your journeys as Registered Nurses.

This is dedicated to my parents, Pearl and Denys Bowring, the epitome of love and commitment. Dad, we didn't quite get to see it through together, but please know, all is well.

Contents

List of Abbreviations

Abbreviation	Term
CAIPE	Centre for the Advancement of Interprofessional Education
CoP	Communities of Practice
COVID-19	COronaVIrus Disease of 2019
DoH	Department of Health
EdD	Doctor of Education
HCSW	Health Care Support Worker
HE	Higher Education
HEIW	Health Education Improvement Wales
CDoH	Council of Deans of Health
IPE	Interprofessional Education
NHS	National Health Service
NMC	Nursing and Midwifery Council
MDT	Multidisciplinary Team
PLO	Practice Learning Opportunity
PPE	Personal Protective Equipment
RCN	Royal College of Nursing
RN	Registered Nurse
STL	Social Theory of Learning
UK	United Kingdom
WG	Welsh Government
WHO	World Health Organisation

Table 1

List of Figures and Tables

Appendices

Chapter 1

Setting out on the search for purple, green and blue

1.0 Introduction

This chapter introduces the thesis and offers a rationale for my study, the aim of which is to explore how mental health student nurses narrate their own identities. Defining the role and securing a professional identity for mental health nurses and mental health nursing has historically been a challenge (Bladon, 2018, Barker and Buchanan-Barker, 2011, Peplau, 1997) and remains an area of debate (Hurley *et al.*, 2022, Terry, 2020). It follows, therefore, that the professional identity of mental health nursing students will be similarly elusive.

Here, I set out the original starting point for my work pre-2020, positioning myself in the landscape to identify the significance this study has for my own personal and professional practice as a Registered Nurse (RN) and lecturer in mental health nursing in Higher Education (HE).

I introduce the underpinning theory of the thesis, Wenger's (1998) Social Theory of Learning (STL). This is multi-layered and designed to explain relationships between the influences on individual learning and development of identity. I also outline the major structures of the theory which I will later use to analyse research findings.

In anticipation of using Interprofessional Education (IPE) as a platform for exploring issues of professional identity with mental health student nurses in a HE setting, I present an outline of IPE. Considering the purpose, I include a brief discussion on the significance of IPE for me and my own practice.

I then discuss the impact on the project of COVID-19 (SARS-CoV-2) - ("the pandemic"), a virus first isolated in December 2019 in Asia (Park *et al*., 2020). As a result of the pandemic there were allied and unique consequences for nurse education in the United Kingdom (UK), which subsequently impacted my research.

Finally, I set out the structure of this thesis, representing a pathway to guide the reader.

1.1 Personal and Professional Context

As a lecturer in mental health nursing at a university in Wales, I have joint responsibility for the education of up to 250 pre-registration, undergraduate mental health nursing students at any one time. Having worked in this capacity for over 20 years, one of my areas of interest is how students learn to "become" student nurses. It is reasonable to expect that all students experience changes to their sense of identity and of place in the world as they evolve, but for some undergraduate mental health nursing students, it is seemingly problematic. Some students assume the identity and some do not. This can lead to unintended consequences, such as apathy and unhappiness. One of my prepositions became that a shortfall in understanding and internalising one's identity can negatively affect the quality and enjoyment of studentship, and that this can lead to excessive distress which can translate into attrition.

The reasons nursing students struggle with professional identity are likely to be multifactorial, not least financial (Stacey, 2022), but for these students there are specific contributory factors. They must fulfil different roles in different environments and are expected to assimilate in each, and they inevitably get pulled in different directions.

Initially, their focus is being part of and belonging to a university community. This includes developing academic skills and acquiring knowledge and understanding theory specific to professional nursing. The focus then moves to being a nursing student in clinical practice, developing practice-based skills, bringing theory and practice together. Students must achieve competence in incrementally challenging clinical and academic activities, usually over a three-year period, for at least 4,600 hours, with a 50/50 split (Nursing and Midwifery Council (NMC), 2023[b]). Unsurprisingly, some students report a "split identity", finding themselves straddling university and clinical practice (Attenborough and Abbott, 2018, p 52).

The landscape these students move across is complex and dynamic and there are professional, academic and legal expectations of them. They are accountable to multiple sources including patients, their families and carers, the public, the regulatory body for nursing and midwifery, the NMC, the university, and ultimately, to themselves. This can be burdensome. Pre-pandemic, these challenges contributed to the rate of attrition of student nurses in the UK, around 25% (Jones-Berry, 2020[a], Clements *et al.,* 2016). Attrition is a well

know, chronic problem (Mitchell *et al.,* 2021) that ultimately impacts workforce numbers. Post-pandemic, some estimates place the figure as high as 33% (Stacey, 2022). If better understanding of professional identity positively affects the experience and quality of studentship, it is reasonable to assume attrition can be better understood and mitigated for.

1.2 Introduction to Wenger's (1998) Social Theory of Learning

Wenger's (1998) Social Theory of Learning (STL) combines different theories of identity, practice, situated experience and social structure. Wenger is clear that his STL does not seek to replace any of the individual theories, rather it brings them together as component parts of the whole. The STL proposes that learning develops within Communities of Practice (CoPs), described as a "point of entry into a broader conceptual framework" (Wenger, 1998, p 5). The growth and development of identity is facilitated through learning situated in CoPs.

Wenger (1998) suggests that each individual inhabits their own landscape of practice made up of a number of CoPs. Adults are generally active within more than one CoP simultaneously, with overlaps in group membership occurring across the trajectory of one's lifetime (Wenger, 2009). Membership is, of course, to some extent, transient. As people progress across their lifespan, they experience changes in their interests, situation and commitments. They may also experience changes to personality traits, such as developing openness to new ideas in young adulthood and becoming less tolerant of change with age (Roberts and Viechtbauer, 2006).

The pertinence of the STL to nurse education is appreciable. Student nurses operate within a number of CoPs, in the landscape of practice. They need to change and adapt to fit in with the group to which they want to belong, both at university and in clinical practice, a complex and multi-faceted process. Therefore, using an adaptation of the STL is appropriate to analyse the data, to explore the experience of the development of professional identity for mental health nursing students and how they express this.

1.3 An Overview of Interprofessional Education

The Centre for the Advancement of Interprofessional Education (CAIPE) is a UK-based organisation fostering the development of IPE internationally. It is the source of several large and influential studies into the implementation and evaluation of IPE projects worldwide

(Barr *et al*., 2017, Barr *et al*., 2014). The CAIPE definition of IPE is widely used: IPE can be considered as the "occasions when members or students of two or more professions learn with, from and about each other to improve collaboration and the quality of care and services" (CAIPE, 2016, p 1). This goes beyond shared learning. Skills acquisition and learning outcomes centre on understanding own individual professional identity and professional contribution, developing the skills of collaborative team working and understanding the roles and responsibilities of others (Barr and Low, 2013). There is an expectation that IPE can address negative stereotyping of one profession towards another. There is evidence to suggest nursing students benefit from participating in IPE (Spencer *et al.,* 2019, Adams *et al.,* 2006) and the inclusion of interprofessional learning is mandated in pre-registration education in the UK by the NMC (2023[a]).

1.4 The impact of COVID-19

Intended to promote the professional profile, the World Health Organisation (WHO) announced 2020 as the International Year of the Nurse and the Midwife, to coincide with the 200th anniversary of the birth of Florence Nightingale (WHO, 2019). The focus was to be on the importance of practice, highlighting the international societal contribution of midwives and nurses, the largest group of professionals in healthcare services. Unfortunately, all plans were disrupted and then dislodged as nursing and professional identity were reimagined through the lens of a pandemic (Jackson *et al.*, 2020).

Early 2020 witnessed the rapid, uncontrolled spread and subsequent devastating effects of COVID-19 globally, leading the WHO to declare a pandemic in March 2020 (WHO[a], 2020). The WHO (2020[b] np) described COVID-19 as "…the most challenging crisis we have ever faced". In August 2020, the WHO (2020[c]) estimated that globally nearly 25,000,000 people had been infected with the virus, leading to over 800,000 deaths. By December 2021, this had risen to 265,000,000 infections and the deaths of over 5,000,000 people (WHO, 2021). The WHO confirmed that by August 2023, 770,000,000 people had contracted COVID-19 and of these, 6,900,000 people had died as a result (WHO, 2023).

In the UK, from the beginning of the pandemic, there were significant demands on high intensity in-patient care (King's Fund, 2021). Resources, already overstretched due to chronic underfunding, were at breaking point (National Health Service (NHS) Confederation,

2021[a]) meaning other patient services were cancelled or disrupted as care for those with COVID-19 was prioritised (NHS Confederation, 2021[b]). Human and physical resources, already pared down by successive governments, were pushed to the limits (NHS Confederation, 2021[a]). In order to try to limit spread of the virus, the UK was put into the first lockdown in March 2020.

Set within this context, the education and training of tens of thousands of healthcare students in the UK were put on hold. Though a devolved matter, Wales was broadly in line with the rest of the UK:

> "Given the significant pressures on the system (the NHS) and the need to ensure that front line services are fully supported, it is not possible to continue to provide the current programme for (nursing) students…"
> (Welsh Government (WG), NHS Wales, Health Education Improvement Wales, (HEIW), 2020, p 7).

Legislators and professional regulators were considering how students could be used within the NHS during the pandemic. Student nurses were identified as an obvious and appropriate choice: they spend regular and significant periods in clinical practice delivering hands-on patient care, and they understand how the NHS operates. Their status as externals with insider knowledge put them in the appropriate position to be able to support staff and plug gaps in practice caused by the pandemic, as unprecedented numbers of people required acute care provision. Nursing students, who met the criteria and who opted in to the scheme were "deployed" to the NHS in April 2020, on short term contracts of employment. They were to become employees for 80% of their working week. This was a unique event in the history of nurse education, life changing for many.

Until this point, student nurses were unpaid and were not employed by the NHS, although they were required to spend at least 2,300 hours in clinical practice (NMC, 2023[b]). Having supernumerary status, they were supervised by a mentor, an RN responsible for overseeing and validating practice learning and achievement. This group of students were initially the sample group for my research. It is worth stating upfront that I was able to complete the first part of my data collection with them before the full force of the pandemic was realised. However, I had to reassess both my method of data collection and the scope of my research, given the seismic change in perception of professional identity that was likely about to

happen as mental health nursing students became employees on deployment, with a new remit and different responsibilities.

Pre-pandemic, the aim of the research was to explore how mental health nursing students narrated their own identities. At that point I was able to collect data as planned, through focus groups, using IPE as a platform to do so. As a result of the pandemic and subsequent, significant, wholesale changes to nurse education in the UK, changes to the data collection method was required. I chose to collect additional data using individual interviews with students who were deployed in practice. These changes also resulted in a lesser focus on IPE as I would not be using this as a way to access students mid-pandemic. Further intentions of developing a theory-based framework for IPE for use in my own practice were also put aside. A description of the methods employed and how the project pivoted with the introduction of lockdown is set out in Chapter 4.

1.5 Structure of the thesis

The structure of the thesis is as follows. Chapter 2 offers a more in-depth consideration of the major concepts of Wenger's (1998) STL. I discuss relevant concepts and theories that comprise the STL framework. I include a short narrative on the nature of IPE, as the mode for collecting the first set of data, pre-pandemic. I consider the significance of identity viewed through a psycho-social lens and give a brief overview of identity.

Chapter 3 reviews the context of the aim of the thesis. Initially I consider the evolution of nursing, socio-political influences and contemporary influences on mental health nursing as this impacts on nurse education. I then offer an exploration of students' own views of themselves, their lived experience.

The methodology for the study is presented in Chapter 4. This details my personal worldview and starting position for the research and includes a description and discussion on the methods. This includes sampling, methods of enquiry and data analysis. I also address ethics and trustworthiness.

The findings are reported and discussed in Chapters 5 and 6. In Chapter 5, I present and analyse the focus group findings and in Chapter 6, I explore findings from individual interviews, using my adaptation of the major concepts of the STL, as outlined in Chapter 2.

The phenomena of "purple, green and blue" is discussed. These colours are key to the participants understandings of themselves in context, purple being the students' uniform, green, that of Health Care Support Workers (HCSWs) and the blue of RNs. These gifted me the title of this study.

In the concluding Chapter (7), I review key findings in relation to each of my research questions. I consider the strengths and limitations of the study, the recommendations, and identify the original contribution of my work. I conclude the thesis and then offer my own final thoughts on my research.

1.6 Chapter Summary

To summarise, here I have outlined some issues associated with professional identity for mental health nursing students and positioned myself as a mental health nurse lecturer in an HE setting. I have given an insight into the impact of COVID-19 on nurse education and changes that were enacted as a result, in the UK in 2020. I have outlined the need to adapt my research to account for these changes.

I have introduced Wenger's STL, and determined its use in exploring issues of professional identity development with students. I have considered the scope and purpose of IPE, speculating that it is a suitable platform for student engagement.

I have also set out the structure of the thesis, briefly describing each chapter.

The following chapter discusses the major concepts associated with the study: Wenger's STL (1998), concepts of IPE and issues pertaining to identity and professional identity.

Chapter 2

Social Theory of Learning, Interprofessional Education, Identity

2.0 Introduction

This chapter explores the three major concepts underpinning this study: Wenger's (1998) Social Theory of Learning (STL), Interprofessional Education (IPE) and identity.

Firstly, I explore the STL in greater detail, considering the concept of, as Wenger describes it, the gateway to the STL, Communities of Practice (CoPs). This includes discussion of the concept of landscapes of practice and modes of identification, which nurture CoPs. I consider the tenet that individual learning is situated in groups, through engagement and social participation. I highlight the composite parts of the STL, the theories Wenger (1998) has drawn together to underpin the framework. This is followed by acknowledgement of some issues potentially affecting the efficacy of the STL.

Secondly, having highlighted the link between the STL and nurse education in Chapter 1, I consider the significance of IPE in health and social care education and its intended purpose and scope. This centres around the need to improve patient experience and facilitate the development of interprofessional collaboration (Barr *et al.,* 2017). I then offer an insight into IPE in the context of my own practice.

Finally, I address issues of identity formation and the formation of professional identity. The concept of identity is in itself a whole academic genre, fuelling many debates and discussions (Kalin and Sambanis, 2018) and informing theories which offer explanations of what it means to *be*, and how to *become* (Spears, 2011). I offer a small window into some of the complexities of this process. I consider briefly, ideas that support theories and models of identity development, from a psychosocial perspective. I offer a brief overview of the issues specific to professional identity.

I now begin with exploring the STL.

2.1 Social Theory of Learning

As previously noted, Wenger's (1998) STL is constructed of four different established theories: identity, practice, situated experience and social structure. Wenger seeks to

amalgamate them to offer a broad but complex conceptualisation of how identity develops through learning, beginning with membership of relevant CoPs.

Wenger-Trayner and Wenger-Trayner (2015[a]) define CoPs as "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" (np). Wenger indicates CoPs must have the following characteristics:

1. The domain – represented by the shared interest members hold and the reason the group exists, working together in a joint enterprise.
2. The community – those individuals who engage in activities pertinent to the domain as a collective, sharing knowledge and understanding. This need not be physical; it can be virtual or a combination of both.
3. The practice - those engaged and participating in the community become practitioners who learn from and with each other, develop shared histories and engender the sustenance of social capital. It is this that sets CoPs aside from other community groups, such as a group of neighbours, who are a community by virtue of their living arrangements.

The underpinning assumptions are that learning occurs as a result of engagement and social participation in CoPs. These communities are set within landscapes of practices and identities are constructed within these as a continuous process (Wenger, 1998). The development of a formed identity is a concurrent part of this process, which requires the individual to identify their own interest and negotiate community membership *(ibid).*

Individual engagement in shared activities tentatively leads to membership of CoPs (*ibid*), which can herald associated learning and consequent development of identity. The conceptualisation of CoPs, first explored in depth by Lave and Wenger (1991), describes the system of relationships between people in specific contexts, which develop across time. From adulthood, individuals will normally operate in several CoPs simultaneously (Handley e*t al*., 2006) and leave and join (or attempt to join) others across their lifespan, as they change and develop other interests. According to Wenger-Trayner and Wenger-Trayner (2015[b]) identities are formed through the trajectory of every individual's lifetime and associated learning "is not merely the acquisition of knowledge" (p 19).

Group membership attracts an expected level of competence from those individuals within the group to maintain membership, as well as for those striving for membership. This develops with experience and understanding and initially, while seeking membership, one is legitimately peripheral to the group. This gives time for the individual to develop an understanding of what the community does, to engage with group members and to learn to use the resources developed through shared histories (Wenger, 1998). The activity of reification to produce resources is as important as participation. Situated learning in this way is intrinsically correlated with identity. The resources produced may not be physical, but social capital that is exclusive to the group (though, this is less likely to be measurable). Mutual development and support can be evidenced through the sharing of information, experiences and problem solving (Wenger-Trayner and Wenger-Trayner, 2015[b]).

According to this theory, the individual learner can become competent and reflect the already achieved competence of the group and so be accepted as a full-time member of the group. There will be those who remain peripheral, but who are accepted as such, compared to those core group members. Student nurses are likely to engage in legitimate peripheral participation (Lave and Wenger, 1991) as they move between different clinical environments.

Alternatively, the individual in the periphery may opt for dis-identification if, after the period of contemplation of membership, the group does not meet (their) expectations (Wenger-Trayner and Wenger-Trayner, 2015[b]). Working to gain access to a CoP can be frustrating and distressing. A peripheral newcomer for whom competence is provisional or underdeveloped, could be rejected by the CoP. For another, moving from a CoP where one has a sense of identity through proven competence to another where that competence is not valued, can be disenfranchising and devaluing, potentially reducing accountability for practice which can lead to impoverished experience (Farnsworth *et al.,* 2016). The STL recognises although we might not learn equally in all communities, this too is part of the journey of identity development and seeking membership has the potential to make the individual vulnerable *(ibid).*

This process of identity development is crucial to the individual because ultimately this facilitates their individual learning within the community *(ibid).* This is a dynamic process, which may not have a clear ending but progress can be measured periodically and reification

of participation can occur at different times across the lifespan. For nursing students, this could be realised through successful completion of a clinical placement.

Those who strive to join specific communities must hold or aspire to hold similar values, attitudes and beliefs and wish to attain the same level of knowledge as existing members. Knowledge can be tested and reified, (Wenger, 1998), but competence is more than measured knowledge and understanding the immediate community: "Learning to become a practitioner is not best understood as approximating better and better a reified body of knowledge" (Wenger-Trayner and Wenger-Trayner, 2015[b], p 23). It is concerned with recognising the complexity of the landscape, described as concurrently political, flat and diverse, within which the community sits and how they can participate and contribute to this.

Different modes of identification, engagement, imagination and alignment, influence participation. This can be seen as, for example, individuals engaging in different CoPs, welcoming new ideas and seeking new opportunities for co-productions, and, conversely, also of non-participation, for example, through passivity, withdrawal, or not taking responsibility for own actions. These are found throughout the process of identity development, identification and negotiability, and whether positive or negative, are all part of the process.

2.1.2 Theories embedded in the Social Theory of Learning

In Figure 1, overleaf, Wenger (1998) sets out the theories considered most weighty, in the structure of the STL. These will be used to explore the findings of this study in Chapters 5 and 6, as detailed in Chapter 4.

The theories on the vertical axis, social structure and situated experience are, according to Wenger, most significant to the individual's perception of their own identity development. Theories of social structure emphasise the primacy of institutions and community (Wenger, 2009). Here, the importance of rules and culture in the group is captured. Individuals communicate pursuits they are engaged with and consider worthy, and demonstrate their competence in these pursuits which is recognised; learning as belonging.

Theories of situated experience see the individual caught up in the dynamics of life with, possibly less prescribed and more individually driven activities that take place outside the

limits of the theories of social structure; learning as experience. This is the tension that can have the greatest influence on people most often, or one they recognise most often, as it potentially involves conflict or unexpected or unmanageable consequences for individuals (Wenger, 2009).

On the horizontal axis, theories of practice are concerned with what happens in everyday life. Importance is placed on shared mutual collaboration and the impact this has on individuals, who pursue this for themselves in the CoPs to which they belong; learning as doing (*ibid*). At the other end of this axis, theories of identity are concerned with the way social identity is formed, and changes the individual at a personal level within the wider context of the community; learning as becoming (*ibid).*

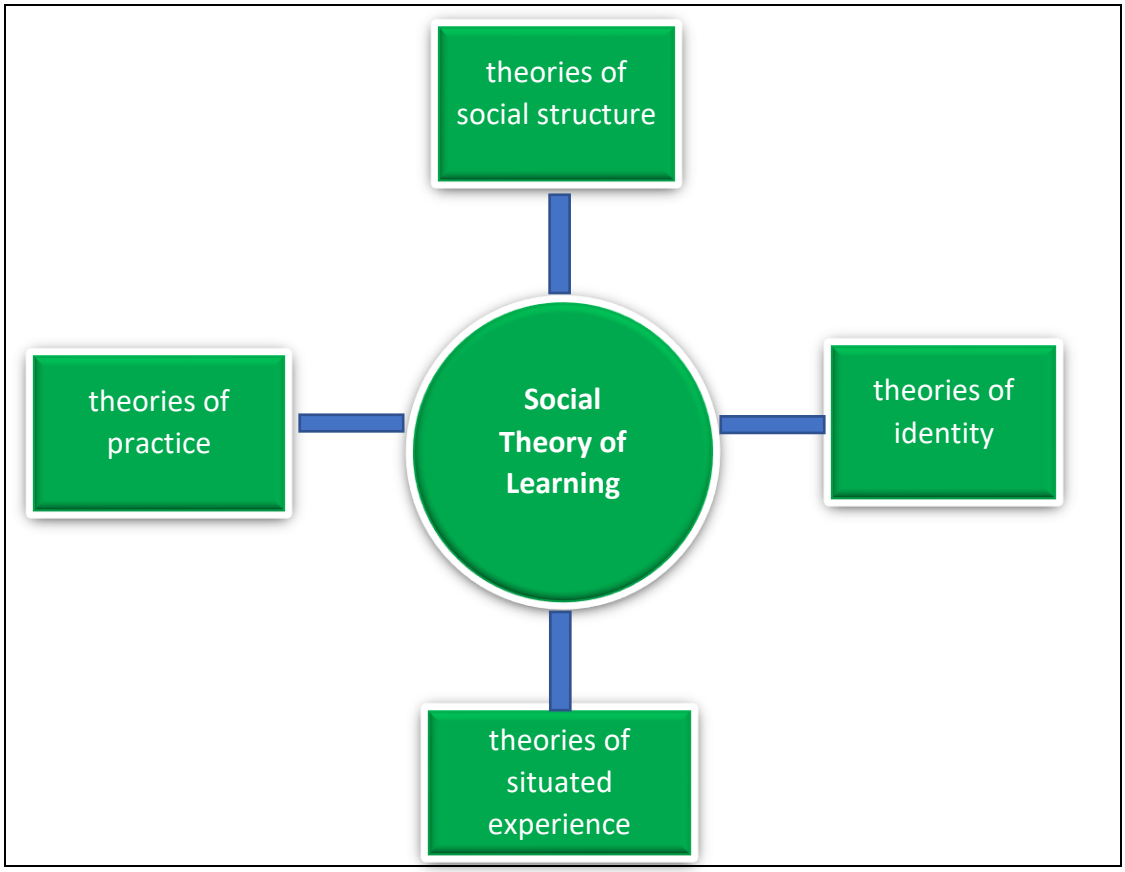


Figure 1. Two main axes of the Social Theory of Learning (Wenger, 1998 p 12)

2.1.3 Issues to consider

Wenger's theory is not perfect and is not the "magic bullet" to facilitate sharing of knowledge development (Kerno, 2008, p 69) and so inform identity development. Initially and perhaps most obviously, a CoP cannot be formally designated, it has to grow organically to be meaningful to its members. So, whilst any organisation can sanction and support the development of a CoP (Koliba and Gajda, 2009), it does not automatically become a CoP (Roberts, 2006). Koliba and Gajda (2009) suggest CoPs must have some affiliation to a formal system (of work) and demonstrate some reification in order to develop the gravitas required to afford it a legitimate status; it is more than a casual chat amongst friends. Additionally, CoPs may have a limited lifespan, not all are long term and enduring (Wenger, 1998).

CoPs take passion and commitment from members in order to work and develop, and this can be problematic if these values are lacking (Kerno, 2008). There must be a degree of trust within the CoP to ensure sharing and transferring knowledge. Trust is borne of experience and is sometimes difficult to nurture (Roberts, 2006).

Within most organisations vertical lines of hierarchical relationships support and guide the system (Kerno, 2008), meaning there will always be people in any group who have more influence over members either through position, knowledge, experience or wealth (Roberts, 2006). Whilst Wenger (2009) concedes power is an issue, he is also clear it will always be so and should be foreshadowed as a concern.

Within CoPs there is a constant and naturally occurring negotiation of position as sharing and learning occurs (Handley *et al*., 2006). This includes conflict identification and resolution for which all members are accountable, although some may choose to avoid conflict altogether, either interpersonal or intrapersonal, by not attempting to join the group *(ibid*). Additionally, the individual may find internal conflict when inhabiting groups that hold different values and ideals from the other (*ibid*). Sometimes the strongest core members may stifle membership for those on the periphery, wary of change incomers may wish to facilitate.

In summary, the STL, most easily observed through CoPs set within landscapes of practice, offers a useful platform to explore learning and subsequent development of professional identity.

2.2 Interprofessional Education

In 1988, although IPE had already been internationally recognised, the WHO (1988) clearly reiterated its value. This was later reflected in the Department of Health's (DoH) raising awareness of its worth in the UK (DoH, 2001). One of the DoH's pledges for action was to ensure that good practice for interprofessional learning would be part of all healthcare professional curricula by 2004.

In collaboration with the DoH, CAIPE (2007) published a framework for IPE and training for health and social care professionals across the UK. Key stakeholders, commissioners of education, education providers and employers were called upon to ensure IPE was integrated into all aspects of health, social care and children's health and wellbeing services. Another recommendation was that professional bodies, such as my own, the NMC, needed to assure the delivery of quality IPE. Commissioners and providers of education were tasked to ensure assessed IPE activity was a mandatory element of education and training programmes for these professional groups.

The WHO (2010) has since proposed the expectation that an improvement in health and social outcomes is linked closely to the implementation of IPE in health and social care education, stating "Interprofessional education is a necessary step in preparing a 'collaborative practice-ready' health workforce that is better prepared to respond to local health needs" (WHO, 2010, p 7). The WHO recommends IPE is situated in healthcare undergraduate and postgraduate education to, ultimately, enhance patient experience. Barr *et al*., (2017) consider the values of IPE in practice focus primarily on increasing the quality of patient care and the holistic experience for the patient, to be achieved through collaborative learning for professionals.

Patient safety is one of the most significant drivers for IPE in health and social care (Bainbridge and Wood, 2012). Ineffective collaboration, poor communication, misunderstanding of roles and responsibilities within and between teams of healthcare professionals, have had catastrophic effects on patient health and outcomes for some patients in the UK (Ion *et al.,* 2019, Andrews and Butler, 2014, Francis, 2013). Eliminating bad practice in healthcare must be top of the agenda and development of the collaborative skills promoted through IPE can contribute to this (Green and Johnson, 2015).

Skills acquisition and learning outcomes of IPE centre on developing the skills of collaborative team working; understanding one's own individual professional identity and understanding the roles and responsibilities of others (Barr and Low, 2013). IPE can be a conduit for exploring how students perceive themselves as professionals and their attitude towards others (Stull and Blue, 2016).

2.2.1 Interprofessional Education in context

Commonly used approaches to the organisation of IPE at university include the development of complex, simulated health and social care scenarios, which demand critical thinking of actors in teams of multiple professions, to find comprehensive and realistic solutions to complex problems (Barr *et al*., 2017). This might include simulated role play, which can be used to good effect (Hovland *et al.,* 2021). The purpose of IPE at this point of delivery is learning and practicing skills in simulation, skills which can be transferred into the real healthcare environment. It should follow that the patient experience will be enhanced through a care delivery process facilitated by cohesive and efficient team members, empowered by the skills of collaborative working. However, this is not always guaranteed (Cleary *et al.,* 2023).

In pursuit of collaborative and contemporary ways of learning and teaching, I have led and been involved with developing IPE at meso and micro levels at university. I have organised and facilitated this for students for a number of years, giving them opportunities to work with others to develop the knowledge, skills and attitudes necessary for collaborative team working (Barr *et al*., 2014). This was not a requirement of the syllabus, but something I saw value in. At that time, although these were *ad-hoc* days, they offered students an experience to mingle with students from other professions and other schools. These sessions were consistently well evaluated, students enjoyed the chance to work with other professions.

It is generally agreed though, that frequency of IPE is important and should be viewed as a process, set within an organised programme, rather than an occasional occurrence (Reeves *et al.,* 2012). Clark (2006) suggests "titrating the dose of IPE" (p 585) through the transformational learning process of the student's journey. For me, at that time, this was not possible.

In 2017, the School was given a mandate for the inclusion of IPE in all new curricula, including, but not exclusive to nursing, to be rolled out from 2020 onwards. This was to ensure IPE is a constant component of all pre-registration undergraduate study in the School (typically around 1200 students). Such strategic recognition of IPE at senior level in this way is crucial (Barr *et al.*, 2017) and must be maintained to ensure IPE becomes culturally embedded because it is logistically testing (Guraya and Barr, 2018, Stephens and Ormandy, 2018). Bringing timetabled activities together, aligning curricula and having space to situate large numbers of students concurrently are significant challenges, making it more difficult to determine a scheme of IPE across a curriculum, rather than making do with *ad-hoc* or one-off sessions. IPE is not easy to develop and maintain, it is a time consuming, human and physical resource intensive long-term project (Reeves *et al.*, 2012). However, if IPE helps students to develop their sense of professional identity, lack of access to it reduces opportunities to explore this. Put differently, if they have fewer opportunities to appreciate their own identities and those of others within an interprofessional setting, arguably, their educational experience is the poorer for it.

IPE has the support of the significant professional and regulatory bodies for health and social care professions in the UK (Health and Care Professions Council 2014, Care Council for Wales, 2013, General Medical Council, 2009). The NMC indicated that post 2018 it would only validate new pre-registration nurse education curricula overtly demonstrating the innovative use of interprofessional learning, very clearly endorsing an interprofessional approach to learning both in clinical practice and in university settings (NMC, 2023[a]).

In summary, IPE is not a luxury; it has become a non-negotiable foundation of contemporary healthcare professional education. A theory-led, educationally sound programme of learning that can be evaluated offers gravitas to commissioners of services and, vicariously, to those who receive health and social care.

2.3 Identity and professional identity

2.3.1 Identity

The concept of one person holding an individual identity is relatively modern (Taylor, 1989), a development of a rights-based, equality-driven society. Having an identity can be a moral undertaking as it infers personal agency and the right to self-determine (Benwell and Stokeo,

2006) with an associated sense of responsibility. Identity is a significant and important part of *being*, although it is nebulous and sometimes difficult to define, making this more complicated. It changes as we adapt to different situations across the lifespan (Brennan and Timmins, 2012) and a degree of fluidity is important as it helps us fit into different contexts (La Guardia and Ryan, 2007).

2.3.2 Identity formation

The study of individual development has attracted much attention since the end of the 19th century. Individual identity does not develop in a vacuum. It is a social process. Other people, generally, initially, a child's family/carers are implicated in the developmental process, with different interpretations and extrapolations as to how this occurs (for example, Marcia, 1966, Erikson, 1950). It seems clear that people need the input of others in their evolution to "individual", the practice of being oneself, holding a unique identity. This input across the lifespan affects all aspects of development, a process which can continue into old age.

There are points in a person's life when identity is malleable before it becomes generally more stable. Early adulthood is a usual, but not exclusive, entry point for students into university education and is typically recognised as important in identity maturation (Mancini *et al.,* 2015) and group identity takes on a greater significance.

Tajfel and Turner's Social Identity Theory speculates that, generally individuals want to have a positive self-concept, to see themselves as of value. This can partially be measured as having been achieved or as being achievable when, as a member of a CoP, one's own attributes and achievements compare favourably with the individuals of another group in that they are perceived to be of the same or of higher value (Tajfel and Turner, 1986). Although the measurement of "higher value" is subjective, that it *is* subjective is a phenomenon understood by the group members themselves, and high-status groups make members work harder to keep their membership (Sollami *et al.,* 2018). Group members are engaged and participatory, valuing membership.

As social beings, individuals like to belong to groups according to shared identifying characteristics, such as ethnicity, age, similarly held beliefs, gender, nationality and profession (Adams *et al.,* 2006). It is within groups the process of socialisation takes place.

The individual can learn how to "be" through consciously modelling, then learning and assimilating values and beliefs similar to those held by other members of the group (Dinmohammadi *et al.,* 2013).

Identity development holds our interest for obvious reasons: the experience of being human, having personhood and agency and belonging is not always easy. Knowing how this can best be facilitated may make us more insightful and our passage through life more pleasant (Myin and Zahnoun, 2018, Strachan *et al.,* 2018) or, less altruistically, may also allow us to be moulded to be less unpredictable and more easily controlled (Cinoğlu and Arıkan, 2012).

At any point in one's life, having active membership of one group may be more important to the individual than being an active member of another, because of the individual's need to adapt to their changing environment; context is significant. However, it is membership of a professional group, which relies on professional commitment (Sollami *et al*., 2018), that is likely to be of greatest significance to the individual (Adams *et al.,* 2006).

2.3.4 Professional identity

Early conceptualisation of "profession" in the westernised world developed in the powerful, male dominated, traditional closed occupations of law, theology and medicine (Crook, 2008) often, but not always, linked to social status (Abbott, 1988). Later, trait approaches to rank occupations and identify professions, saw the development of criteria describing the expected attributes of any given occupational group, enabling the creation of an ideal type for any profession (Abbott and Meerabeau, 1998). Saks (2016) identified the significance of control of the label and status of "profession".

Occupational control is complicated (Evetts, 2012) in a society that values self-regulation and autonomy. Working towards the status of profession requires an occupation to go through a period of professionalisation, allowing time to assure the profession will be of wider benefit to society (*ibid*). In a complex society that endures constant negotiation in the development and evolution of occupational groups, the issue of how occupation and profession are perceived and managed by in-groups and out-groups remains current. Professions can both maintain and lose status across time as expertise changes and society's needs change (Abbott, 1988).

Larson (1977) considers an occupation that consistently demonstrates competence and dynamism is more important than the label it attracts. Similarly, Evetts (2014) contends both traditional professions and other occupations can deliver the same expert service, exhibiting the same traits, without the need for a special title. In the informality of the workplace, it is usual to find different occupations tussle for ownership of their occupation (and the control of any associated agency) in the blurred boundaries commonly observed in practice (Abbott, 1988).

It is not the remit of this study to explore wholesale, but it is pertinent to mention the vexation that has followed nursing for decades, about whether or not nursing meets the criteria to be considered a "profession". This has proved testing to the international nursing community (Willetts and Clarke, 2014, Morris and Faulk, 2012, Varjus *et al.,* 2011, Friedson 2001, Porter 1992). McKeown and White (2015), pondered whether the pursuit for the "Holy Grail" of professionalisation, has been "a fool's errand" (p 727).

To summarise, holding an identity is considered to be an important characteristic of sentient beings. Development is influenced by a myriad of variables as an individual strives to become and belong and there will be changes and the need to adapt, through the ebb and flow of life. Curating and nurturing a professional identity can be a complex process.

2.4 Chapter Summary

In this chapter, I identified and explored the major theoretical concepts that support and guide this study: the STL, IPE and identity.

Starting with an introduction to CoPs, upon which the STL rests, I considered landscapes of practice and modes of identification, platforms supporting the individual as they learn and grow. I underlined the importance of engagement and participation in CoPs, to inform identity development. I considered the theories that comprise the STL, which will inform the data analysis. I highlighted potential issues affecting the efficacy of the framework.

I discussed the justification for facilitating IPE in healthcare education, acknowledging it may not be a straightforward process. I set out the significance of IPE and understanding own

professional identity. I offered an overview of how I have facilitated IPE and how my practice has been influenced by professional and organisational requirements.

Finally, I offered a brief discourse on the nature of the development of, and the contemporaneous importance of identity, and the genesis and direction of flow of the concept of professional identity.

The following chapter represents a review of the context of my study, linking this to the aim, which is to consider how mental health nursing students narrate their own professional identities and variables that can influence this.

Chapter 3

On the trail for "purple, green and blue": reviewing the context

3.0 Introduction

The purpose of this chapter is to review the context for the aim of this thesis, mental health student nurses' narration of their professional identities. The development of nursing and subsequent emergence of nurse identity within the auspices of professional boundaries is complicated, as is the development of identity for pre-registration student nurses. Students must gather a wealth of knowledge and skills, siting themselves simultaneously as a university student and a student in clinical practice, integrating into several discrete environments. Understanding professional identity, to know where and how one fits in, is significant to the individual (Jackson and Steven, 2020). Although countries have different approaches to the organisation and administration of nurse education, challenges in understanding identity development are not exclusive to the UK. For example, Thomas *et al.,* (2023) in Norway, Ewertsson *et al*., (2017) in Sweden, and Walker *et al*., (2014) in Australia, all report difficulties concerning different aspects of professional identity for nursing students. Identity development is complex.

In order to offer a review of the wider context, I consider the evolution of nursing and the socio-political context within which nursing sits, to highlight how professional identity has evolved. I then focus my discussion on the specific nature of the development of mental health nursing in the UK which influences nurse education.

Following this, I offer an explorative review of the lived experience of nursing students, as they describe themselves and the influences upon them. This is done through discussing the three themes I identify in the research literature: personal suitability for nursing, the realities of nursing practice, and the significance of self-reliance and self-care. The latter two themes are considered pre and mid-pandemic.

As mentioned in Chapter 1, in early 2020 nursing students in the UK were withdrawn from the clinical element of their studentship as a result of the pandemic. Those who were able to, and who opted in to the scheme, were deployed into practice as employees of the NHS on short term contracts in order to assist with extraordinary demands on healthcare services. It

is reasonable to assume that there will be differences in the experiences and the impact on self-reliance and self-care for students, pre and mid-pandemic.

Finally I offer a synopsis of literature pertinent to IPE. This is limited due to changes in the methods, as set out in Chapter 1 and detailed in Chapter 4.

Following a summary of the chapter, I recap the purpose of my thesis, set out my objectives and guide the reader to the subsequent chapter.

3.1 The evolution of nursing

Long considered a part of every woman's duty, (Ayala *et al.,* 2014), the identity of the collective of nursing has been influenced by the association with gender (Teresa-Morales *et al.*, 2022). Early iterations of training allowed female domestic servants to progress to the status of nurse, and by the early 1900s nursing had moved towards being a recognisable occupation (Friedson, 2001). The 1919 UK Nurses Registration Act required all nurses to successfully complete a recognised training programme to register to practice, and legally use the title "nurse" (RCN, 2019[b]), an entitlement that continues to the present day. A regulatory body was created, designed to assure standards, aiming to establish self-governance through agency and accountability. It was anticipated autonomy would progress the transition from occupation to profession. As identified in Chapter 2, this has not been straightforward.

Arguably of greater significance, is the pursuit of professionalism, developed through professional socialisation. Socialisation facilitates the individual's depth of knowledge and understanding of context and, when comfortable with their own sense of self and clinical competence, heralds the beginnings of assimilation and internalisation of the characteristics of the profession (Pugsley, 2012). This is a complicated, iterative, subtle process, that is difficult to measure. This "hidden curriculum" (Kelly, 2020, p 1250), aspects of practice that cannot be wholly taught in a classroom, facilitates the values, attributes and qualities considered critical to professional nursing practice, to be passed on to incoming registrants (Godfrey and Young, 2017). Gibbon and Crane (2018) consider professional socialisation in nursing as the "acquisition of behaviours and cultural norms" (p 19). This process can have a positive or negative effect on students, dependent on the norms and values that they are exposed to (*ibid*). When students have been exposed to negativity and poor practice that

does not demonstrate desirable values, Lee and Yang (2019) describe this as a disruption to the socialisation of nursing students and something that can cause a sense of disengagement, the opposite of the desired outcome, a sense of belongingness and understanding.

3.2 Contemporaneous socio-political context

Historically, mental health nursing has suffered from negative stereotyping. "Mental" or "psychiatric" nurses were often seen as the agents of social control, authority figures, powerful representatives of a system that sought to deny and disempower the already vulnerable (McKeown *et al.,* 2018). Some of this persists (Cleary *et al.,* 2018) and there remains the shadow of a general lack of awareness that mental health nursing is a speciality although it was first recognised as such nearly 70 years ago (Carr *et al.,* 1980). The position of mental health nursing in the UK and the regard in which it is held as a speciality is perhaps more complex than the other fields of nursing (adult, child and learning disability) because of its history. Reshaping and remarketing mental health nursing has been a challenge, sometimes complicated by a series of systemic changes to the organisation of nurse education in the UK.

Through the late 20th and early 21st century, these changes saw the move from the hospital-based apprenticeship style of learning, to university-based education (Bradshaw, 2001). Consequently, by 2013 all students entering the register for the first time had to hold a nursing degree. Even though the nursing community remains undecided about the appropriateness of this (Findlow, 2012, Andrew and Robb, 2011), it encouraged reconsideration of professionalisation, as, in part, achievement in HE is commensurate with higher-level thinking skills associated with "profession" (Tholen, 2017). Whilst this change was supported and driven by the desire held by many nurses to become a profession, it has been divisive within the nursing community (Stacey *et al.,* 2015). Divisions between groups of nurses have served to highlight issues of professional identity which has become confused for nurses themselves (Willetts and Clarke, 2014). Adding to this confusion, in 2010, the then UK Prime Minister, David Cameron, declared nurse education had become "too academic" (Santry, 2010). This highlights a need for public understanding as to why higher educational achievement for nurses is important (Andrew, 2012); nurses need critical thinking skills to make difficult, time-sensitive decisions (Council of Deans of Health (CDoH) (2016).

Public opinion in the UK consistently reflects the feeling that nurses are one of the most trusted professional groups (Ipsos, 2023). Rodríguez-Pérez *et al.,* (2022) report that nurses, while perceived as competent and caring, are also perceived as professionally inferior to doctors and this can be attributed, in some part, to a lack of public understanding on the nature of nursing and the scope of nursing practice. The nurse is sometimes seen as subservient, waiting, with good grace, to be told what to do. As ten Hoeve *et al.,* (2014) observed, nurses have been "prized generally for their virtues, not their knowledge" (p 298). The arena is complicated and care delivery is often complex (Kim, 2015). Nursing practice is sited in a complicated socio-political economic context that often obfuscates and confuses nursing activity.

It is significant to note that the NHS is the largest employer in the UK, and nurses are the largest professional group of employees (King's Fund, 2023). UK-wide, fewer nursing students are being recruited (RCN, 2023 [b]) and following recruitment, attrition remains problematic (Edge and Gladstone, 2022, Mitchell *et al.,* 2021). Nursing and nurse education is of political and societal concern, with far reaching consequences and, as Cottam *et al.,* (2023) contend, student nurses are integral to the constitution of the NHS.

3.3 Contemporary influences on mental health nursing

Nurse education curricula have undergone a number of iterations under several administrations over the past few decades. Significantly, as part of the aforementioned transfer into HE in the late 1980s, the "Project 2000" curriculum was launched (Coffey *et al.,* 2015). Students from all four fields of nursing (adult, child, learning disability and mental health) spent the first 18 months of their education as generalists following a generic curriculum, moving into their chosen field for the second 18-month period. This model received persistent criticism from employers and nurses, concerned about student levels of competence during studentship and at registration (Ousey, 2011, RCN, 2007). Individual identity of different fields of nursing was compromised.

Since the beginning of this century, standards for nurse education have again been rewritten and revised. The influential Shape of Caring Review (Willis, 2015), asked the NMC to consider a new model of nurse education, colloquially known as 2+1+1. Under this scheme, students

would undertake two years of generic education, one year in their chosen speciality and one full year of preceptorship.

The following year the CDoH (2016) acknowledged the importance of addressing societal health needs, noting that all future RNs must demonstrate a wide knowledge base in regard to both the mental health and the physical health care needs of all patients. This acknowledges as McKeown and White (2015) point out, the "scandal of unmet physical needs amongst people with serious mental health problems" (p 725).

Butterworth and Shaw (2017) recognising this as an important issue, considered how incorporating physical nursing care skills into a mental health nursing curriculum could be addressed. This came with a warning that changes to curricula to promote physical health nursing, may introduce a potential shift in focus for mental health nurse education.

In 2018, the NMC introduced significant changes to proficiency standards (NMC, 2018[a]), intended to future proof nursing practice. However, this heralded the inclusion on the syllabus for the first time of a plethora of mandatory physical health based competencies for all students, under an ethos of genericism. This has been perceived by some as unnecessary and inappropriate. As an example, Rooney cited in Evans (2023) pointed out, "registered mental health nurses will rarely, if ever, manage blood transfusions" (p 7) something for which they must currently demonstrate an enhanced level of understanding.

Buescher and McGugan (2022) describe the growth of "centralism" (p 745) in mental health nursing education and it has been suggested that the philosophy of mental health nursing has shifted (Connell *et al.,* 2022). Buescher and McGugan (2022) warn that genericism is a high-risk strategy, ultimately, potentially putting people who use services into jeopardy. Warrender *et al.,* (2023) argue that education with a generic focus raises concerns for patients and their families, who may not have access to nurses who are specifically prepared to meet their needs in mental health services.

This is writ large in Connell *et al's*., (2022) analysis of the NMC's proficiency standards. Connell *et al*., (2022) suggest there is an adult nursing skills bias to the detriment of mental health nursing skills education, considering mental health nursing skills have been "undervalued and under-represented" (p 472). In any event, there is considerable resistance

towards teaching skills to mental health nursing students, regarded by many as irrelevant to them (Evans, 2023, Warrender *et al.,* 2023, Connell *et al.,* 2022).

Perceived irrelevancy may have unintended consequences for mental health nursing. Understanding their own identity remains a challenge that follows mental health nursing students into post-registration practice (Terry, 2020). Identity is, arguably, further obfuscated by the need to be taught and show some level of competence in irrelevant skills.

To summarise, it is suggested here that there are clear indicators that professional identity for mental health nursing students is not secure because the future of mental health nursing is not fully assured, nor, as Collier-Sewell and Monteux (2024) contend, is the purpose of nurse education.

Students are acknowledged as expert consumers of their own educational experiences, immersed in the process. Student nurses' consideration of their own identities and the influences on their socialisation and development will be explored further here, adding to the review of the context of this thesis.

3.4 Lived experience

The following discussions are led by the findings generated from pertinent research focussed on the thoughts and feelings of nursing students. For ease of reading in this section, "nursing students" are referred to as "students", unless the participants are specifically mental health nursing students, when this is highlighted in the text. From this literature, three discrete areas arose for consideration; personal suitability for nursing, the realities of the practice environment and the importance of self-reliance and self-care. As previously indicated, the latter two themes are considered both pre and mid-pandemic.

This is followed by a succinct exploration of the student nurses' experiences of IPE. This is more concise than originally intended as a result of pandemic-related changes, as IPE became a less prominent focus, as previously noted.

3.4.1 Personal suitability for nursing

Internationally, there is a wealth of evidence suggesting that, before they started their undergraduate studies, students identified very strongly with what they considered to be

core nursing values, such as compassion and empathy (Kelly, 2020 in the US, Browne *et al.,* 2018 in Australia, Traynor and Buus, 2016, in the UK, for example).

Using focus groups to gather data in their small, UK qualitative study, Traynor and Buss (2016) reported that generally students voiced their conviction of their own suitability for nursing as a result of such innate qualities, "I think nursing is who you are" (p 190). However, this was not always wholly altruistic. A more practical approach was also evidenced in this study; nursing offered safe job prospects and a steady income but initially personal suitability led to the starting point.

Likewise, Keeling and Templeman's (2013) small UK study, employing focus groups and individual interviews, found students who were convinced of their suitability, and uncovered an almost inevitability that they would become nurses, "You are a nurse. That's it." (p 19). The wish to align to the nursing profession, one that students considered to be worthy, was justified for them as a result of their natural suitability to caring for others.

Reporting on the qualitative results of their larger mixed method study with neophyte students, Browne *et al.,* (2018) explored the preconceptions students held about how they thought they could assimilate the professional identity of the nurse using drawings and mind maps to gather the data. This was multi-layered, including the importance of engaging in specific nursing-related practices, led by the individual's caring and compassionate nature, qualities they already possessed. This was fuelled by a desire to belong to what they considered to be a special professional group.

Thomas *et al.'s,* (2023) large, mixed method, multi-national study determined that despite studying at university, students were not particularly concerned about holding a university student identity. This was partly because they did not have many opportunities to do so, but also because university was only the conduit to achieve the goal of becoming a nurse. Belonging to a university community was "incidental" (p 99), much less significant than belonging to the professional group, which they felt they were already hardwired for. Here, some determined a sense of morality in their wish to care for others. Likewise, Eckardt and Lindfelt's (2018) qualitative Finish study found students often reported nursing to be an activity anchored in morality, which required focussed commitment from each individual, it was not something that could be undertaken lightly. Keeling and Templeman (2013)

determined that students felt a moral obligation to behave well, sometimes made difficult by practising in trying circumstances.

Findings from Teskereci and Boz's (2019) small qualitative study and Williams and Burke's (2015) pilot study, pointed towards students' thinking that they were morally obligated to have a high level of dedication for nursing, as they realised the onus of responsibility required to nurse, once in practice. Some participants felt that they had a level of accountability (for the health and wellbeing of others) not experienced in other jobs and this was not confined to the physical tasks of care delivery. Some believed that the "burden of taking responsibility for a human life" (Teskereci and Boz, 2019, p 41) could not be countered without steadfast dedication and commitment.

Walsh' (2015) small UK study with exclusively mental health nursing students using focus groups and individual interviews to gather data, found students believed they could easily identify a lack of commitment from fellow students, through behaviour and general demeanour of these others. They considered this to be rude and disrespectful, unbecoming of mental health nursing. Thomas *et al.,* (2015) found some students considered nursing to be an obvious choice for them because of their desire to help others and care for vulnerable people and this was necessarily underpinned by commitment. Similarly, Clements *et., al.* (2016) found students in their study thought that dedication was intrinsic to them, which required their commitment which, they hoped, could foster their belonging to the group.

In summary, although this brief discussion is (necessarily) limited, literature suggests that students considered they innately possessed good qualities such as compassion and a caring nature. Furthermore, they appreciated that nursing practice can be a moral activity and that they were well placed to demonstrate a high level of commitment and dedication to be personally suitable to undertake nurse education.

3.4.2 Realities of the practice environment

As previously stated, this section has been divided into two subsections to allow for consideration of the realities of the practice environment, both pre and mid-pandemic.

- Pre-pandemic

Traynor and Buus' (2016) findings indicated that students often began their practice education with a rose tinted filter that quickly dissipated once the novice was sited in the less than ideal realities of everyday practice. The authors reported the dissatisfaction that students felt as they found discrepancies between their expectations and reality. Things were not what they thought they would be like in practice, leading to feelings of dismay. Grealish and Trevitt's (2005) Australian study found students identified a disconnect between what they were taught at university and what they experienced in practice, which was disappointing.

Similarly, Lundell Rudberg *et al. (*2022) found the dream of nursing or the "fairytale world" (p 6) that students had come to expect was often not to be realised. In their analysis of student diaries used to gather data, Thomas *et al*., (2015) found that this challenge of reality versus the imagined idyll often pushed the novice off balance. Lundell Rudberg *et al.,* (2022) confirmed this "reality shock" (p 6) which was often distracting and anxiety-provoking. Several other studies found that students felt called to make compromises by lowering personal standards and changing expectations as a result of the realities of practice that they faced (Browne *et al.,* 2018, Stacey *et al.,* 2015, Grealish and Trevitt, 2005). Crigger and Godfrey (2014) considered this the challenge of socialisation, which involved displacing the individual's current identity or *"denying a uniqueness* (of that individual)" (p 377) so to rebrand with a new identity, to reassemble. Eckardt and Lindfelt (2018) found that some students considered this an unpleasant experience for those who believed they have already assimilated their own identity, which they did not think they would lose or be called upon to compromise.

Although unsettling and upsetting, experiencing negativity in practice was not atypical for students and again, there is international recognition of this phenomenon (de Swardt *et al.,* 2017 in South Africa, Rees *et al.,* 2015, in the UK, for example). Rees *et al.,* (2015) reporting

on data gathered in one arm of their larger UK study involving students in all four home nations, found for some their "most memorable professionalism dilemmas" (p 1) (seeing or hearing something that seemed wrong) came from the actions of a more experienced nurse they worked with. Although the students in Rees *et al.'s* (2015) study seemed to demonstrate a level of compassion towards nurses in this situation, acknowledging that they often experienced high levels of stress in challenging situations which affected their practice, they also realised nurses could make mistakes and behave badly. There was a sense that they too might be in a position to be similarly compromised in their own future practice. Students in Grealish and Trevitt's (2005) study described a powerlessness to speak up, sometimes feeling as if they were the "lowest of the low" (p 143). Rees *et al.,* (2015) found students worried that raising concerns would make them vulnerable and they could find themselves isolated as a result of complaining. They had to accept the status quo because the alternative was rejection by the group.

There is evidence that for students being belittled, being made to feel stupid or inferior in clinical practice by nursing staff at some point, was probably to be expected (Rees *et al.,* 2015, Thomas *et al.,* 2015, Walker *et al.,* 2014). Students have reported being bullied, ignored, ridiculed and excluded because of their status. This represented an unpleasant aspect of clinical practice which disappointed and hurt them. Jack *et al.,* (2017) and Thomas *et al.,* (2015) found students who considered that they were thought of as a burden to nursing staff at some time, or as Walker *et al.,* (2014) similarly determined, were made to feel as if they were in the way and did not belong. Walker *et al*., (2023) reported on the experiences of nursing students in the UK and concluded that bullying and harassment were regular experiences for most of their small sample but these experiences were magnified for the ethnically minoritised students in the sample.

However, despite the difficulties that students undoubtedly encountered as they moved into practice, the literature revealed the recognition that students preferred spending time in clinical practice to studying theory, as it helped them to develop their professional personae very clearly (Fitzgerald and Clukey, 2022).

Fitzgerald and Clukey (2022) and Traynor and Buss (2016) found negativity in practice could be countered by students when they worked with nurses who provided, as they perceived it, high quality care and who they believed expressed interest in and enthusiasm for student

development and wellbeing. In Sweden, Ewertsson *et al.,'s* (2017), data gathered through a combination of observation, conversations and formal interviews revealed that students appreciated being addressed by name, something that did not always happen. Ó Lúanaigh (2015) found similar results in his small study. The importance of being called by one's name could foster the importance of belonging.

Generally, students valued the clinical competence of nurses they worked with and respected them for their knowledge and experience (Connor, 2019, Jack *et al.,* 2017). Working with those who demonstrated their expert clinical decision making in practice was seen as irreplaceable by students in terms of their personal and professional learning (Lundell Rudberg *et al.,* 2022, Ewertsson *et al.,* 2017, Thomas *et al.,* 2015, Williams and Burke, 2015) and therefore the curation of their own identity and, subsequently, professional socialisation.

Qualitative data from Williams and Burke (2015) and Grealish and Trevitt's (2005) studies determined that delivering personal care to patients for the first time often came as a shock for students in practice, but it aligned with a developing feeling of authenticity. Fitzgerald and Clukey (2022) and Ranjbar *et al*., (2017) attributed this to a growing sense of responsibility as students moved towards occupying a position of trust. The vulnerable patient had no choice but to put their trust in students, which was daunting, but meaningful.

Being allowed and facilitated to manage and carry out such nursing activities helped students develop their sense of self and place. Williams and Burke (2015) suggested that when students realised they were not rote learning the tasks of nursing, they were required to invest emotion into their work with patients and think about how they did this, what it might mean to be a nurse, "they begin to feel like a nurse" (p 51).

In her large, US mixed methods study, Kelly (2020) considered the role of the "hidden curriculum"(p 1250) in nurse education. Students described learning the physical tasks of nursing in simulation at university but once engaged in real practice they were exposed to more than just the physical work, they encountered values in action. This is part of the process of professional socialisation. Adamson (2018) and Nibbelink and Brewer (2017) contend that learning is both formal and informal and tacit knowledge is integral to this.

Abbott (1988) considered the importance of this "knowledge transfer as part of "workplace assimilation" (p 65).

Some studies have identified that students welcomed being asked to complete tasks and undertake activities delegated from RNs, valuing the trust that had been placed in them to be competent (Fitzgerald and Clukey, 2022, Ó Lúanaigh, 2015, Keeling and Templeman, 2013). From data gathered from interviews with a small number of mental health nursing students in South Wales, Galvin *et al.,* (2015) sounded a note of caution. For some, being relied upon to work without appropriate supervision or used as an employee rather than being a supernumerary student, could have the opposite effect, reducing confidence and increasing stress in an already stressful environment.

- Mid-pandemic

There is international recognition in the literature that students were not well prepared for the realities of the work they were to undertake during the pandemic (for example, Orazietti *et al.,* 2023 in Canada, Kane *et al.,* 2021 in the UK). Qualitative studies in the UK by Henshall *et al.,* (2023) reporting on one aspect of their larger study, and in Spain by Martin-Delgado *et al*., (2021) reporting on their mixed profession study, determined that widespread lack of understanding and uncertainty was commonplace for students before they went into practice and once there, they often found practice frustrating and distressing.

Later into the deployment, other stressors became apparent for students, such as lack of nursing staff in some areas (Kane *et al.,* 2022, Godbold *et al.,* 2021). The paucity of appropriate Personal Protective Equipment (PPE) was another concern for students globally (Orazietti *et al.,* 2023 in Canada, Griffin and Riley, 2022 in the UK and Ulenaers *et al,* 2021 in Belgium, for example).

Students in Godbold *et al.'s,* (2021) UK study found the level of responsibility shouldered by students on deployment could be onerous. The significance of being with and caring for many people who were close to death or who died of COVID-19 was something they were very conscious of, and it affected them greatly. Many of the patients the students cared for, died alone, and students felt the impact of this loneliness and distress for the patient and their families. The sheer number of patient deaths on a daily basis could be overwhelming for students (Griffin and Riley, 2022, Martin-Delgado *et al.*, 2021). As a result some found

clinical practice arduous, beleaguered by psychological and physical fatigue (Griffin and Riley, 2022). Rohde *et al.*'s (2022) mixed method Norwegian study found students additionally pressured by their fears for their own pre-existing health challenges.

For some, there was a sense that they were no longer students, displaced but also unplaced. They had been given a remit, to care for acutely unwell people, but they were not all given the support to do this, as students should have been. McSherry *et al.,* (2021) in their UK based qualitative inquiry, found some students who reported that they were left to practice with minimal or no supervision, despite their student status and the blatantly emotional nature of the work.

There were also positives to be found as detailed by students in Rood *et al.'s* (2022), Martin-Delgado *et al.'s*, (2021) and McSherry *et al.'s,* (2021) studies. For some, their experiences affirmed their choice to become a nurse. Godbold *et al.,* (2021) and Griffin and Riley, (2022) described those students who, in being aware of the uniqueness of their learning experience, saw it as positive and the impact upon their development as useful preparation for post pandemic practice and for their personal development. Orazietti *et al.,* (2023) found some were enthused about the level of responsibility they had been given, and, as final year students, considered that their experiences gave them a better overview of services as a whole; they understood the situation better. They also felt they were better prepared to manage uncertainties of clinical life in the future.

Orazietti *et al.,* (2023) also interviewed a small number of faculty who despite worrying about the students lack of preparedness and the risks they faced in practice, declared their pride in the students' achievements. Students also often determined a feeling of pride in themselves for the contribution they had made to patient care during tumultuous times, something contemporaneous commentators had also noted (Swift *et al.,* 2020, Townsend, 2020). For others, this was despite feeling, as they did, that there had been a moral obligation to join the workforce (Kane *et al.,* 2022, McSherry, *et al.,* 2021). Many expected to be morally obligated, because they were entering a caring profession. However, Swift *et al.,* (2020) pointed out that this raised issues for those considering the risks/ benefits of choosing whether to opt in; being made to feel as if they had to, regardless of whether they wanted to or were in a position to, was problematic.

Again, although a brief discussion, it is possible to surmise that, pre-pandemic students found themselves in both negative and positive scenarios as the realities of practice emerged. Mid-pandemic, although the nature of the context is incomparable, students experienced negatives and perhaps more surprisingly, positives of clinical practice.

3.4.3 The significance of self-reliance and self-care

As in the previous section, this has been divided into two subsections to allow for consideration of the significance of self-reliance and self-care, both pre and mid-pandemic, again acknowledging that there are likely to be differences between these points in time.

- Pre-pandemic

To be in a better position to learn, students often reported that they had to drive themselves forward and deliberately take responsibility for their own development (Ó Lúanaigh, 2015, Walker *et al.,* 2014). Connor's (2019) study reports on a small number of individual interviews held with mixed field students. Students acknowledged that they needed to be assertive and determined to be successful in practice, understanding that they largely had to take responsibility for their own learning and development.

This, however, could be problematic since being proactive might have attracted criticism from others. Thomas *et al.,* (2015) found some students in their two part study, which consisted of a larger qualitative survey and a smaller number of individual interviews, appreciated the importance of delicately negotiating their position in practice to attract others' positive approval and acceptance of them. For example, students who were willing to pick up unwanted tasks from others could demonstrate their desire to be accepted by the group, outwardly advertising their wish to belong. Another advantage of offering to take routine or boring tasks from fellow students, was that this could be used as currency, banked and later traded for other, more interesting activities.

Walsh's (2015) study found that all participants agreed that the challenges of being a student in practice could be addressed through peer group support. This was a form of looking out for oneself as students opted in to the activities of their peer group. Elsewhere, Traynor and Buss (2016) Walsh (2015) and Walker *et al.,* (2014) yielded similar findings. Students reported that, in addition to sharing knowledge with peers, being part of this group helped to

strengthen their sense of identity as nursing students. It seems that support from those in similar situations was invaluable as they were considered best placed to offer this support as they understood what it was like to be a student. The emotional care students gave to their peers was found to be irreplaceable and was thought to be fundamental to developing the ability to become and remain resilient. The importance of resilience is highlighted elsewhere throughout the literature. For example, Rees *et al.,* (2015) and Thomas *et al.,* (2015) determined that students appreciated this as an integral part of their development, gained through the experience of professional socialisation and exposure to difficult situations.

In clinical practice, group membership was thought to be vital to the development of professional identity, Clements *et al.,* (2016), Ó Lúanaigh (2015) and Walker *et al.,* (2014). Students knew that nursing staff in practice held the power to facilitate acceptance to the in-group although sometimes found this was not always forthcoming. When this did happen, through their own negotiations, students valued the sense of belonging that these nurses and other team members facilitated. Walsh (2015), discussing the process of entry to the group through negotiation, noted this was sometimes "hazardous" (p 9) for students. There could be a pressure to be flexible and fit in when seeking belonging, which some had reported was not always easy (Traynor and Buus, 2016, Grealish and Trevitt, 2005).

- Mid-pandemic

Rohde *et al.,* (2022) found that for some students working during the pandemic was a lonely experience. Sometimes students were cut off from their families. Moving out of their homes so they could work and avoid spreading the virus was not unusual (Kane *et al.,* 2022, Martin-Delgado, 2021). Quite often students were detached from friends and peers. Those who were able to keep relationships with peers, because they worked together, for example, described these as invaluable sources of support (Henshall *et al.,* 2023). Orazietti *et al.,* (2023), noted some students found that living with peers could be helpful and bolster their wellbeing, however, Rohde *et al.,* (2022) found sometimes students felt a sense of loneliness anyway, perhaps related to stringent controls on interacting with others elsewhere, a consequence of lockdowns.

Students noted that they had to develop new coping mechanisms or build on self-care skills they ordinarily practiced in order to maintain resilience. Some kept journals, or physically exercised when it was possible during lockdowns (Henshall *et al.,* 2023, Martin-Delgado *et al.,* 2021). Some meditated or engaged in other mindfulness activities. Joseph *et al.'s.,* (2022) mixed method study with students at a faith based university found that of students who already practised their faith, some of these experienced a sense of peace which they attributed to the faith they held, as they worked in extreme conditions. This seemed to help maintain positive mental health and also determined greater resilience for these students. Quantitative data though, revealed students were at higher risk than they were previously to develop post-traumatic stress disorder.

Students had to rely on themselves to keep psychologically well, knowing when to ask for help and who to ask. Rohde *et al.,* (2022) found that sometimes asking for help was just not possible, something that was particularly problematic for those with pre-existing health issues.

In summary, peer group support was an integral part of student's safe-reliance and self-care regimes. This helped to develop a level of resilience required when seeking group membership in the practice environment. Embracing self-care mechanisms to bolster resilience mid-pandemic was significant.

It is important to acknowledge that the majority of evidence presented here pertaining to lived experience is largely gathered from small, qualitative studies which affects generalisability. However, when considering the aim of this thesis is to explore student nurse experience at an individual level, this is acceptable. Interestingly, there is a level of consistency in findings reported internationally on specific student nurse experiences which engenders confidence in the trustworthiness of the data.

3.4.4 Interprofessional Education

IPE appeals to students as an enjoyable way of spending time in the learning environment with students of other professions. In the US, North *et al.,* (2023) conducted a large mixed method study that concluded that students found interprofessional learning a useful way of collaborating with others. They also concluded that large scale interprofessional learning (n= 1,220) was possible, when carefully managed. In their Australian study, Jorm *et al.,* (2016)

students similarly found that IPE can be an enjoyable way of spending time in the learning environment.

Stephens and Ormandy's (2018) smaller, qualitative UK study, using focus groups to gather data, found that students appreciated the informality found in IPE, not found in other learning platforms, which added to the enjoyment of the activity. Stephens and Ormandy (2018) identified a spiral learning framework to explore three stages of student IPE engagement, from compliance to identification to internalisation.

North *et al.,* (2023), Jorm *et al.,* (2016) concurred with Stephens and Ormandy (2018) that whilst the IPE they facilitated did not always result in internalising learning (authentically changing values and behaviours to develop an interprofessional identity) for students nor did it always meet the IPE brief (learning with, from and about each other) it could be fun and a welcome change in modality for students.

In Michalec *et al.'s*, (2017) large mixed methods study in the US, students appreciated seeing other students as individuals in a more informal environment which largely impacted positively on their perceptions of the other profession. Michalec *et al.,* (2017) described students who had developed their perspective from a "them" and "us" stance to a position of "we" (p 78), as a result of this.

Having opportunities to develop greater understanding of the roles and responsibilities of others is a theme running through the literature (Brashers *et al.,* 2016, King *et al.,* 2016, Priest *et al.,* 2011). In their study into the efficacy of a specific IPE module designed and delivered to over 2,000 multi-profession students over several years, McGuire *et al*., (2020) found evidence that students often recognised the connection between understanding others better and the impact on collaborative team working during IPE. Linking collaborative team working to patient care outcomes, students realised that patients benefitted from being cared for by teams who communicated effectively, and IPE supported this.

Understanding the roles and clinical responsibilities of others included developing a greater understanding of the values and ethical frameworks other professions are guided by (*ibid*). This involved appreciating that different professions may approach clinical problems differently. In valuing these differences and alternative starting positions, students were better able to understand and explore the complexities of problems, again of benefit to the

experience of the patient. IPE enabled individuals to address their own bias and stereotyping of others.

Stephens and Ormandy (2018) determined that understanding what others do helped students to illuminate own role and responsibilities and site themselves comfortably within an interprofessional team. Allied to this, students were able to see themselves as the professionals they were working towards becoming, being taken seriously as such by students of other professions. This helped individuals to build confidence both in themselves as practitioners and in their position in the team.

Amongst others, Stephens and Ormandy (2018) and Jorm *et al*., (2016) concluded in their studies that the point(s) at which IPE was facilitated on the students' journey was an important factor. Opinion on the optimum point has been debated. Reeves *et al.,* (2012) posit that, on one hand, negative stereotypes veiling negative attitudes about other professions are established early on in studentship and can be best addressed promptly through IPE. Conversely, a number of studies have indicated that IPE facilitated too early risked disrupting the students' developing identity (Brashers *et al.,* 2016, Hean *et al.,* 2013).

Being asked to consider what others did in the interprofessional forum and identify different perspectives and values others may hold, before they had established themselves as the individual representative and role holder of their own profession, could be counterproductive. Stephens and Ormandy (2018) and Brashers *et al.,* (2016) considered that new students who had not yet been socialised into their own profession, with its discrete norms and values, could find it difficult to collaborate in this way with a mixed profession group. IPE could be an overwhelming and confusing experience and IPE facilitated too soon could present a "threat to achievement of one's professional identity" (Brashers *et al.,* 2016, p 453). Stephens and Ormandy (2018) determined final year students were in the best position to engage and participate; they understood enough about themselves and about other professions to be certain about their own professional domain, less likely to become confused or destabilised.

One aim of IPE is to expose and address negative stereotyping between professional groups, a not inconsiderable problem, causing misunderstanding and conflict. Although Michalec *et al.,* (2017) and Brashers *et al.,* (2016) found some students became more positive towards

others as a result of participating and engaging in IPE delivered in a timely manner and some negative stereotyping was reduced, this was not always the case. Unfortunately, professional feuds and the presentation of hierarchical entitlement were sometimes exposed by the activity of IPE.

To summarise this brief discussion on IPE, the broad brush of IPE has proven a useful, popular method of teaching and learning although internalisation is not always achieved. However, a range of international studies considered here indicated that students are able to learn about others and use the space to cement their professional identity, and themselves, into the context of the interprofessional team. This collaborative approach of the interprofessional practitioner can be used to contribute to address the ultimate aim of IPE; to improve patient experience.

3.5 Chapter Summary

The purpose of this chapter was to review the context for the aim of this thesis, student nurses' narration of their professional identities. This was done through considering the evolution of nursing and professional identity, acknowledging the influences on this process and the significance of professional socialisation. I considered matters specific to the development of and potential changes to mental health nurse education which will arguably affect perception of identity.

I then considered aspects of the lived experience of student nurses in clinical practice, as reported in the research literature, and the significant influences on them and their development. Finally, I briefly considered the part that IPE can play in the student's experience of education, learning and the development of identity.

In conclusion, from the evidence presented in this chapter, it is reasonable to consider that identity development for nursing students is a complex construct, dependent on a number of different internal and external variables, some of which are beyond the agency of students.

The concept of identity and how it is nurtured must be central to nurse education (Halverson *et al.,* 2022, Severinsson and Sand, 2010) if students are to flourish and nursing is to continue as the major contributor to healthcare provision in the UK, as it stands currently.

To recap, the purpose of my thesis is to explore how pre-registration undergraduate mental health student nurses narrate their own professional identity. Arguably, holding a secure identity curates a sense of becoming and belonging, increasing the quality of studentship and retention, potentially reducing attrition. Having explored relevant literature, I next set out the methods to address research questions which have arisen from this review:

1. How do mental health nursing students narrate their own professional identity?
2. What influences do these students perceive as impactful on the development of their professional identity in clinical practice?
3. How do these students describe their experiences of professional socialisation in clinical practice?
4. What are these students' perceptions of Interprofessional Education?

The following chapter details the methodology for my study, determining the methods for exploring the findings and addressing the research questions.

Chapter 4

Methodology: setting the compass for purple, green and blue

4.0 Introduction

This chapter describes the methodology of the research and justifies this as suitable for this study. Initially, paradigms of educational research are considered, and my own position is discussed. My chosen research design, ethical issues, the sampling strategy, methods of inquiry, and data analysis are detailed. I also consider issues of trustworthiness. I offer some discussion relating to significant changes in data collection methods as a result of the pandemic, the need to conduct individual interviews remotely. Following a chapter conclusion, I pave the way for the next chapter, the analysis of the first data set drawn from two focus groups.

4.1 Ontological and epistemological assumptions

A paradigm (worldview) in educational research acknowledges a shared belief system held by groups of researchers who broadly agree what needs to be investigated, how understanding is uncovered and how this is best achieved (Cohen *et al*., 2018). Kivunja and Kuyini (2017) note "… a paradigm constitutes the abstract beliefs and principles that shape how a researcher sees the world, and how s/he interprets and acts within that world…" (p 26). The researcher uses this lens to consider methodologies and methods appropriate to them (Scotland, 2012).

Ontology considers the nature of reality and ontological assumptions are concerned with what constitutes reality, what can be known about it (Guba and Lincoln, 1989). Epistemology is concerned with the nature and forms of knowledge and epistemological assumptions are concerned with what it means to know (Scotland, 2012).

Some consider knowledge, being independent of the human mind, already exists. There is a degree of objectivity here (Kivunja and Kuyini, 2017), as neither the object (the phenomena or knowledge to be known) nor the observer (of the knowledge/phenomena) is influenced by this process (Levers, 2013). Conversely, some consider new knowledge can be found and garnered through observations, filtered through the bias of the observer which introduces a value to the knowledge (*ibid*).

Cohen *et al.,* (2018) are clear on the importance of exploring ontological and epistemological assumptions and preferences to better understand the researcher's motivation, since research will undoubtedly be affected by beliefs, whether conscious or unconscious (Kivunja and Kuyini, 2017). Researchers hold biases and preferences simply as a result of being in the world (Scotland, 2012).

My own ontological assumption is that reality is subjective, based on individual construction and interpretation and so differs from person to person; there are as many realities as there are people experiencing it. Epistemologically, I consider knowledge is gained inductively through personal experience in particular situations which is not reducible to a simple transaction-based analysis. My ontological and epistemological position suit an interpretivist constructivist approach.

4.1.1 Interpretivism

Interpretivism is considered to be built on relativism and on the acknowledgment of the significant and intrinsic complexities that exist when making human inquiry. Motivations, intentions and actions of humans cannot always be accurately represented or measured because of the complexities of these phenomena (Sapolsky, 2017). As individuals have their own experience of being a participant in the world, so reality and therefore 'truth', is their own, as reality does not exist separately (Levers, 2013, Scotland, 2012). Methodologically, interpretive theory is both grounded and inductive because the researcher does not have a theory to prove; rather, the theory may arise from the research (Scotland, 2012).

The starting premise, all experiences are differently interpreted, make validity and reliability unlikely. However, the aim is not to generalise. Gathering multiple layers of data from a variety of sources allows individual stories to be found, immersed in rich, thick description which becomes the central focus (Alexander *et al.,* 2016).

4.1.2 Constructivism

Individuals construct meaning from interactions between others in their reality and people do this in different ways, depending on individual bias, cultural and historical ideology. Constructivism allows for identifying and interpreting how individuals understand phenomena as social products, given meaning through interaction (Yin, 2014).

Through social interactions in everyday life, meanings change quickly and are constantly revised so knowledge cannot be determined as a single 'truth'. Constructivism assumes people act with the intention to draw meaning from situations and happenings themselves, rather than being passive accepters (Cohen *et al.*, 2018), and this constant revision allows individuals their understanding of their reality. In this paradigm, the significance of the subjectivity of perception in individual experience is demonstrated through the interplay between researcher and researched (Pascale, 2011). Whilst the aim is to present the view of the researched and not that of the researcher (Cohen *et al.,* 2018), as Scotland (2012) notes, the researcher, quite naturally, as the instrument of data collection and analysis, has the "final interpretation of the data" (p 13).

4.1.3 Interpretive Constructivism

Interpretivism is often linked, seemingly quite naturally, to constructivism (Cohen *et al.,* 2018, Ponterotto, 2005) and social constructivism (Creswell and Creswell, 2018). Some seem to shift between the two potentially different paradigms, making them sum parts of one whole (Kivunja and Kuyini, 2017, Charmaz, 1995).

As interpretivist and constructivist approaches are often considered part of the same process (Creswell and Creswell, 2018, Kivunja and Kuyini, 2017, Charmaz, 1995) having interest in the "what" as well as the "how" is central to this process of duality. Silverman (2014) suggests a constructionist agenda allows the "desire to describe 'what's going on', but with decided emphasis on how these *whats* are sustained as realities of everyday life" (p 26).

To summarise, an interpretive construction approach allows for the making sense of human relationships/ interactions especially in large organisations (such as hospitals or universities) as positions are constantly negotiated and renegotiated. Individuals appreciate the wider context that already exists (for example, the physical environment – the university or hospital building, and also culturally – the role expectations of the student and of the student nurse when sited in the building). Reality is constructed from situated experience, in real time. This is the approach I have adopted to address the research questions posed.

4.2 My position in context

Floyd and Arthur (2012) comment on a rising trend of taught EdD programmes across the UK for university lecturers, and as employers are likely to be facilitating some of this activity,

they may expect these students to conduct their research in their own institutions. There are potential issues with this in terms of differences in expectations. An employer's consideration of what needs investigation may juxtapose with the employees', a mismatch which may be unsettling; research findings may not provide answers to questions posed or not elicit anticipated findings; employees may become indebted to employers (potentially contractually obliged). Fundamentally, employees may not want to take on research projects aligned to employers' preferences and the potential for conflict is obvious.

However, it is likely to be an individual choice as to whether to pursue an EdD (in the UK holding a doctorate is not yet compulsory for lecturers in HE). Students are likely better able to consider a research project that dovetails with their personal worldview, as is the case for me.

4.3 Research design: case study

I chose to use a case study as my research design. The case study is designed to address how and why questions, focussing on contemporary events, generally outside the control of the researcher (Yin, 2014). Although case studies do not exclusively attract qualitative research methods, using a case study in this instance supports a qualitative approach, which, as demonstrated, is a typical small-scale study. This sits well within the interpretivist/ constructionist paradigm and my ontological and epistemological assumptions.

However, in theory, all research, regardless of how the data are gathered, could be described as a "case study" (Cohen *et al.,* 2018) because what constitutes a "case" is not always clear and almost anything can be a "case", depending on the approach of the researcher. For example, Hamilton and Corbett-Whittier (2013) note how case studies could be conceived of as method, a genre or an approach.

Whilst researchers do not always do so, it is important to be clear as to what the "case" is (Simons, 2014) as a unit of analysis needs to be tightly bounded (Rosenberg and Yates 2007). For my research, the unit of analysis is the group of mental health nursing students, and initially the case study is IPE as stimulus to explore the development of professional identity.

The case study acknowledges the importance of the individual story, empowering participants to present their own narratives, all of which are given equal value (Simons,

2014). Providing "an in-depth exploration for multiple perspectives of the complexity and uniqueness of a particular project…. in a "real life" context" (Simons, 2009, p 21). Cohen *et al.,* (2018) similarly describe the reality case studies bring.

There are different ways to classify case studies. Stake (2005) considers case studies can be either intrinsic (to understand a particular case), instrumental (to examine to gain insight), multiple (to collect data from more than one case) or they can be used to both test a theory or generate theory. Yin (2014) classifies case studies as either critical, extreme or unique, representative, revelatory and longitudinal, and notes there is not necessarily any exclusivity between classification.

Simons (2014) suggests single case study findings can be generalised in different ways, depending on the quality of the narrative, the researcher's skills in setting the context and their ability to interpret the data. If done well, the application of theory can address issues of external validity (Yin, 2014). It becomes possible to analyse single case studies together and pattern matching and themes or similarities that arise can help to strengthen the internal validity of the case study.

This case study is both intrinsic and representative of its genre, being idiographic, looking at the particular and the individual (Cohen *et al.,* 2018). It is an example of an exemplifying study, typifying similar cases which allows the researcher to match themes or patterns in the individual narratives to themes or patterns found in other similar case studies (Seawright and Gerring, 2008). This helps experts in the field to have confidence in the findings of other experts and to make use of these findings.

Whilst situated generalisation is useful, "the real business of case study is particularisation not generalisation" (Stake, 1995 p 8) which occurs through an inductive approach of careful observation. Thomas and Myers (2015) consider the importance of identifying and appreciating the uniqueness of the case study, which by definition, is particular. This "bottom up" approach allows theory to be developed from the data, such as found in the approach of grounded theory (for example, Glaser and Strauss, 1967), requiring the researchers to be immersed in the case study.

However, as previously highlighted, the study necessarily evolved due to the effects of the pandemic. This meant a shift from case study as method, to case study as approach following pandemic related changes to data collection. Pre- pandemic the unit of analysis was the student group and the case study was IPE as stimulus to explore identity. Mid-pandemic whilst the students remained the unit of analysis, the case study became an approach, as the context changed. Significantly, the inductive exploration of the particular remained.

To summarise, case studies provide an in-depth study of one natural setting, focussing on process/ interactions and relationships (Denscombe, 2014). Through immersion, the researcher can provide rich, thick description of the narrative (Cohen *et al.,* 2018). This approach was wholly appropriate to address my research questions focussing on exploring identity and professional socialisation.

4.4 Ethics

Ethically appropriate conduct is central to all research, beginning with the premise research should cause no harm. I applied for ethical approval from the School of Social Sciences Research Ethics Committee to conduct the study, a process Floyd and Arthur (2012) consider "external ethical engagement" (p 171). This was granted in March 2019 (Appendix 1). Changes to the data collection methods and to refocus the study required ethical approval and this was granted in October 2019 (Appendix 2). I then requested a further amendment as I needed to conduct individual interviews in addition to focus group interviews. This was approved in February 2020 (Appendix 3), with a further minor amendment in May 2020, to capture the process to reflect pandemic related changes (Appendix 4).

As part of this process, participant information sheets were freely available (Appendix 5) and consent forms (Appendix 6) were given to students who volunteered to take part in the focus groups. I administered this at a pre-arranged meeting. I reiterated that participation was voluntary, choosing not to participate would not disadvantage them, they could withdraw their consent at any time and withdrawal would not have a negative effect on their studentship, nor disadvantage them in any way.

Completed consent forms were kept in a secure facility on Cardiff University premises. I ensured the students were aware their personal data was anonymised and stored securely in

line with data protection legislation and Cardiff University's Research Integrity and Governance Code of Practice (2018).

Participants for the individual interviews were emailed information forms (Appendix 7) and consent forms (Appendix 8) and completed consent forms were returned to me and stored on a Cardiff University encrypted computer.

The immersive nature of my role as lecturer/researcher emphasised the importance of identifying my own positionality. I ensured the students were clear that I was facilitating the project as a doctoral student and not in my capacity as a university lecturer. I endeavoured to demarcate these two roles as clearly as possible, both on the information sheet and verbally prior to the focus groups and the individual interviews.

It was important also to acknowledge the possibility that as a researcher my position as their lecturer could affect the participants and inhibit their responses. Comer (2009) suggests this unequal power relationship potentially renders students vulnerable and so lecturers should avoid doing research with their own students. However, this is countered by the lecturers' ethical obligation to contribute to research into nurse education. It is suggested this can reasonably be met by conducting research with one's own students if rigorously managed and handled with integrity.

Floyd and Arthur (2012) consider the importance of "internal ethical engagement", the appreciation that interpersonal interactions in research will constantly and naturally expose ethical and moral issues. The nature of these is not easily foreseeable as ethicalness and morality of individual autonomy sit within complexities of the individuals concerned, both the researcher and the researched. Sikes (2006) suggests "research is neither neutral nor innocent" (p 105) nor value-free, and this engagement is an ongoing part of the research process. The novice researcher, like me, in considering the Ethics Committee have approved the research and that "ethics" has been addressed, may be moving towards difficulties, unaware and unprepared (Floyd and Arthur, 2012) so such engagement and awareness is important.

4.5 Sampling strategy

4.5.1 Focus groups

These participants were enrolled on a three-year Bachelor of Nursing programme which leads to registration with the regulatory body for nurses and midwives, the NMC, and the legal right to practice as a Registered Nurse, Mental Health (RN MH) in the UK. At that point in their journey, as students, the participants were two thirds of the way through the programme.

Purposive sampling was conducted, as is typical for focus groups, as the researcher needs to ensure the participants share a particular characteristic, so to be able to participate in in-depth discussions about that characteristic (Smithson, 2000). Hence, participants for my study were purposively sampled from one whole cohort of mental health nursing students (n = 22) and all were invited to take part.

An optimum number of participants required for focus groups may vary due to the subject and context. For example, Cronin (2016) suggests between four and ten participants, Cohen *et al.,* (2018) opt for an average of six and Kitzinger (2005) suggests as few as three and as many as fifteen could be a suitable number. Kitzinger (2005), however, is mindful of the potential for a very small group to have a reduced level of interaction by virtue of its size and a larger group to be too busy to manage successfully. Kitzinger (2005), therefore, encourages the over-recruitment for focus groups in the anticipation there will be participants who drop out of the study and do not attend the group(s). In general, and without careful forethought, one is more likely to recruit too few rather than too many participants, a situation to be avoided, if possible, because of the potential for a smaller group to yield a less rich data set.

The invitation to participate in the focus groups was sent electronically and included details of the study, the purpose of the study and the commitment required of the participants. Subsequent to this, information and an invitation were also given verbally by me in person immediately prior to one of the students timetabled (but unrelated) teaching activities, with the permission of the lecturer facilitating the session. I was able to recruit seven participants for the focus groups (Appendix 12). In view of the small number, I decided to use one focus group rather than the two originally planned. All seven participants attended both focus

groups. I used pseudonyms for all participants in both the focus groups and individual interviews.

4.5.2 Individual interviews – mid-pandemic

In March 2020, shortly after the second focus group, the UK was put into lockdown to try to limit the spread of the COVID-19 virus. The necessitated changes to my data collection methods and focussed my research on identity, taking the spotlight away from IPE.
As I already had a relationship with the focus group participants, a decision was taken to recruit the individual interviewees from this group via an email which I sent out to all, detailing this part of the study and inviting them to consider participating. At this time the students were due to be deployed into clinical practice, in line with pandemic-related, wholesale changes to nurse education, as previously discussed. This drastically curtailed my access to the participants as they did not attend university during this period.

Initially three participants responded to my email invite to consider taking part in this part of the study, but this reduced to two when one of the three did not respond to my individual follow up email to them. At that time, I was very aware of the stresses on them. The participants were now working in a new way, on deployment as student/ employees during a pandemic. It was reasonable to assume that this was a stressful experience, and I did not contact them again after receiving no further response to my second email. I did not want to bother them and potentially add to their stressors.

4.6 Methods of enquiry

4.6.1 Focus groups

Focus groups and interviews are essential in gathering data which concerns human experience (Yin, 2014) such as attitudes, perceptions, and opinions (Cohen *et al.,* 2018). Focus groups were chosen because of the importance of capturing interactions between members, something individual interviews or conventional group interviews could not accommodate, although later it became apparent that individual interviews would also be needed (see Sampling Strategy). Focus groups are able to facilitate engagement in a social setting through language, such as questioning, challenging, critiquing and appraising each other (Doody *et al.,* 2013[a]). There is the potential through the researcher's immersion to

yield a high level of understanding and analysis of the data. The flip side is that this can only be obtained through high yields of data, which are time consuming and resource intensive to analyse (Doody *et al.,* 2013[b]).

During focus groups, one of the most obvious issues is that one participant may dominate proceedings, causing others to modify opinions or become inhibited (Cohen *et al.,* 2018). Conversely, there is a potential advantage for group members in having a dominant participant. One who states opinions without filter, caution or awareness, may encourage others to consider their own thoughts and opinions, helping them to recognise phenomena for themselves in ways they had not previously considered.

For me, as the facilitator responsible for group dynamics (Cohen *et al.,* 2018) and wanting to ensure parity and inclusivity, I was mindful to avoid having one voice dominate the discussions. I needed to connect with the group, giving the best chance that all research questions would be attended to by all members. I was aware of the significance of my own interpersonal and intrapersonal skills and level of self-awareness, considered key to successful group facilitation (Cronin, 2016).

Flexibility during the focus groups was important as it allowed me to ensure participant understanding (through re-phrasing statements, for example) and to allow the participants to consider their responses and perhaps "stray" off the main pathway but keep within the boundaries set by the purpose of the process. The potential to stray is a feature of focus groups as the individuals' natural discourse will facilitate this by its very nature, as participants are encouraged to interact with one another. Flexibility allows for a natural, more conversational flow (Gill *et al.,* 2008). I needed this to ensure smooth progression through inquiry and my role of facilitator also included a degree of moderation to achieve this.

The focus groups were conducted post IPE event one (October 2019) and post IPE event two (March 2020). Both groups took place on the university campus in a fit for purpose meeting room with a "do not disturb" sign on the door. I spent a few minutes before each group introducing myself, making sure consent forms were completed and reiterated the conditions of participating, including the right to withdraw without prejudice. I set out the context for my research and explained the process, offering opportunities for questions. I thanked the

group for participating and did this again at the end of each group. The groups lasted 71 minutes and 75 minutes respectively, both were audio recorded and the same seven participants attended each one. As is good practice, all recordings were transcribed verbatim as soon as possible (Gill *et al.,* 2008). The original recordings were stored on an encrypted Cardiff University computer.

The group all knew each other well, and I knew them relatively well. In focus group one they spoke freely, with some digression. As their discussions focussed on themselves and their experiences in practice, things they knew well, my steering of the discussions was minimal.

Once again, in focus group two the discussions moved freely. This mirrored the process in the first group, as discussions indicated the participants were comfortable without the need for prescriptive and scripted questions.

I created an interview guide for focus group one (Appendix 9) and developed root questions, cross referenced to the research questions and also to the element of the STL the research questions were designed to correlate with. For focus group two, I created further questions around differentness (D) (Appendix 10) as an evolution from their discussions about themselves in group one, again cross referenced to the research questions and the STL. The majority of my questions were then supplementary, organic in nature, arising from ideas developed from the root questions, and I used these to clarify, summarise and/ probe.

The groups were held about four months apart because of the limited time I had to access the participants and the timing of the IPE within their timetable. There was a potential for change between the first and second groups, which I anticipated in the third question in column two of the interview guide for focus group two (Appendix 10). However, there was limited dialogue relating specifically from one point in time to another. For example, there was no substantive change across time in the dialogue relating to IPE. As a consequence, the participants narrative sit well as one set of data.

4.6.2 Individual Interviews – mid-pandemic

This group of students were unique as the context had never occurred before. This represented an opportunity to explore their experiences, and to give voice to their unique lived experience in a completely unknown environment, that is to say, nursing in clinical practice during a pandemic.

There are clear advantages to individual interviews. The most obvious is that it is easier to negotiate the time and place on an individual basis. Due to the pandemic, the interviews had to be carried out via video link using university software (Microsoft Teams) which did add an unexpected dimension. There are disadvantages when interviewees are in different environments, such as in their own homes. In one of the interviews a barking dog in the background interrupted the flow of the discussions but, unfortunately, such instances cannot always be avoided (Mason, 2018).

Mason (2018) suggests the picture conjured up by the label "qualitative interviews", largely infers they are in-depth and semi-structured. Initially, the interviews were to be semi-structured, and I determined to ask the interviewees broadly similar questions. I was prepared to follow the interviewees lead and I was less concerned with the sequencing of the questions, aware secondary probing questions might need to be different between the participants, which is an acceptable practice when this is deemed necessary (Fielding and Thomas, 2016). The potential for the interviewees to have very different opinions about their situation was anticipated. This would have reflected opinion within the wider student population and so asking different questions would have been appropriate.

Mason (2018) describes typical features of interviews, such as being relatively relaxed but a channeled process that becomes an exchange of dialogue. There is almost an element of co-production given the subjectivity inherent for both parties. The understanding that the knowledge already exists and is to be uncovered and made meaningful, rather than the invention of anything new, adds to this.

However, the interviewees inhabited a unique status which they were willing to share, making them key informants (Zelditch, 1962). Their atypical presentation may affect representation (LeCompte and Preissle Goetz, 1982) but any potential for bias was outweighed by the unique opportunities interviewing the participants gave to me to present their views as a minority, in an unprecedented situation. Whilst I shared common ground and similar experiences to the participants when they were in the focus groups in terms of their nurse education, I had no understanding of their current situation because nursing in a pandemic had not occurred within living memory. This research offered opportunities to explore identity and changing identity in the unexpected and unforeseen move for the students to a hybrid position of student/ employee. Until this point, the situation had not

been widely explored. Therefore, I determined that the interviews would be unstructured. This seems more appropriate given these circumstances although as Mason (2018) points out, interviews cannot be wholly unstructured, by their very nature.

Both interviews were carried out via the university virtual meeting platform and I audio recorded them. Again, after introductions and establishing etiquette, I checked their consent forms, that they understood the nature of the research and their right to withdraw without giving reason or invoking prejudice. The first interview with "Danielle" on 19.06.20 lasted 71 minutes and the second with "Grace" on 08.07.20 was 62 minutes long. The recordings were transcribed verbatim as soon as possible, as is good practice, (Gill *et al.,* 2008) and stored on an encrypted Cardiff University computer.

As demonstrated in the guide for the individual interviews (Appendix 11), I set out the research questions and determined three categories around which to hang the questions ("early days", "relationships in practice" and "being a student on deployment"), using a soft touch approach, rather than setting specific questions. I did not address IPE overtly, as outlined in Chapter 1. Given the unstructured nature of the interviews, I did not deliberately cross reference these categories to each of the four elements of the STL, but I did anticipate participants narrative around the categories would enable the research questions to be addressed. Supplementary questions did naturally arise and were necessary for me to seek clarification to secure meaning, following the participants own, often quite lengthy and detailed, narrative.

4.7 Data analysis

4.7.1 Transcription

Audio recording, rather than note making, was preferred for a number of reasons. Contemporaneous note taking can be an unnecessary distraction and can be stressful for the note taker. Cohen *et al.,* (2018) consider note taking may reduce the experience to a platform merely for data collection rather than a more valued experience of social contact. There is also the possibility of mishearing or missing content. I was aware of the risk of misreading my own writing, so misrecord the content and then misrepresent the students. As well as capturing substantive content, audio recordings may be able to capture the interviewees' delivery which may help with interpreting and contextualizing data. Mason

(2018), however, cautions that transcripts (and indeed audio recordings) are only ever partial records since not everything can be captured. Paralanguage and other non-verbal aspects of human interaction cannot be fully represented in this medium.

I was able to transcribe the data from the focus groups and the interviews myself, acknowledging this is a time consuming and sometimes difficult process (Silverman, 2014). To try to capture as much of the interaction as possible, Cyr (2019) suggests word-for-word verbatim transcription, paying special attention to the non-verbals. I did include pauses or silences, sighs, laughter and words the participants themselves emphasised. On occasion, I had to make a judgement on the participants' real meaning, when for instance, I sensed a sarcastic or ironic tone which belied the content.

4.7.2 Theoretical framework

Although there is the opportunity to interpret data without the support (and therefore potential bias) of a theoretical framework, this is generally considered undesirable, likely producing unsound findings (Smith *et al.,* 2017). Kilbourn (2006) is clear no research can ever be interpreted in any environment without bias, as it is always filtered at least once through a lens, or using a theoretical perspective to create a reality. This filtering (towards interpretation) has to occur as part of the research process in order to attain some formulation of reality, the purpose of research.

I am interested in how people behave in different spaces in different circumstances and how they give and take cues to and from others, to inform them about their own actions and reactions. This drew me towards considering dramaturgical analysis in a Goffman (1959) approach, using theatrical metaphor and analogy as a way of exploring student experience.

I also considered a narrative approach, as I had determined to explore individual students' stories. This seemed a reasonable way to think about how to analyse the anecdotes that would be sitting in the data I intended to gather.

However, I have past experience of Wenger's CoPs having considered these for students previously as part of a strategy to mitigate for a significant drift of identity. At that time my research led me through CoPs to the STL. I found, as Wenger (1998) noted, CoPs are the gateway to the STL.

I chose to use Wenger's (1998) STL as my theoretical framework to interpret the data, initially because of my familiarity with it. It quickly became clear that this offered a strong, validated framework through which professional identity both for educators and healthcare professionals had been explored elsewhere (for example, Orsmond *et al.,* 2022, Woods *et al.,* 2016).

It is considered a fit for purpose theory, involving exploration of individual experience within group activities, a process termed "thinking together" (Pyrko *et al.,* 2017, p 389). One of the underlying assumptions for my research is, in considering the nature of learning and becoming, advancing to the best theory to facilitate this is important. Wenger's philosophy and practice encompasses and encourages this marriage in the clear links between theory and practice. There are obvious shared characteristics of IPE and STL: participation, engagement, understanding and learning within the context of community.

Engagement and participation are fundamental to how people learn and consequently how they learn to become and continue to develop their identity (Wenger, 2009). This is the fundamental link between the STL and my research, as an exploration of professional identity. To this end, I adapted the four major theories of the STL to guide and structure the findings: theories of social structure or "learning as belonging", theories of situated experience or "learning as experience", theories of practice, or "learning as doing" and theories of identity, or "learning as becoming". I categorised these as "Community", "Meaning", "Practice" and "Identity", respectively.

4.7.3 Coding

For the focus groups, I was guided by Braun and Clarke's (2022) process for engaging with the data, the six phases of reflexive thematic analysis. During the first phase I read the transcripts over and again before transcribing and assigning pseudonyms to the participants. I spent time listening to the recordings whilst simultaneously reading the transcripts to check for accuracy. I spent a long time working with the data in this way.

The second phase, generating the codes, was an interesting process which I did by hand, line by line (see example in Appendix 13). In this example, the participants discuss how to define

the role of the mental health nurse, as they did a number of times throughout both focus groups. I compiled two code books, one for each focus group, (for example Appendix 14).

I also incorporated pre-coding when appropriate (Saldana, 2015). For example, the participants spoke about the colours of their uniforms, purple (student), green (HCSW) and blue (RN) and linked these to other people's perceptions of them and how they thought about themselves. I considered this to be immediately noteworthy at the time so I pre-coded these. I later used these in the title of my thesis, because they succinctly captured the narrative.

Through the third phase, generating initial themes, I spent time developing and constructing "candidate themes" (Braun and Clarke, 2022, p 35). These developed, as above, (1) the present student experience of being a mental health nursing student and (2) looking forward and seeing themselves in clinical practice. I then considered the nuances of sub-theming these and further sub-dividing. For instance, the spider diagram (Appendix 15) which focuses on "Role" (from coding) became a sub-section titled "What does it mean?", sitting in a sub-theme, titled "Considerations of mental health nursing". These are sited in the theme related to their present time experiences as mental health nursing students. There was a great deal of interplay between this phase and phase 4 (developing and reviewing themes) as I was tasked with ensuring that the themes held together appropriately and that they were not too broad so as to inaccurately represent the data, or too narrow so as to omit some important data.

In phase 4, Braun and Clarke (2022) ask the researcher to confirm (1) a "continuing and compelling story about an important pattern of shared meaning related to the dataset" and (2) that "the themes highlight the most important patterns across the dataset in relation to your research question" (p 35). In confirming that the themes represent the most important, consistent patterns across the dataset, able to address the research questions, they became "the final 'outcome' of data coding" (Braun and Clarke, 2022, p 7). This led me into phase 5, refining, defining and naming the themes to accurately represent the content. The themes finally became (1) *being a mental health nursing student*, and (2) *visualising professional registration*.

Similarly, for the interviews I followed the six phases of Braun and Clarke's (2022) process for developing themes for analysis. I read and re-read the transcripts whilst listening to the recordings, becoming immersed in the process. Organising the findings for the unstructured interviews was a challenge, not least because there were, ultimately, only two interviews, but similarities between the participants responses and their stories were identified. Through the process of coding, I developed a theme which I titled *understanding*, in a time and space when understanding was incomplete, missing or misplaced.
For both the focus groups and the individual interviews, phase 6, writing up, is seen in Chapters 5 and 6 respectively.

4.8 Trustworthiness

The four criteria of trustworthiness, credibility, dependability, confirmability and transferability were applied, appropriate to a project of this nature (Guba, 1981). They are reflected in my narrative throughout the findings.

Credibility relates to the degree to which readers can recognise what it is they are reading and have confidence it represents the true picture. As the qualitative equivalent of internal validity, Guba and Lincoln (1989) suggest several ways credibility can be established, some of which I was able to adopt. Immersion in my research was inevitable for me and I was able to prolong engagement both as a result of immersion and deliberately during the focus groups, probing and checking responses with further questions (Korstjens and Moser, 2018). This iterative style helped to weed out any inconsistencies in responses.

Guba and Lincoln (1989) suggest transferability is akin to external validity. Shenton (2004) counters that transferability may not be attainable because most studies of this nature are carried out with small populations and more importantly, it might not be appropriate because context is so important in interpreting the findings. Guba and Lincoln (1989) suggest that if the researcher is careful to provide a full account of what they did and what they found, others in similar situations may be able to apply the findings to their own situation.

Dependability, the third criteria and equivalent of reliability (acknowledging replication is impossible), was achieved through detailed reporting throughout the process. In addition to

details of research design, I included a fine level of operational detail (Shenton, 2004), helped in part by my keeping a reflective diary to capture the minutiae of the study as it progressed. The fourth criteria of trustworthiness, confirmability, akin to objectivity in positivist research, was assured through careful record keeping, showing decision-making and supporting how findings have been reached and conclusions made. Guba and Lincoln (1989) suggest confirmability can be considered once credibility, transferability and reliability have been achieved.

I adopted a transparent way of working and was able to demonstrate an audit trail to show a methodical progression of my study, although this was flexible enough to allow for significant changes, considered a useful and sensible activity (Braun and Clarke, 2022). Keeping notes was useful to help remind myself of the reasons for the decisions I made, in regards to the analysis, which was not always straightforward, in addition to the iterative and reflexive nature of my approach. An audit trail helps demonstrate that each stage of the analysis is significant and consciously determined, helping to draw attention to transparency of the decision-making process (Nowell *et al.,* 2017). As above, I found keeping a personal journal invaluable, sometimes helping me to remember things and sometimes to air my feelings and thoughts safely.

4.9 Chapter Summary

This chapter commenced with a discussion on my worldview and how this affected my overall approach to the research. I discussed the case study as my research design and considered the suitability of this for exploring the phenomena, concluding it was a good fit. I recognised findings are not generalisble but are focused on the particular, dove tailing with my worldview.

I considered associated ethical issues and the importance of adhering to a robust process, in line with data collection and changes as a result of COVID-19 restrictions. I offered an exploration to justify the sampling strategy, methods of enquiry and data analysis for both data collection methods, focus groups and individual interviews.

I discussed the importance of using a theoretical framework to analyse the findings and described my use of Wenger's STL to do this. I described matters of coding the data and how

I approached this as an iterative process. Considering issues of trustworthiness, I described how I ensured my work is presented with honesty and integrity, while acknowledging my position as a university lecturer and researcher in relation to the participants position.

The following chapter constitutes the first of the two findings chapters, pertinent to the focus group interviews.

Chapter 5

Presenting the Focus Group Findings: exploring the meaning of purple, green and blue

5.0 Introduction

This is the first of two findings chapters and relates to the focus group interviews. My approach is one of interpretive constructivism, as I give voice to the participants' reality and find meaning from their narrative, through the lens of Wenger's STL. Wenger (1998) contends learning is lifelong and situated in experience. Across time, the individual is transformed and learning becomes meaningful when it influences the individual's developing identity. This is a temporal process, influenced by individual engagement, participation and consequent reification, outside of a straightforward trajectory (*ibid*).

5.1 Organising and Structuring the Themes

Two themes were identified from the focus group data. The first one, *being a mental health nursing student*, considered the students experience of knowing the environment and making meaning from their lived experience. The second theme, *visualising professional registration*, is concerned with how the participants contemplated their development and looked forward to the challenges of registration. Of course, these themes are interrelated and there are some overlaps given the temporal nature of identity. Sub-themes and sub-sections were determined through each theme (see Table 2 overleaf).

5.2 Theme One: Being a mental health nursing student
5.2.1 Practice, Learning as Doing (i) Optimal conditions for student engagement: a. Communities of Practice b. Preference for practice (ii) Considerations of mental health nursing: a. What does it mean? b. A certain sort of person c. Advocacy **5.2.2 Meaning, Learning as Experience** (i) Multiple faces of the student nurse a. Face work b. The chameleon (ii) Being seen a. Incivility b. Know my name **5.2.3: Summary: Theme One – Being a Mental Health Student Nurse**
5.3 Theme Two: Visualising professional registration
5.3.1 Identity, Learning as Becoming (i) Changes to self a. Professional changes b. Personal changes (ii) Trust a. Conferment of trust b. Trusting self **5.3.2 Community, Learning as Belonging** (i) Realities of practice a. Being in blue b. Reasons not to be in blue (ii) Moral Undertaking a. Worthiness b. Through a different lens **5.3.3 Summary: Theme Two – Visualising Registration**

Table 2: Chapter 5: Themes, sub-themes and sub-sections

Within each of the overarching themes, I use participants' own words to illustrate the ways in which these data relate to the study's research questions.

5.2 Theme One: Being a Mental Health Nursing Student

This theme focuses on the participants' engagement in their endeavour and understanding their own experiences, reflecting the practice and meaning elements of Wenger's (1998) STL.

Theories of practice, learning as doing (Practice), encourages the articulation of "shared histories and resources that sustain a mutual engagement in a pursuit". Theories of situated experience, learning as experience (Meaning), encourages "articulating the ability to make meaning out of individual experience both as an individual, and within a community" (*ibid*). Here, the students explored their knowledge of their environment through actions taken and demonstrated their meaning-making from this lived experience.

5.2.1 Practice, Learning as Doing

The significance of engagement in order to participate when articulating shared histories and resources are highlighted here. The students explored how they engaged best and where, and considered their personae as mental health nursing students. Two areas of interest are identified, (i) " Optimal conditions for student engagement" and (ii) "Considerations of mental health nursing".

(i) Optimal conditions for student engagement

- Community of Practice

The participants knew working with vulnerable and mentally unwell people could be challenging, and they were aware of maintaining their own wellbeing because of the allied potential for emotional overburdening. In one focus group, Grace advocated very keenly for this:

> "we need to be reminding ourselves that we can do this (care) for each other as well as for patients … (we are) not always the kindest to ourselves…. I think when you're in a caring line of work it's very easy to put yourself on the back burner".

As students on the same programme, in the same cohort, through their discussions, it became clear that the participants all had relationships with one another as part of one discrete Community of Practice (CoP). This seemed to be an organic progression as they moved through the programme with a focus on caring for and supporting one another.

The domain for this CoP is the nursing programme itself, seen as a not inconsiderable challenge and described by Alice as 'intensive'. When contemplating the challenges of the programme, Ffion felt well supported, being able to share with her peers, asserting that "no one else understands" their experiences. She continued, "…you go home and you try to explain something and you have to explain what you're explaining so…. you're like, oh… I'm not going to bother."

Each of the participants expressed their appreciation of the camaraderie that their own CoP provided. Alice, for example, valued the space the community had created, "just sit, chat, whatever, moan!". Emma thought group members were often "…feeling overwhelmed…" stating "we're all on the same path at the same time", a path Carly considered a "roller coaster of emotions…". Having a defined space for themselves in which to think, share and just to *be* was significant. As Alice noted, "we've kept one another going".

Group membership relied on trust and honesty and Danielle made a point of saying "we just feel comfortable with being honest (with each other)". Alice noted, "even though we've only known each other for two years it seems… so much longer because we trust one another with things possibly we wouldn't trust anyone else with". Alice considered without peer support she would not have been able to continue on the programme, such was the stressful nature of it. Alice valued the group, considering it to be "like an extended sort of nursing… family".

Support and mutual development were evidenced through sharing information, experience and resources and problem solving together. As Grace noted… " so…we can pull someone else up when they're not feeling great and…. say something like…. "oh you're really good at this". Danielle had looked to the group for support during a particularly difficult academic assignment:

> "We'd meet up in the library and we'd sit there and then the one day I went… and was totally disorientated, didn't have a clue what I was doing … we sat in the library and we literally talked rubbish, with a bit of (assignment) stuff going on but at the end of that I kind of understood what I needed to do and then just sitting there for that following week and talking about it and saying "oh, do you think this is right? ...I probably was very annoying!".

The significance of peer group support is recognised in the literature (Walsh, 2015). It is seen as invaluable, informally developed by those who seek to make an affective connection with others similarly engaged in the pursuit of mental health nursing.

This CoP grew organically as a result of friendships and it was easily discernable from their conversations that the participants were friends with one another, outside this CoP (they knew about one another's family circumstances, for example). The individuals within this CoP demonstrated sharing histories, and developing knowledge and understanding. They demonstrated their foundation as a CoP, as a group of "…people who share a concern or passion for something they do and learn how to do it better as they interact regularly" (Wenger-Trayner and Wenger-Trayner, 2015[a], np).

- Preference for practice

The majority of the participants noted their preference for practice, as opposed to time at university, and they found engagement in the clinical area easier. Alice considered, "I feel far more comfortable on placement… than I do when I'm back (at university)". Bridie stated she feels "quite sort of calm… you know where you are on placement", and time spent in the clinical environment is the "best bit" of the programme. Carly found returning to university from placement was an upheaval, not an enjoyable experience, neither was it pleasurable for Bridie, who considered it a "struggle coming back to the academic side of things" (from placement to university).

Several participants were wary of what they thought of as looming academic assessments. Danielle, for example, recalled completing her application for the programme several years before, when she was sure she wanted to be a mental health nurse. As she explained, "I knew what I wanted as an outcome, but I had no idea what the middle bit was all about… the

whole academic underpinning stuff, I knew you had to do it but…. (I didn't think about it)". She had not considered how her ambition could be fully realised and was now working hard to marry practice to theory.

Two of the group, Emma and Grace held different views about their academic pursuits. Grace enjoyed engaging in both elements and believed that theory and practice were simultaneously part of her journey, the former informed the latter. Emma had completed a first degree elsewhere and found she "quite liked the academic stuff" but without the support of their own CoP, thought her relationship with this programme would be tenuous because of the academic challenges. Emma described a distinct split between theory and practice, "(the programme) is two separate things, you've got your placements and you've got your theory", and between them these were all consuming.

Eraut (2004) contends that an assumption that "working and learning are two quite separate activities that never overlap" (p 249) is not unusual. The perception of a theory practice gap in nursing has a long history (for example, Barbagallo 2021, Weeks *et al.,* 2019, Scully, 2011, Hopton, 1996) although Greenway *et al.,* (2019) suggest even though the gap exists and is usually considered undesirable, it has not been well defined. It is, however, "most often expressed as a negative entity, with adverse consequences" (*ibid*, p 1).

In her seminal work based on Dreyfus' skills acquisition model, Benner (1984) considered practice without theory can be valueless. They are naturally interrelated and interdependent, which needs to be articulated to explain the practice wisdom of the skilled knower. One could "know how" (have the knowledge and skills) without the "know that" (why the knowledge is pertinent). For the nurse to deliver a holistic performance, demonstrating how the skills of clinical decision-making dovetail comfortably with the immeasurability of intuition, both are required (Benner *et al.,* 1996).

Wenger (1998) considers the theory/ practice divide to be artificial because practice is always theory, making theory a practice in itself. Practice cannot be immune to the influence of theory. To reify achievements into tangible artefacts, students must engage and participate in both.

Emma identified the potential for linking theory and practice through IPE. Working within a Multidisciplinary Team (MDT) on placement had helped her understand what other

professionals do which had been bolstered through engaging in IPE in theory, so “to not have that [experience of IPE] would be a detriment to the patient”. Danielle agreed that not knowing what other professionals contribute to patient care meant the patient could not receive the “best care”, and the search to know how this could be achieved could be part of the IPE process.

One of the IPE sessions, as non-traditional teaching, took place in another school at the university (and was not in a classroom or seminar room). The whole setting seemed to be more comfortable for participants who reported a struggle with, or a dislike of, academia compared to a traditional classroom based approach.

For example, Bridie, stated that practice was the “best bit” of the programme for her, but also took value from the IPE sessions, detailing her participation in the process with enthusiasm. She described her interest in hearing the views of students from other professions and she felt able to engage, being comfortable with sharing her thoughts and challenging the ideas of others for clear reasons, “…it is vital for everyone to be talking about their views… because you’re less likely to be missing something, aren’t you?”. Bridie had considered there was a problem with one group holding stereotypical views of others, but further discussion had helped her to understand others, and also how she might appear to them.

Carly found value in being challenged by other professionals in IPE. As the only mental health nursing student in her group, reflecting on her own actions in practice, she had asked herself, “am I doing the right thing there?”. This allowed her to listen carefully to other perspectives. Discussions had opened up, leading Carly to conclude, “it was very much like ‘we’re all in this together’”. She realised other students had encountered “the same sort of hurdles and pitfalls (in practice)” that she had and she described a sort of camaraderie through her engagement in IPE.

When asked about the idea that not all health care profession students think IPE is suitable for them, Carly expressed some concern, suggesting this was “a bit naïve….(because) you’re not going to be working in isolation if you really want to do person centred care”. In this group, Alice was clear that learning together in this context was wholly appropriate as the

nurse is part of the MDT, “I can’t see it being anything other than a benefit really”. Grace considered, “ you need to know how someone else works so that you can work with them”.

All of the participants who attended the IPE events confirmed that they had enjoyed the experience. Whilst North *et al.,* (2023) consider that enjoyment does not necessary equate with internalisation of the IPE or knowledge acquisition, students here had taken some learning from it. Arguably, this tacit or informal learning is as important as, and is an adjunct to, understanding the principles of IPE practice and acquiring knowledge. While the majority opinion was that real life experience cannot be replaced by simulation, simulation can be a building block towards helping to work in the clinical area.

(ii) Considerations of mental health nursing

- What does it mean?

Identifying mental health nursing was not clear cut for any of the participants. There was the belief it is hard to define, and the group offered various articulations of the role in order to think about a definition. Consequently, their development into mental health nurses was not a straightforward trajectory because it was not predictable.

Contemplating what she would be doing as a mental health nurse, Carly considered, “oh I help people recover and help them…. get back on their feet… setting goals and helping people to achieve their goals”. Similarly, Bridie thought mental health nursing was about developing coping strategies to reach a quality of life the individual wants, “you go in, solve the problem as much as you can or help the person solve their own problem”. Generally, mental health nursing meant supporting people with their mental health needs, whatever they are. Reflecting Hurley *et al.’s* (2022) findings, Ffion considered the role, and so the identity of the RN, as “anything a patient needs you to be “.

Danielle considered defining mental health nursing was made difficult by the uniqueness of the patient and their needs. As she explained,

> “In adult nursing (the issue is) generally something that is dealt with the same for most people, if you break your leg, it’s put in a plaster or you have an op… whereas…. say… on a dementia ward… every one of those patients has a different need”.

Grace agreed, "… if you're on a kidney ward, everyone's got kidney problems" whereas on an adult acute mental health ward, "everyone's got a different problem and no one fits into any particular category, it's quite chaotic". Ffion noted "it's quite hard [defining the role] because on each ward it's different…and each area is different". McKeown *et al.,* (2018) consider a lack of definition can be a good thing, allowing the nurse to align what they do with, and for, the individual patient, something Ffion, Grace and Danielle emphasised as an inevitability that was aimed at assuring a patient centred approach to practice.

In any event, the foundation of the role was being kind, taking time and advocating for vulnerable people. Ffion suggested, "we've seen people at the very end, at the bottom, so we appreciate it more, like being kind, being nice". There was a sense of the centrality of the importance of maintaining hope in supporting the individual who found themselves at the "very end". Fisher (2023) suggests that "Hope is everything…. the gift of holding this for others is immeasurably valuable…" (p 2).

For Ffion, her role as a mental health nursing student meant she had to do whatever was required as indicated by patient need, so any definition of identity was very much dependent on the specific clinical environment. The participants considered the diversity of patients and patient need ensured there could be no single definitive definition, and that is how it should be.

Hurley (2009) suggests that mental health nurses narrate several identities linked to professional role, describing an aligned "cluster of seven MHN identity characteristics", unique to mental health nursing (Hurley, 2009, p 383). Nurses describe themselves as "generic specialists" (p 383) able to easily adapt to service user/ patient need.

Carly suggested that the mental health nurse might be considered a "Jack of all trades, master of none". The application of this label is not exclusively used with mental health nursing, for example Cootes and Heinsch (2022) discuss the *Jack of All* label for Social Workers. However, there is a tradition of the use of this label to describe mental health nurses (Terry, 2020, Hurley, 2009, Crawford *et al.,* 2008, Skidmore *et al*., 2004). Terry (2020) found some mental health nurses described themselves thus, and found that this could be interpreted in one of two ways:

> "The term can signify that mental health nursing work encapsulates a range of skills and is a multifaceted role, or conversely is considered an occupation requiring multiple skills at a purely superficial level" (p 420).

However, Terry (2020) is clear that being "in the middle" (p 414), the mental health nurse is occupying a co-ordinating/ organising/ administrative role, which is complex, significant and pivotal to patient care. Nurses can bridge the gaps between other professionals and the patients they work with. Warrender *et al*., (2023) suggest that the mental health nurse holds a "cocktail of unique skills" (p 206) based on person to person connections and relationships in complex scenarios, it is neither simple nor superficial.

Carly and Danielle thought other people often perceived mental health nursing as "unusual", and Ffion considered it to be "completely different" (to other fields of nursing). Carly, when responding to others when she was asked what she did, found a standard response was one of surprise, "… you mention that you're a mental health nurse and they go, 'really?'". It was considered atypical enough for other people to think it worthy of their comment. Emma reported avoiding telling others that mental health was her chosen field of nursing, "I just tell people I'm a student nurse, and they just don't ask". The implication was that adult, child or learning disability nursing were more mainstream and more acceptable to others. Being different, not fitting in with other people's expectations, seemed to make mental health nursing an interesting endeavour.

However, the perception of difference did not initially sit comfortably with some of the participants. Bridie described her reluctance at the beginning of the programme to tell others outside her family group she was going to study mental health nursing. The reasons for this seemed to be concern about other people's perceptions of it and stigma associated with mental illness, her perception of others' misunderstandings and her anxieties about the expectations others might have of her because of this. Goffman (1963) described "courtesy stigma" as that which an individual experiences as a result of having a close association with someone who has a mental illness or is in anyway different from others. The phenomenon of the transfer of stigma from those people with mental health problems to those working with them is widely recognised (Lewis and Bartlett, 2015), later "stigma by association".

Despite this, Emma described an attachment to mental health nursing. Discussing her motivation to become a mental health nurse as an aid to help her avoid "just sort of floating around (in life)", Emma was clear she needed direction and a purpose and whatever she did must be "something right and good" and to the benefit of other people. She believed she had found this in mental health nursing. Similarly, Carly considered her desire to help others, believing she had the experience and skills to do this as a mental health nurse. Mental health nursing could enable her to "feel good and morally better about myself". Grace saw herself as wanting to "make a difference" to other people's lives as a mental health nurse.

- "A certain sort of person"

There is a recognised moral aspect of becoming a nurse. Echoing Kelly (2020), Traynor and Buss (2016) and Keeling and Templeman's (2013) findings, these participants believed they needed to be a certain sort of person to be a mental health student nurse, it was not something that just anyone can do. Carly, for example, considered, "because of the nature of what nursing is, you have to have certain attributes". Emma agreed that for her the instinct to be a mental health nurse and to care for others was intrinsic. She thought it was something people could either do or could not do, it was not suitable for everyone. Emma considered that her motivation was a part of her, "… you've always had it in you". Ffion confirmed Emma's thoughts, "… you have to be a certain sort of person…. to be a mental health nurse", valuing people and wanting to help people was central to this.

Grace considered there was an element of privilege to working with vulnerable people in her capacity as a student nurse. Seeing herself in "a unique position to help people", Grace believed she had a level of insight into people's (patient's) lives that most others do not have, which enabled her to "make a difference" to patients she worked with. This insight was a privilege, something to be valued. Likewise, Emma considered it "a real privilege to see people at their worst and see how they can progress ... the experiences I've had (as a student) since I've been on this course… I would never have seen anything like that before".

Bridie spoke with pride at being able to communicate effectively in a professional capacity with someone in crisis, something she did not think she would have been capable of previously. Bridie agreed that having the opportunities to make a connection with a vulnerable person (patient) made her feel "…really… honoured…". Williams and Burke

(2015) contend that mastery of the affective and cognitive spheres of nursing care enables students to be, and think like nurses.

Generally, the participants aligned themselves and their behaviours to McKeown *et al.'s,* (2018) human set of responses, suitable for mental health nursing: responding appropriately to those in distress, helping people to cope with difficulties, listening to stories and helping people to determine their own worth and regain status. They identified how they demonstrated the importance of advocating for vulnerable people, a core skill of mental health nursing (Treloar and Bleus, 2021). The participants showed themselves as flexible, adaptable, able to work confidently with uncertainty.

- Advocacy

For Grace, one tenet of mental health nursing was "the ability to help people who are vulnerable, sort of give them a voice". Bridie was also clear that patient advocacy was one of her responsibilities, giving patients "a voice" when they cannot speak for themselves was an integral part of her role as student, as well as part of the RN's role.

For Ffion and Grace, advocating came in the need to challenge the apparently stigmatising views and judgemental attitudes about people with mental health problems as voiced by one of their student nurse peers. Grace was empowered to "…get on my soap box… and… go 'No!' (you can't say that)". Ffion was especially affronted, "…how dare he say that! You cannot know what that person is going through". Although they thought most others do not hold similar prejudices, they were frustrated and disappointed because they considered they had worked closely with their peers who should know better, but who seemed to be mired in "a lack of understanding" about mental health issues. Galvin *et al*., (2015) similarly found mental health student nurse's experience of working with peers from other fields fell short of their expectations, in terms of discriminatory attitudes held. For Carly, such stigmatising attitudes, whilst representing at best a lack of understanding, contended "…it goes against the identity and the expectations of what the nurse is then, doesn't it?".

Pre-judging and making assumptions of others based on certain characteristics is part of the human condition. Goffman (1963) described stigma as an "…attribute that is deeply discrediting… that reduces someone from a whole and usual person to a tainted, discounted

one… (with a) … spoiled identity (p 3)". This leads to stigmatisation, "the social process by which the mark (the stigma) affects the lives of all touched by it" (Pescosolido and Martin, 2015 p 91), mental illness being one characteristic of stigma, both a cause and an effect. Stigma can both contribute to the development of and, through processes of discrimination as a result, exacerbate mental ill health. Stigmatisation is commonly experienced by those with mental health problems, fuelled by social and health inequalities and a subsequent loss of social status (Bates and Stickley, 2013). The Centre for Mental Health (2020) states that addressing health inequalities, described as "a stain on our society" (p 9) should be on everyone's agenda. Grace described her "soap box antics" in response to a friend's assumptions about homeless people and substance use (that all homeless people use illicit substances). She was very clear she had challenged judgemental comments and would continue to do so in order to make others "question how they think about it a little bit".

Being a student, then, was not easy. Ffion considered "it (mental health nursing) is really challenging and I can do it, sort of, I think!". Grace echoed Ffion's feelings, "I love it (mental health nursing) and it is yeah, really challenging but again, I think that makes me like it more". Despite the challenges, such as working with people in crisis and constantly pushing back against stigma and discrimination, Grace reported she was happy to study mental health nursing, something she realised early on, "really soon into the course I was like, yes, this is right!".

5.2.2 Meaning, Learning as Experience

Making meaning out of individual experience as a mental health nursing student occurred as part of an iterative, and potentially, subtle process of negotiation and re-negotiation. Here, the participants explored ideas that were central to their position as mental health nursing students. The areas of interest that arose were (i) "Multiple faces of the student nurse" and (ii) "Being seen".

(i) Multiple faces of the student nurse

- Face work

Working with vulnerable or mentally unwell patients was sometimes challenging. Some of the participants found their introduction to clinical practice difficult because of the nature of the environment. Initially, this had affected their ability to engage with patients.

Emma described her first time on a ward placement, which she found to be chaotic and bewildering, "…I walked out into the ward and …. I had no idea (what it would be like) … I found it very intimidating, thinking what on earth have I done (started on the programme)?!" Ffion similarly recorded her first experience:

> "… I don't know if anyone else felt this or not. From my first placement I had to learn very quickly to be self-aware because you look at somebody the wrong way or you talk to them in a way…. you get shut down pretty quickly so I had to learn pretty quickly that I needed to be aware of how I talk and how I perceive people and how I sit, how I stand".

Working with vulnerable patients bought her to the realisation that her actions or words may be misinterpreted. Ffion worried that saying the wrong thing would cause distress, but did not know what the "wrong thing" was. Needing to pay more attention to what she did and said than she would ordinarily have done because of unintended consequences, was something Ffion had not considered previously. The significance of emotional intelligence, correctly perceiving the emotions and feelings of others by looking (Mayer and Salovey, 1997) came to the fore.

In similar circumstances, Carly described developing her own "poker face" as a coping mechanism to avoid showing what she was feeling (when intimidated). Ffion agreed with Carly that a "poker face" was a good tool to have but she had found it "very, very hard" to develop.

Here, Carly is describing "saving face". Goffman (1967) contends that face "is the positive value a person claims for himself by the line others assume he has taken during a particular contact" (p 5), and line is the pattern of verbal and non-verbal behaviours that individuals use to express themselves. Working to save face, Carly had taken action to "make whatever (s)he is doing consistent with (her) his face" (p 12), that is to say, appearing calm and measured, when this is not the case. Curtis (2014) similarly describes this process as "surface acting" (p 212), something nursing students are adept at.

Bridie spoke of adopting a "thick skin" during difficult clinical experiences. Knowing she could not personalise such incidents, Bridie used this "thick skin" to protect herself (Curtis, 2014 p 217). Bridie described maintaining face and did not allow herself to feel overwhelmed by

such challenges. Forming a robust base from which to develop resilience, the ability to bounce back from an out of profile emotional event, is considered integral to the practice of mental health nursing students (Rees *et al*., 2015). Bridie facilitated a kind of protective face-work, additionally demonstrating respect for the other, ensuring they too maintained an in face status, without the need to explain their own decisions or behaviour.

Loss of face or ending up in the wrong face (looking, or seeming to look incongruous in the circumstances) could be damaging. The importance of recognising this element of socialisation can be seen throughout the literature (Thomas *et al.,* 2015, Rees *et al.*, 2015). Holding a repertoire of techniques, such as having recourse to a poker face, enhanced self-awareness, self-care and thick skin, for example, enabled participants to develop their own line. These were important elements of finding one's own style, and using these techniques in order to assimilate.

- The chameleon

Choosing the face to inhabit was closely linked to practice in specific clinical areas and specific patient groups. Expectations of the faces the participants needed to wear differed between these environments and between different clinical teams.

For Danielle, working in any particular clinical area with a specific patient group was a complex undertaking because of the needs of the patient and she had to be adaptable to manage this, "(people with) dementia, young people (with) eating disorders, everybody …they will have a completely different…. (issue)". Grace agreed that diversity of mental health issues in the same clinical space (such as an acute admissions ward) can be quite marked and so, learning who to be, could be complicated. Carly agreed that it was impossible to "box" patients into categories as each had different needs, they would require different knowledge and skills to meet these. For Ffion, this was highlighted on each placement as she thought she "could do something different every day" and additionally advised that students could "definitely be doing something different every placement". Consequently, it was imperative to adapt quickly to meet patient need as they moved between placements, chameleon-like.

This was not always easy. Carly expressed feelings of frustration at times when trying to engage in practice. There was a sense of vagueness and transience in passing through a variety of roles that caused discomfort. The challenge for Carly lay in understanding her own positionality, such was the temporal nature of it:

> "(there is) a thin line between that student identity and that nurse identity…I'm a student this morning and I've got to put that head back on…and then I've got the nurse, what is this, what am I? …We've got a lot of identities right now…the student… the nurse, the learner and the doer at the same time and it's like 'where do I fall?'"

Emma voiced similar concerns. "…we don't know how to define ourselves but, on the wards… other people (nursing staff predominantly) don't know how to either. They don't know what we can do or can't do", a phenomena described elsewhere (Galvin *et al.,* 2015).

Whilst there was a feeling that there was inconsistency amongst staff in knowing parameters for students, the reasons for this were understood; differing policies and rules could be interpreted differently by staff, and this could be influenced by an understandable reluctance to take positive risks by allowing and facilitating students to practice skills in the clinical environment, for the first time.

However, this could prove frustrating. For some, not knowing how to site one's self in context was made more complicated than warranted by the potential benefit involved. Bridie considered that acting to intervene during one incident was the right thing to do but her desire to help was scuppered by policies and procedures, being told, "…but you're a student, you shouldn't (intervene)". She found this counterintuitive and was frustrated by having to adapt to fit in with the environment and agree to a procedure she found hard to follow and which seemed to potentially disadvantage patients. Galvin *et al.,* (2015) found such situations were not unusual for mental health nursing students.

Generally, the participants recognised that firstly, to engage and secondly, to participate and assimilate was not always easy. Having to change face and line became a considered task, dependent upon circumstances. As Crigger and Godfrey (2014) contend, socialisation can be painful when "denying the uniqueness of the individual"(p 377), clearly something the participants had experienced.

(ii) Being seen

- Incivility

The process of assimilation could be challenging and sometimes unpleasant for reasons the participants had not considered. Whilst expressing the value they placed on respecting the patient, the participants noted that they had not always been afforded respect by the nursing staff and other professionals they worked with, whilst on placement in practice. This contradicted their own beliefs that treating others with respect was important, something they considered of value and sought to uphold. There was some surprise that staff could be difficult to work with. Carly laughingly said "it's hard enough dealing with the staff sometimes, let alone the patients!", mirroring the findings of Rees *et al.,* (2015) and Thomas *et al.,* (2015) that sometimes nursing staff were rude and disrespectful towards students.

Some participants reported being ignored or made to feel as if they were in the way by staff, which they found hurtful, echoing findings in the literature that highlight the frequency of feeling like a burden (Jack *et al.,* 2017, Walker *et al.,* 2014). Grace considered:

> "some people really don't like students and they will really let you know or certainly let you feel it anyway… you're either not there or you're a hindrance (in the clinical area) and…it's pretty deflating, feeling like that".

Over time, Grace's confidence had been knocked, but she had learnt to manage this: "I just tend to shrug it off nowadays". Being made to feel unwelcome in some placement areas at some time was clearly not unusual for students, and accepting other people's rudeness seemed par for the course, echoing the incivility described by Thomas *et al's* (2015) participants.

The participants here, generally thought, as students, they could sometimes be seen as interchangeable, transient subjects, which they thought might have explained a reluctance to engage with them. As Grace explained "… the general mentality is that students come and go (in rapid succession)".

Ffion recounted that she had been on a ward as a student (in her purple uniform) and had returned as a bank HCSW (wearing a green uniform). When talking to another member of staff, it transpired that this person did not remember her, "I was like… 'I was here before, I was here a couple of months ago', [she said] 'oh I never noticed ya!'… she didn't know who I was, she was talking to me like she'd never met me before and I was like, 'I was here for 10 weeks!'". As a student, Ffion believed she was of little significance to this particular member of staff.

The participants described the phenomenon of incivility from staff, initially this was surprising. Later into their studentships, whilst it was not ubiquitous nor commonplace, being treated with rudeness and incivility was possible.

- Know my name

Another of the ways participants saw themselves as being treated disrespectfully by co-workers was that others did not always address them by name, considered rude and unnecessary. They explained that they did want to have the identity of a student nurse, but that they also wanted to be an individual student nurse. They did not think of themselves as a homogenous group or an interchangeable entity, which was sometimes implied.

Ffion recalled several occasions when she had not been addressed by name which was at odds with her own appreciation of how professionals should interact with one another. She stated that she would never address someone by their title alone "….because that's not you. You are a person. So, if I don't remember what somebody said [their own name], I'll say, 'sorry, I don't remember your name', but they won't, they don't do the same thing to me". Emma agreed with Ffion that this was disempowering and described it as a lack of respect, by casual disregard, to not be addressed by name, "…because they have not taken the time to know who I am". This reflects back to participants in Ó Lúanaigh's (2015) study who considered that good nurses took time to learn the students' names.

Like Ffion and Emma, Grace considered it rude and it did not measure up against her own expectations of how to behave, "…no, I wouldn't do it to someone, if I did, I'd feel really bad about it", so affording dignity to others was important. For Eckardt and Lindfelt (2018) being called by one's name confers responsibility, making the individual take ownership of

themselves in the scenario. The inference is that the experience is more valuable to the individual engaged in it and it is important to those around them as recipients of, or players within, the student's considered enterprise.

Emma pondered on the lack of empathy of the nurses, although few in number, who did not address a student by their name, "I feel like they don't understand that we will be the nurses (in the future) and that they were all (once) in the same position that we are". For Grace, this had led to the assertion that she was not going to be influenced by negative attitudes of others who seemed irritated by, or oblivious to students. "I may be a student and you [staff] only see me as that, but I'm still a person and you shouldn't treat me like that".

Holding their individual identity was important to the participants and not all staff seemed to pay heed to this. This was a source of frustration and caused some animosity towards staff.

5.2.3 Summary: Theme One – Being a mental health nursing student

The environment for engaging and participating in the endeavour of being a mental health student nurse needed careful consideration and was curated by the participants themselves. They considered peer support to be invaluable, vital to their continuing progress. They demonstrated how they learnt to seek and maintain important relationships with other students.

Whilst they had differing preferred platforms for their own learning, as one of these, IPE, could be useful to development as it opens up opportunities to spend time with students from other professions. Learning with, from and about each other, seemed an appropriate pre-cursor to formulating quality patient care. It proved an interesting way to learn about themselves, their role, and the role and scope of other professional groups.

Through practice, participants found that defining mental health nursing was not straightforward and clarity was not always possible. Managing uncertainty (of definition) was commonplace but the participants came to understand this; they found that individual patients and individual clinical areas needed different approaches, there was no "one size fits all" mental health nurse role. Consequently, they concluded that a precise professional

identity for mental health nurses was difficult to pin down, and being able to manage this abstraction was a prerequisite for the job.

Working with mentally ill and vulnerable people provided unique experiences for students which were seen as special, putting them into a position of privilege. As individuals, they thought their choice of career pathway was initially possible because of their fundamental nature.

They described appropriate clinical responses for mental health nurses, including the significance of challenging stigma. They were surprised to learn that some people did not understand the unconscious nature of stigma and discrimination, and so patient advocacy was an important part of their role.

Participants learnt to be flexible in the clinical environment so as to fit in. They managed this process themselves, and were required to make personal changes to be in a position to assimilate into practice. As individuals, they adapted their behaviours and learnt how to *be* in unfamiliar environments, assimilating in a chameleon-like way, recognising the significance of emotional intelligence to their learning and development. Although participants did describe some agency, they understood they did not have full control over the scenarios they were in, which could be frustrating.

The participants learnt through difficult experience that, as students, they could be treated rudely or with distain by RNs and others. This was an unwelcome surprise but they learnt to manage this. The participants' motivation and enthusiasm for pursuing a career in mental health nursing seemed to make this behaviour tolerable. They demonstrated the importance of being resilient and were aware of the significance of assimilating cultural norms and values into their practice.

Despite the challenges they faced, the participants wanted to work with vulnerable people who experienced mental ill health. For some, mental health nursing became a way of validating themselves whilst also being of benefit to others.

5.3 Theme Two: Visualising professional registration

Here, the participants considered the steps they were taking towards registration and tried to recognise for themselves how they have made this happen. As they saw themselves coming towards the end of this part of their journey, they began to explore the worth of mental health nursing work and themselves within the landscape.

Theories of identity, learning as becoming (Identity), is concerned with "articulating how learning changes us and creates personal histories of becoming, in the wider context of community". Theories of social structure, learning as belonging (Community), allows for the "communication of our social configurations within what we do, or the enterprises we are pursuing can be seen as worthy of pursuing, and our participation in this can be recognised as competent" (Wenger, 1998).

5.3.1 Identity, Learning as Becoming

At this point in their journey, the students were more than halfway through the programme and their ambition of registration was in sight, as they continued to negotiate their way through a fluid and dynamic process. As the participants thought about the steps they were taking, they began to consider how this process had unfolded, how they continued to change and develop, learning to become mental health nurses. Two particular areas of interest arose here, (i) "Changes to self" and (ii)" Trust".

(i) Changes to self

- Professional changes

Some of the participants could clearly see their own development towards RN status and knew that they have changed to prepare for this. However, how these changes had occurred was not always clear, but there were tangible patterns of knowing found within their narrative, even though they were not always easily articulated.

Bridie earlier described her reluctance at the beginning of the programme to tell others what she was studying, because of perceived negative attitudes, but this had clearly changed.

Bridie believed an increase in self-confidence had been impacted by her level of competence and also in her ability to "speak up". She could track changes from her first year to the present, acknowledging that she had "learned so much".

Bridie considered one of her first mentor's approach to facilitating her learning was not structured enough for her, so had negotiated a change of mentor. She noted, "I need someone with rules, I need someone to tell me what to do". Reflecting on the possibility that she, as a first-year student could have been asked to speak at a ward round, a complicated clinical based exchange between a myriad of professionals, Bridie stated "I wouldn't even know what to say". She now felt that doing this "all came quite naturally" having moved from a position of needing complete guidance as a novice, in "tell me what to do!" mode, she was now able to make decisions independently. Bridie felt that as she was now a third-year student, she expected this to happen, as she put it, "it's like, yeah! I'm a mental health nurse!".

Benner's (1984) *Novice to Expert* model determines that knowledge of abstract concepts, can, under the right conditions, be eventually translated into expert practice. The novice, one without any nursing experience, is task-orientated, needing to follow guidelines and sticking exactly to a pre-determined formula. The novice needs time to gather experience through many different practice situations to allow the theoretical concepts to be made real and become meaningful. Eventually nursing actions may become automatic but they are well-reasoned and delivered with expertise, although one cannot be an expert in all contexts. Building up to the level of expert requires the ongoing progression from abstract concepts to the creation of concrete experience. It is important to note that expertise does not equate to "time served" and so not all nurses, however experienced, will become experts (Perksy and Robinson, 2017). The assimilation and internalisation of norms and values pertinent to professional nursing practice is integral to this development.

During the second focus group, Grace considered that she felt different as a third-year student, although she could not recall stepping over a metaphorical line from year 2 to year 3, as she did not "know where that line was…. but I feel like it has happened!". It is reasonable to anticipate that Grace, in unconsciously or unknowingly stepping over an imaginary line, was describing her own tacit learning which is difficult to articulate. Grace saw

and felt changes in herself. She seemed to feel grounded in mental health nursing and ready to move forward:

> "now that I'm getting to the stage where I'm recognising those identity changes in myself, you know, outside…yes, I'm a student nurse but I'm also, like sometimes…yes, I'm a nurse and I thought, 'ooh, I thought of myself as a nurse' but I feel like it all the time, not just when I'm here, not just when I'm on placement, it's just all the time….. and I think I never recognised it before".

Grace was describing a change from 'rule book' to 'rule of thumb', being able to work outside of an algorithmic approach, towards being able to make decisions in a more freehand way, the result of pattern recognition, engagement and participation and knowing. With expertise and experience, Benner's (1984) "knowing that" can be transformed into tacit knowledge. Gourlay (2002) contends that tacit knowledge/ knowing (interchangeably used) comes with experience and age, but Benner (1984) warns against any assumption that gathered knowledge and experience across time facilitates tacit knowledge to masquerade as expertise. Inversely, this is something that Danielle was very wary of: rather than she herself masquerading as an expert, she anticipated that on registration others will be placed in the position of expecting her to be an expert, fuelling a masquerade.

Developing clinical knowledge and skills and moving forward to some level of expertise was an exciting prospect for the participants. This was also tinged with, and sometimes overridden by, a sense of foreboding when they considered the implications of moving away from the status of novice.

- Personal changes

In addition to professional changes, the participants thought that they had experienced personal changes. Whilst the decision to study mental health nursing caused significant life changes for them all, those with families described changes that their families had to make to fulfil their professional ambitions. Bridie, for example, whilst working, volunteered on a ward for people with dementia "because I wanted to make sure I could deal with it". This was a significant undertaking, testing her own aptitude and commitment to mental health nursing

but ultimately reduced the time she could spend elsewhere, with her family or in paid employment.

Bridie and Alice considered later, that undertaking their nurse education had been beneficial to their relationships with their children and had changed them in some ways, for instance how they responded to their children. For Alice, whilst she did have less time to spend with her children than she would have liked, she did not consider this wholly negatively:

> "…I think I've become a better mum as a result of this because I feel as though I haven't got as much time with the children but I do feel as though some of the skills, sort of listening…. not… judging what they've done…. I don't feel as stressed around them; I feel stressed in the course, but not around the children".

Similarly, Bridie found herself to be more "mindful of what (I) you do with the kids, and sort of what they're going through and…think more behind it don't you?".

Mental health nursing students are frequently older than their peers in other fields of nursing. Older students are more likely than younger ones to have their own families to care for. The participants recognised in one another the effort that was put in to maintaining their other selves, Carly and Emma both commented that some of the other participants were parents and were deferential in their attitude, as Carly put it, "I don't know how you guys do it". Having the additional and substantial role of parent was seen as a complicating factor in their busy studentships.

Kevern and Webb (2003) considered the difficulties that mature women faced when studying as undergraduates; childcare and maintaining a framework to ensure the safety and wellbeing of their children caused heightened anxieties and great stress. Galvin *et al*., (2015) demonstrated that a work/life balance was often hard to achieve for this group of student nurses, and that familial responsibilities were likely to be a reason for this. Likewise, here, some of the participants described the side effects of being a student; it was not always easy to maintain their private relationships because of the time and energy required to be a student. This cut into other areas of life including family responsibilities, necessitating wider personal changes.

Danielle described changes that the rest of her family were simultaneously experiencing, "… my whole family life is changing, there's so many big changes going on there with…, different ages and people leaving….". Similar findings in Galvin *et al.*'s (2015) study found that their family lives impacted on students' professional lives, describing "home life demands" (p 777) as consuming and concerning. Knight *et al.,* (2012) contend that students both derive support from their family, but also that changes and upheavals within familial relationships cause a great stress on them, as they continue with their studies.

(ii) Trust

- Conferment of professional trust

In her last placement, Alice recalled a nurse telling her that as a third year student she would be able to delegate (to more junior students and other healthcare staff) and felt this was simultaneously exciting and anxiety provoking. Akin to Ó Lúanaigh's (2015) findings that being recognised as responsible was valued by students, Alice felt that nurses were showing a lot more confidence in her which in turn made her feel more confident "to give it a go". However, Alice could not see changes in herself in clinical practice but thought that others could. Carly also felt that she had taken on more responsibility because of the trust that others had put in her, because of where she was on the programme, at the end of the second year: "yeah, it felt like more responsibility in terms of like "OK…. I trust you to do this"…

During her last placement Bridie stated that she had "started to feel … people were trusting me with a bit more" as an end of year student, and that she now felt ready to take on more responsibility. Bridie felt that her confidence had grown through the last placement and that, as a third year student, she expected this to happen.

There is a symbiosis of trust here; Carly, Bridie and Alice are being trusted and simultaneously (and perhaps hesitantly at first for Alice) they trusted their mentor's assignation of their trust in them. As Eckardt and Lindfelt (2018) commented, when students are able to hold responsibility in this way, their sense of identity can be bolstered. They are in the act of doing what they set out to achieve, become mental health nurses. Trust is an integral part of becoming for the participants.

- Trusting self

Some of the participants considered that having other people trust their judgement and value their opinion, was an integral part of their development. Ffion described examples in clinical practice when other less experienced students were asking her opinion. As she was able to make reasonable and reasoned responses to the questions, Ffion considered that "you don't know how much you know until somebody asks you!". Grace had similar experiences, "you always feel a little bit chuffed…. when someone asks me a question and I answer and catch myself, "I know a thing!"

For Ffion, the depth of her underpinning knowledge became apparent in IPE. Testing her ability to address all aspects of different questions from others, Ffion was pleased she had been able to share her clinical knowledge and expertise with others in the IPE group.

Addressing questions from others, Ffion was asked for her clinical opinion about a complex scenario that she described. Carper's (1978) ways of knowing are in evidence and Ffion had used this template to articulate the complexity of nursing knowledge. Carper describes patterns of knowing through four component elements (empiric, ethical, aesthetic and personal). Ffion demonstrated her understanding of the empirics (diagnosis and seriousness of the situation), she had attended to the ethics (using valued personal relationships to refer back to in order to determine the rightness of behaviour), and had demonstrated aesthetic knowing, regarding the wholeness of the patient, anticipating unspoken or unmet needs.

Additionally, this was informed by Ffion's own appreciation of herself in this context (what she could bring to the situation, albeit, initially with uncertainty) and being authentic in the moment. Personal knowing is the self-aware, subjective understanding that arises through experience. Driven by authenticity of being in the moment, this is the most difficult to articulate but may be reflected in increased confidence.

Ffion's confidence in herself may have been boosted during the IPE as she had worked in a group with a mental health nurse training to be a health visitor, and found that "she had the same views (as me) because she's still a mental health nurse". Ffion considered this shared background to be significant. Whilst this does indicate a sharing of empirical knowing (recognising similar situations from previous experience and how they are technically

managed) there is also the implied tacit understanding between the two students, in that they understand the situation without needing to make this explicit. IPE had allowed Ffion to confidently offer the contribution of mental health nursing in a safe environment, and she had trusted herself to do this.

5.3.2 Community, Learning as Belonging

Here, the participants were thinking about their future selves and how they felt about moving into this unchartered territory. Whilst it was clear that they wished to belong to the community of RNs, there was a great deal of trepidation. However, they were mindful of the moral aspects of being an RN, so whilst getting to the destination was not easy and despite misgivings, the participants were sure that arriving at the destination was a worthy pursuit. The areas of interest that arose here are (i) Realities of practice and (ii) Moral undertaking.

(i) Realities of practice

- Being in blue

Emma, looking towards her future as an RN was "still scared to be a blue (RN uniform) but it's not quite so much now". She had felt reassured following the last practice period that she now knew more about what she should be doing, although she did not know why her fear had abated. It may be that being immersed in the practice area had led to feeling more comfortable in her role or, similar to Grace, that the reification of being certified as passing from one academic year to the next, had increased her self-confidence in her abilities.

Grace also considered the "end (of the programme) is in sight… but whilst that's really exciting, it's forcing us to focus". Carly described an anticipation rather than a fear "…you are kind of…raring to go because you can see the end in sight, and I'm like, "I want to do this" but at the same time, I'm like 'oh no!'". Such a dichotomy is neither unusual nor unexpected (RCN, 2019[a]). Grace was also trepidatious:

> "…it's like the realising that we know bits, it's becoming, it's happening more so, then you're just like "ah it's less infrequent now! and I'm like, I know stuff, and… it's just all flowing a bit better, and all this stuff you've learnt in theory, you are actually getting to practice in practice…. Automatically… switched into what I would do, as opposed to what I am learning to do, for one day when we eventually get there……. yes, this is going to be real, very soon".

The sense of anticipation as they stood on the brink of registration caused mixed feelings for the participants. In the same way that changes to professional profile invoked some anxieties when contemplating the implications of not being a novice, so realising that they are assimilating the building blocks of expertise, was both exciting and foreboding.

- Reasons not to be in blue

Some of the participants described their anxiety as they moved closer to inhabiting the role of the newly qualified RN. Danielle voiced her anxiety as she remembered working with a newly registered nurse, describing them as panicking, "like a startled rabbit…" as everything was new to her and "everyone else was rushing around…" so could not help her. Danielle was concerned about being the startled rabbit, anxious and without agency. The expectation was that, as an RN, she would have to work without supervision or support she currently receives as a student, with immediate effect. Wanting to avoid the panic she saw in others, she worried she still had much to learn and that time was running out, as she was a matter of months away from registration.

Similarly, Ffion voiced her own anxieties. As a student she believed that she could take her time to concentrate on practising complicated, complex activities, "… there's less time pressure in most places when you're a student…" but anticipated that on registration this would change instantly, "… if you're in blue (RN uniform), you're in blue, that's it, there's no distinction between newly qualified and twenty years on the job, you're in blue". Ffion considered at that point she would not be able to take the time she needed, or be able to practice skills in the same way that she was currently able to do. This immediate conferring of responsibility for people's safety and wellbeing, and an assumption of immediate competence, was anxiety provoking.

For Danielle, moving forward towards *becoming* was not a smooth process. Danielle could not begin to think of herself as a "nurse". She seemed confused because she was not sure about the space she occupied, "I have no idea, really who I am, what I'm doing". Having occupied numerous clinical localities as a legitimate peripheral student participant, and enjoyed the experiences in each, Danielle had become enmeshed in a hybridity of the hybrid landscape. Having equally fulfilling clinical placements had muddied the waters and bought her to an unexpected hiatus. Danielle described her struggle to "get my head around (being) a nurse…because I'm still trying to get to the end of it (the programme)". Her apprehension was obvious, year three required her to "step up… the expectation on you is that… you've done two years, pull your finger out and actually do what you're supposed to do in 6 months' time, because you might have a job!".

RNs were thought to have a great responsibility for administrative tasks, generated by, as Grace put it, "massive caseloads". This could be seen as problematic if it led to them having to make decisions about whether to prioritise direct patient care or complete the necessary paperwork. For Danielle, those prioritising direct patient care meant they could be "absolutely outstanding", whilst those considered to prioritise documentation would "rather hide in the office and pretend to do paperwork". Later, acknowledging that the dichotomy is more complex than choosing paperwork over patient, Danielle considered individual workload management to be a critical part of the nurse's role.

Time and how to spend it was recognised as being important. Bridie considered that as a student she had "…. a lot of time to spend with patients which I think is a luxury that is going to be taken away once I qualify". This time would be spent talking, "I've sat and listened to full life stories [from patients] and not had to walk away to do something else". Danielle agreed that this was part of her role, "I would rather spend all my time speaking to somebody and understanding [their situation] and then if I had to stay on a bit to finish off [stay late on the shift to complete paperwork], I would, rather than not…". Emma felt that as a student having longer to spend with patients than RNs could help the patient, "I feel like as a student you can just observe patients sometimes, we can pick up on things that maybe nurses missed?". As she relished the student's freedom based on her supernumerary status to "spend an extra 5 or 10 minutes with somebody to build up a relationship…" Alice thought

that post-registration, these opportunities would lessen, and their time as RNs would be configured very differently. The apprehension was that they would spend less time with patients.

In making the most of their supernumerary position, students were given opportunities to visit different clinical areas for short periods of time whilst on placement. As Grace remarked, "we get to have a nose at what other jobs entail… almost like 'try before you buy!'". Danielle considered time in one service helped her to identify how services interact with one another, "… I think sometimes you don't appreciate how each service links in with another service…. or doesn't".

Nicholl and Tracey (2007) suggest professional networking, securing professional relationships with those in other areas of work to form connections for mutual benefit is invaluable. Forming alliances in this way can lead to future collaboration, peer support, sharing of ideas and practices. Networking opportunities had come through the IPE activities, reflecting the development of Wenger-Trayner and Wenger-Trayner's (2015[b]) "flat" landscape. Bridie, for example, was pleased to have swapped contact details with others in her IPE group and she intended to make use of this when in clinical practice, "… (we) are going to be working with other people (other professionals) when (you) qualify so I think it's good to start as a student, building relationships". The significance of the alignment element of Wenger's (1998) modes of identification can be seen clearly in IPE when students participate and are engaged.

(ii) Moral undertaking

- Worthiness

The participants were clear that mental health nursing was niche, not easily knowable by themselves or others, but the benefits of facilitating the wellbeing of others outweighed a lack of role definition. Values such as honesty, compassion and trustworthiness might be more important. The assimilation of cultural norms, integral to the hidden curriculum, was well underway. The participants believed that mental health nursing was worthy of their present attention and continuing commitment.

The nature of the nurse – patient relationship is demanding. Described as "a significant therapeutic interpersonal process" (Peplau, 1988, p 16), it relies on the formation of an alliance (Hartley *et al.,* 2020). This is an individual personal relationship between two people that requires maintenance and needs attention for it to thrive. Engaging in and managing these relationships from a nurses perspective can be quite daunting, as it is a significant undertaking that requires a level of skill to do so. There is evidence that managing any therapeutic alliance can be onerous (*ibid*) and it needs careful curation (Hurley *et al.,* 2022, Harris and Panozzo, 2019). Given the level of difficulty, it is reasonable to assume a level of worth.

As they aspire to their professional registration, the participants were able to describe the worthiness of this pursuit to themselves as individuals and to the wider community. Grace illustrated this when thinking about her future self, "I want to be like, 30, 40 years down the line saying, you know, I'm doing a job that I still love and that's made a difference (to other people) and it's been really worthwhile". Put simply, Danielle considered mental health nursing as a "really worthwhile job".

There was a sense that mental health nursing is of use to society, despite chaos and challenges. Ffion considered, "when you say, "I'm a mental health nurse", they (others) take it a bit more seriously". This was explored a number of times, "more people are recognising what mental health nursing is, the importance of it, so I think it makes you feel more secure, knowing what you do". Danielle and Alice gave examples from practice of mental health nurses working in traditionally non-mental health environments, and considered these as examples of the value attached to the expertise and knowledge of these nurses in the community.

Other people's thoughts about mental health nursing were influential. Ffion described being part of a family and having a "proud mum" who was quick to tell strangers in public that her daughter was a nurse, "Oh this is Ffion, she's a nurse", having become the "nurse in the family" (Keeling and Templeman, 2013, p 20). Reflecting on this apparent declaration of pride, Danielle concluded, "it's just one of those professions, isn't it? I think it is just well received, everyone's like "oh you're a nurse, that's so good!", Alice agreed, "especially mental health nursing".

Mental health nursing was seen by the participants as a worthy pursuit, and they were also pleased that those close to them saw this as well.

- Through a different lens

Ffion, Carly and Grace expressed their worries relating to identity and role, believing that whilst they themselves could not steadfastly identify the nurse's role, patients could pay the price for this, seen in the possibility of falling through gaps in service provision. The sense of uncertain definition was seen to extend into post-registration practice, which was anxiety provoking. Grace contended that there is a lack of identity and role clarity, "… it doesn't feel like anything is set in stone and defined in terms of what is entirely your role or someone else's…" Although this provided the necessary flexibility (as each patient's needs are different and each area is a specialty), this is problematic. Unclear boundaries could put patients at risk, "they're (another professional) "is this my job?", is that your job? When someone's got to do it and then someone doesn't want to do it because there's already too much going on…". Pomare *et al.,* (2018) describe the nuances of "professional role uncertainty" (p 5), similarly identifying issues about their own agency and scope of practice felt by nurses working in multiprofessional mental health services. Grace thought it was stressful not to have a definition, but acknowledged that it would be difficult, "because flexibility is so necessary".

Wenger-Trayner and Wenger-Trayner (2015[b]) identified a potential use for boundaries between professionals as they can provide opportunities to negotiate and to gain further knowledge and enhance self-development as a result. Perhaps for novices this is something that they can look forward to, once they have developed a firmer understanding of where they sit in the landscape of the RN as their professional socialisation unfolds.

Barker and Buchanan-Barker (2011) argue that mental health nurses have no unique interface with this patient group so any accepted role of the mental health nurse has no real basis. They contend that "… the concept of mental health nursing has grown in popularity over the past 35 years, (but) it remains a myth. People believe that they know what it is and value it highly but cannot describe or define it other than in vague terms" (p 337). Although

it may be simplifying the point these authors make, this highlights difficulties in articulating the underpinning philosophy, which feeds into the students' consternations about role and responsibilities.

Butterworth and Shaw (2017) agree that there is some difficulty briefly defining mental health nursing and what mental health nurses do. Although it is not a mystic entity, it is not a simple construct. As previously, Warrender *et al.,* (2023) contend that mental health nursing can be regarded as a "cocktail of unique skills " (p 206) that are more than the sum total of what is formally taught and known, although theory does inform practice. These skills are found in "…immersion in relational practice…" (*ibid*) and take time to develop through "…good critical thinking, role modelling, experience and reflection" (*ibid*).

There is no definition but there is definitive purpose and aim and the ethos is captured. Connell *et al.,* (2022), Terry (2020) and Butterworth and Shaw (2017) are clear that mental health nurses do have a unique interface with the patient group, allied with the unique contribution mental health nursing makes, although it is currently undervalued. There is recognition that articulating the value of mental health nursing work must be addressed swiftly and definitively by the nursing community. Warrender *et al.,* (2023) contend that the unique contribution of mental health nurses is not acknowledged, as previously discussed, in the NMC's ambitions to future proof nursing, nor in the interpretation of the subsequent standards at the point of delivery.

To summarise, the scope of mental health nursing for the participants is not easily recognised and this is echoed within the wider collective.

5.3.3 Summary: Theme two – Visualising professional registration

In the push towards registration and learning to become mental health nurses, the participants were able to determine that they had developed professionally and changed personally through their experiences, but were not always sure of how or when this had occurred or what they had learnt in order to facilitate this. This may have been as a result of time served, and it was anticipated that the passage of time had brought greater

understanding of self in context, and this was linked back to increased levels of confidence. However, increased levels of confidence in practice did not wholly explain their learning.

Some participants gave examples of the resultant learning, what it looked like and felt like for them. Some identified how their learning helped them to contribute during the IPE sessions, enabling them to see that they were moving towards becoming. They realised that they had experienced a change to their identity; they thought that they looked to others like mental health nurses and certainly felt this themselves.

There were tangible patterns of knowing to be found in their narrative, but this was not easily articulated. It was not a straightforward trajectory to describe, seemingly part of the process of tacit learning but for most of the participants an accepted iteration of the identity of "mental health nurse" had emerged, as they learnt to become. The participants were clear on the purpose of the role of the mental health nurse and they described how IPE activities had been helpful in underlining the scope of the role, setting it into relief against the roles of other health and social care professionals.

The concept of trust in practice was significant to all, both being trusted by others and accepting that trust and to (eventually) comfortably demonstrate the ability to trust in self. IPE provided a good platform to test the practice of trust. Having others invest trust and knowing oneself that this trust was well invested based on experience and knowledge, was invaluable in terms of developing belief in own capabilities.

IPE had also helped them to identify themselves as future registrants and how they could legitimately operate within a team, and add value to the work of the team. This enhanced their own understanding of their identity and potentially helped the move towards belonging. They realised that they could, and would, belong simultaneously to the community of mental health nursing, and to the wider community of mental health and social care professionals.

The participants ascribed an individual sense of worth to their pursuit of registration, and it was also societally worthy, because of the benefit of their registration to those who need care. Being able to wear the blue uniform of the RN resonated with the participants, it is a desired state and represents a clear visualisation of belonging to this community.

The trepidation of registration and assuming the mantle of the RN, the responsibility this entails whilst being wholly accountable for ensuring patient care and safety, loomed large. Having others assume their competence and having to take accountability immediately upon registration, was both a daunting and exciting aspect of learning to belong.

Some elements of the imagined role, such as being overwhelmed by managerial tasks and needing to choose paperwork over engaging with patients, was worrisome. Participants understood that belonging to the community of mental health nursing relied on learning the administrative aspects of the role, with allied legal and professional responsibilities and this was integral to their professional profile. However, this was something that seemed to have the potential to get in the way of nursing practice and, therefore, be of detriment to the patient. Similarly, potentially detrimental was the feeling that, when working alongside others, the interface between the responsibilities and scope of different professions was not well demarcated.

As the door to becoming mental health nurses was opening, achieving the status necessary to remain and to belong to the community of mental health nursing beyond this, through demonstrable learning, was tantalizingly close. The individual pursuit of registration, of belonging through becoming, was considered worthy and there was an understanding of the wider benefit that mental health nurses bring. The participants wanted to belong to the community of mental health nurses. Recognising the significance of having a strong sense of resilience and a high tolerance threshold, they clearly considered themselves as being adept at working with uncertainty in trying circumstances. Mental health nursing is often unpredictable (Cranage and Foster, 2022) and these participants were largely confident that they could manage unpredictability.

5.4 Chapter Summary

In this chapter, I have presented the findings from the focus groups. The groups yielded a wealth of information from the participants who described important aspects of their studentships, and in doing so offered a clear insight into how mental health student nurses narrate their professional identity.

The participants found themselves to be a good fit with mental health nursing from the outset, in terms of personal philosophy, as they wanted to work with vulnerable people with mental health problems. In doing so they met their own expectations of themselves both morally and professionally, and they regarded working with the client group a privilege.

However, they found it difficult to articulate and define the role of the mental health nurse although they knew what they thought the qualities required were, such as compassion and the ability to care, and thought they innately held such qualities themselves. The ability to hold onto hope for others was significant. Ambiguity potentially blurred lines of accountability with other professional groups. An unclear professional identity often led to lack of role clarity and uncertainty as to who would deliver care, was considered to be potentially detrimental.

However, IPE was a useful tool to facilitate learning about the roles and responsibilities of other groups of professionals, helping them to assess their own contributions to patient care, and their place in practice. They felt like mental health nurses working in teams and adding value to the work of the team. Engaging and participating in university-based IPE was welcomed as an interesting mode of teaching and learning.

Participants found their work emotionally challenging and realised that they needed to adapt themselves and their behaviours to fit into different clinical environments and work with different groups of people, to be the chameleon, although sometimes they worked on instinct. Being supported by and supporting peers was an intrinsic part of their practice, and developing personal resilience was an important aspect of being a mental health nursing student. Their fortitude was tested by the incivility of staff towards them. Such behaviours came as a surprise but became accepted and could be anticipated, something that was to be tolerated.

The participants described changes that had occurred as a result of their experience although it was not always clear how or when the changes had been facilitated. Tacit knowledge was an integral part of their evolution. They described changes in their current status as they moved from novice, through becoming, as they looked beyond, into belonging to the mental health nursing community.

Articulating how to learn to belong to the community of mental health nursing was intrinsically challenging, because it was difficult to identify learning that had occurred during the journey of becoming and how this had happened, emphasised by the lack of agreed definition of identity. The hidden curriculum of professional socialisation was in evidence as they became comfortable with themselves and their understanding of the values and norms of mental health nursing.

The participants were aware of some of the challenges that they still had to overcome in order to move from studenthood into the community of registrants, and some were very wary of the perceived difficulties associated with this. Fortunately, the imagined benefits of facilitating the mental health of others, and in doing so meeting their own expectations of themselves and achieving their ambition of registration, seemed to outweigh associated risks.

The pursuit of mental health nurse registration was individually rewarding and satisfying, meeting individual needs and validating concepts of being innately fit for purpose to the benefit of those they wished to work with. It was also a worthy pursuit within and for the community and there were wider societal gains to be found in their endeavours, which others appreciated.

The following findings chapter is presented as two vignettes telling the stories of two participants, Danielle and Grace, as they negotiated their way through their student deployment, following workforce changes due to the pandemic, as outlined in Chapter 1.

Chapter 6

Presenting the Individual Interview Findings:

Danielle and Grace's Stories: mixing the colours

6.0 Introduction

This is the second of the two findings chapters and reports on the individual interviews. As previously indicated, these interviews were unstructured so to encourage the voices of the participants with the lightest filter possible. Their situation in time, space and place was unique. Nursing students had, until this point, never been in the position of working through a pandemic. In this chapter, I explain the organisation and structure of the findings and how Wenger's STL has been used to explore these. Firstly, Danielle's and then Grace's stories are documented, summarised individually and as a whole to demonstrate similarities and differences in their stories.

I begin by providing some further background to explain the situation the interviewees found themselves in.

6.1 Prologue

To recap, as set out in Chapter 1, at the end of March 2020, a jointly authored document from the Welsh Government (WG), NHS Wales and Health Education and Improvement Wales (HEIW) set out changes to nursing programmes, described as having been negotiated between themselves, the NMC, The Royal Colleges of Nursing and Midwifery, the CDoH and UK central government. This document set out emergency measures meaning eligible student nurses in years 2 and 3 on pre-registration undergraduate programmes could be deployed to clinical practice as students, being paid by NHS local health boards. They would lose their supernumerary status and would be allocated an RN mentor.

It stated that students would be given "appropriate support and supervision within an appropriate delegation framework" (WG, NHS Wales, HEIW 2020, p 7). They would retain their academic studentship for 20% of their working week (one day per week), but would be on deployment in practice for 80% of their time, but not as employees (*ibid*). The students would be contracted and be paid for 30 hours at the agreed Agenda for Change Band 3 pay

grade and could be placed anywhere in line with local clinical need. Maintenance loans and bursaries would continue as normal.

There was only one point underlined in the whole document, suggesting its significance and acknowledging the interest it would have for students. It states, "You will continue to wear your student uniform when you are working in clinical practice" (*ibid* p 9), revealing the apparent deliberate hybridity of the role; simultaneously student and employee. This applied to the majority of the participants in this study who started 12-week contracts of deployment on 27th April 2020. At the end of their contracts most returned to the accepted status of student, once again supernumerary and, consequently, unwaged.

All eligible nursing students in the UK from all four fields of nursing were invited to opt in or opt out of this scheme. The complex, unchartered, social and clinical landscape was beset with complicating variables such as their own health, the health of those close to them, other practical reasons and personal choice (Swift *et al.*, 2020). The decision was not easy but had to be made quickly.

In Wales, those who could not opt in or did not want to, were advised that they would be "supported by (their) your university to consider the options available to you… including a period of authorised absence or a suspension of studies, or if available, an alternative academic pathway" (WG, NHS Wales, HEIW, 2020, p 7). At Cardiff University, there were no immediately available alternative academic pathways and in March 2020 it was initially decided that the alternative pathway would be suspension of the student's studies for 12 months. This meant that on return to the programme they would join another cohort of students and graduate 12 months later; aside from opting-in, this was the only option.

Godbold *et al.,* (2021) describe students' difficulties in deciding whether to opt in, and more widely it was clear that students should have been facilitated to have free choice (Ulenaers *et al.,* 2021, Swift *et al*., 2020). The risk of creating "two cadres of nursing student…" (Hayter and Jackson, 2020, p 3115) was acknowledged, with the possibility that those who opted in would be regarded more favourably, as those carrying out their duty. This sense of obligation is widespread (Kane *et al*., 2021, McSherry *et al*., 2021) As Danielle later described the situation she found herself in: "It was pretty much, you opt in or get back-cohorted (studies suspended for 12 months) we didn't really have a choice, did we?". At the time of the

interviews Danielle was half way through her contract of employment and Grace a couple of weeks further on.

6.2 Organising and Structuring the Findings

Here, I present the findings in the form of two separate vignettes although there is a theme which runs through both stories*, Understanding*. This theme is comprised of two constituents, feeling lost and the reality of deployment, although there is overlap between the two. This in mirrored in the learning as experience element of Wenger's (1998) STL, "meaning". Both Danielle and Grace are trying to draw meaning from the situation.

6.2.1 Theme: Understanding

This theme relates to Danielle and Grace's attempts to firstly develop an understanding of the landscape before they could begin to understand their experiences, a tremendous task during the pandemic. Understanding can be seen as three threads; no understanding, little understanding and misunderstanding. These, although not exclusive to Danielle and Grace, as evidenced in Chapter 5, were part of the hinterland they came to occupy.

6.2.2. Meaning, Learning as Experience

Making meaning out of individual experience as a mental health nursing student would usually have occurred as part of an iterative, process of negotiation and re-negotiation. Here, Danielle and Grace initially have some difficulty exploring this process because of their position in the hinterland, which started off as a very unpleasant experience, "feeling lost". However, as time progressed and they became more familiar with an environment that itself had lost familiarity due to the pandemic, they were able to explore "the reality of deployment".

6.3. Danielle's story

Danielle had worked previously in professional services for many years and decided on a life change, returning to university and embarking into the realm of mental health nursing. In the focus groups, Danielle had often steered discussions and facilitated others to explore their views. Her way of working in her previous professional life, in guiding proceedings was in evidence. During the interview, Danielle stated that through the pre-deployment period other students had asked her questions about what they would, or should be doing, looking

for her guidance, but she concluded that her "glass ball ... (was) a bit misty at the moment". Her eagerness to "get-on-with-it" (the deployment) came through very clearly at points in the interview, although this was not straightforward.

(i) Feeling lost

Danielle talked freely about her anxieties, recounting the time between the temporary cessation of the programme and the beginning of the new contract of employment, prior to being deployed into clinical practice. Danielle described the effects of the uncertainties of not knowing when the contract would begin, or where she would be working, as very unsettling during, what turned out to be, a six-week period of waiting: "it was awful, really awful, I've never felt so out of my depth… not out of my depth but… lost, if you like… I can't ever think of a time when I felt like that."

Danielle articulated her frustrations clearly. She considered that the university had not supported students clinically or academically and it was the latter that irritated her. On a couple of occasions during the focus groups, Danielle had voiced her trepidation about the academic requirements of the programme, but she seemed able to manage this through being organised and accessing peer support. Ordinarily, ongoing trepidation about achieving academically and meeting university and NMC expectations are not unusual in this population (Lees *et al.,* 2023, Kotera *et al*., 2021). Immediately prior to deployment, changes to the configuration of students' academic assessments had been described by lecturing staff as inevitable, but details of what this would look like were not forthcoming. Consequently, Danielle could not organise herself as she wanted. During the COVID-19 pre-placement period, she found herself waiting at home for details about her clinical deployment and changes to academic assessment. Quinn *et al.,* (2021) found students had been worried and confused during this time of rapid change, which appeared to be as a direct consequence of the leadership style of those making and enacting decisions, such as when and where students would be deployed. Henshall *et al.,* (2023) identified a lack of certainty and an apparent inability by those in charge, such as university and government leaders, to make decisions, had increased levels of fear for this student group.

For Danielle being "kicked out of uni" at lunchtime on the day in mid-March when the university shut down physically, was the starting point for her distress. She spoke about being asked to make the decision to opt-in or opt-out quickly, made more difficult by a lack of information about where they would go and what they would be doing. Preparedness was a wider issue for students across the UK (Henshall *et al.,* 2023, Kane *et al.,* 2021, McSherry *et al.,* 2021).

Danielle stated she was initially informed the timescale for the start of the deployment would be sooner rather than later, something that transpired not to be the case:

> "… you are going to be starting work on 6th April and everybody was like, 'Oh my god', nothing 6th April, nothing, no academic work, no 'work work', no idea of placements, everything was just completely thrown up in the air and left there and we were sat, it was probably the worst month I can honestly say I've had in the whole time I've been in … uni. It was awful and it wasn't just me, it was everybody…"

In the event, Danielle's contract of employment started on 27th April, approximately three weeks after the initially mooted date: this brought with it a crisis point. As a result of the changing situation, Danielle considered that if further changes were foisted upon her (for example a late transfer to another ward, which had happened to others), she would withdraw from the programme: "… I honestly thought 'if you move me, that's honestly my lot, I'm opting out, I can't cope with it anymore'".

Hayter and Jackson (2020), writing during this hinterland, asked "what is the evidence students are needed?". For Danielle, going out "four weeks late" meant "by the time we got to our ward, we had four, five patients on our ward (a 22 bedded ward) and there were like 500 of us! It was literally sometimes three staff to one patient." This juxtaposes with the experiences of other students, who found staff shortages commonplace, leading to increased levels of stress caused by pressure of workload (Griffin and Riley, 2022). This may be because adult and child nursing students were likely to be exposed to increased levels of clinical acuity whilst caring for physically unwell patients with COVID-19. In Danielle's experience, patients on a mental health ward, if their physical safety was relatively assured, had been discharged

home. However, over time patients were being readmitted and Danielle noted later that "…now we are busy and we are really busy greens!" (the colour of the HCSWs uniform).

For Danielle, the lack of certainty about academic schedules continued well into her deployment. The anticipated date of publication was sometime in May, but this was reset to the 27th July, the end date of the contract of employment. Danielle stated she had continued to read and study in preparation for several imminent academic assignments, but not knowing when they were to be submitted was causing consternation, "…I'm ready to do it (her dissertation) now, I just wish I knew what we were doing".

Whilst being frustrated by university processes and not having any input into decisions about schedules or placement, Danielle seems to have coped, as she developed a pragmatic, "get-on-with-it" attitude, although she felt let down by the local NHS health board as well as the university. She considered the two institutions had not worked in harmony, and consequently felt that she and fellow students had fallen through the gap that this presented. Danielle recalled examples from her peers being told by those in practice they were neither needed nor welcome,

> "… they (fellow students) are ringing their placements and they (nurses in practice) are saying 'we don't want you because we don't need you', and they (fellow students) are like, 'well you haven't got a choice', 'well we haven't been told we're having you'…. I think it's been really quite distressing."

All students were given their deployment details by the university, and university staff did not appreciate there would be this sort of negative response from nursing staff in clinical areas. Godbold *et al.,* (2021) explored similar scenarios elsewhere for students who were lost in a world of uncertainties, as some were in unfamiliar clinical areas with RNs who themselves were unfamiliar with the work, having been transferred from elsewhere to plug gaps. Danielle was pragmatic and resigned herself to the experience of her deployment: "I can't change it, so I've got to make the most of it… there's no point in moithering about it…". This developed attitude of commitment was not unusual for similar groups of students (Goodwin, 2021). However, it was clear going into practice as an employee who looked like a student would not be straightforward.

In the NHS, in Wales, uniform colours for nurses and nursing students are standardised (Welsh Assembly Government, 2009) helping to offer quick and clear information about the wearer to patients and others (Shaw and Timmons, 2010, Spragley and Francis, 2006). Uniforms should offer the beholder a variety of assumptions, such as rank, authority and agency (Ely and Stephenson 2021, Jones-Berry 2020[b], Stone, 2016). As the visual representation of status with implied expectations for standards of behaviour, competence and ability (RCN, 2020) uniforms are a fundamental part of nursing identity.

During the focus groups it was evident the colour of their uniform (purple) and what this represented, was important to the students. This was emphasised in the second focus group as the participants edged forward from the purple of the student uniform, toward the blue of the RN's uniform. Danielle was clearly aware then that the colour was a symbolic and significant identifier of rank, and assumed capability in the hierarchy. Having joined the nurse bank during her studentship to work as a HCSW in her own time, Danielle also often donned the green uniform of this additional role.

At the outset of the interview, Danielle considered that when she had been on placement as a student pre-pandemic, in her own mind, she purposefully and simultaneously took the role of HCSW, "if you go out (as a student) and you work the ward, you do the green, even if you're in purple". This was significant: engaging in two different roles simultaneously seemed to help Danielle understand the student role, setting it into relief in the wider clinical context and helping the transition from support worker to student to registrant. She was happy to carry out the two roles side-by-side, but described knowing the difference between them and felt different performing each one, though this was manageable. There was clear understanding about boundaries (such as activities students could not do but HCSWs could) and expectations (students were assumed to take on managerial and leadership responsibilities that HCSWs were not). Danielle was confident in herself as a student (in purple) and had also been extremely comfortable with the HCSW role, "…when I wear my green uniform, I go in knowing exactly what my role is….".

During the pandemic, though, this changed significantly. The hybridity born of deployment caused confusion. Danielle's formerly identified opportunities to be both student and HCSW concurrently, had been usurped by the temporary shift from student to student/ employee.

Ordinarily the role of the student was, in part, defined by a supernumerary status which, as previously indicated, was revoked for the period of deployment:

> "…we are in the numbers so with all the best intentions of them (WG, HEIW, NMC) saying you need to be a student …..fundamentally you are still a student, you still do a student role but you are (counted) in the numbers, (and so being a student) absolutely goes out of the window. You are in the numbers and you will do the job. You will do a green job, without a shadow of a doubt…"

Danielle was perplexed about her status, "… when I've got my purple uniform on, I go in, and I sometimes haven't got a clue who I am...I feel as though I am a very competent green, but I'm not a green, I am supposed to be a student…".

Danielle's uniform represented her identity and provided an anchor of stability, but this had been changed for reasons beyond her control. It was now not possible to retreat to the comfort afforded by the "green" because taking up the HCSW role was no longer an option. "I feel as though I should have green bottoms and a purple top or a green top and purple bottoms!", two roles were now merged to form one rather than as previously, two discrete parts. This was disquieting for Danielle.

This was a faint echo of a schism to be heard in Danielle's words that seemed to surface during the focus groups. In the first focus group, Danielle appeared assured and confident, but as registration came closer, this confidence seemed to falter. In the second focus group, she expressed her misgivings that had grown between clinical placements, she was unsure of her status of "student." Already, pre-COVID, there was a sense of unease, anticipating the shift into registration. Therefore, in the immediate pre-deployment period, the immense changes to her position as a student nurse may have seemed overwhelming to Danielle; shifting sand on top of shifting sand with reducing permanence and ever-increasing levels of anxiety.

(ii) The reality of deployment

In making the most of her clinical experience, Danielle described herself as having to be "selfish" to achieve what she needed. She explained that students in her cohort were due to

have one final "management" placement, Practice Learning Opportunity (PLO7), after this period of deployment, to allow them to achieve competencies so to be able to complete the programme, and register as a nurse. It was not clear to Danielle whether she would be able to do that in a timely fashion, a common worry for some students (McSherry *et al.,* 2021, Swift *et al.,* 2020). Danielle worried that a potential second wave of COVID-19 could influence her trajectory and the placement after deployment would not materialise, delaying registration.

Danielle described this "constant not knowing" as a source of concern and the reason for her "selfish" approach. Whilst Danielle did have a mentor who was nominally able to supervise her practice, this was not an easy relationship to manage because of her mentor's limited availability, "… to be honest our mentors are basically not even on the same shift as us because we're backfilling where the holes are." Being "selfish" involved purposefully striving to engage mentors and other staff in practice to achieve competencies and get them signed off, rather than simply carrying out the work without assessment or reification, "…well yeah to be fair, I ram (my portfolio) in everybody's face!".

Whilst students were quietly discouraged from taking their portfolios into the practice area with them by the university, acting on NMC and HEIW guidance, Danielle made it clear she would not be discouraged, telling her mentor, "… right, I need to do this (the competency) because you need to sign this off".

Not all students were able to be as assertive as Danielle described herself, the cause of stress for some who could not complete their competencies (Godbold *et al.*, 2021). Danielle described some of her peers who were in this position, and she thought herself "lucky" in this respect, but recognised luck should not be the reason competence is assessed or is not assessed.

However, despite being a student in name, Danielle explained she did not feel like a student, and she did not consider herself to be one. Whilst she had pushed to achieve her aims as a student, she felt she had "missed out massively" in not taking the student role. In the previous academic year on the immediate previous placement, Danielle felt she had learned a great deal but was now unable to build on what she had learnt. "I feel as though I haven't

been given the option to practice my skills and I worry that… if I'm honest that I'm going to end up qualifying and not having learnt anything in this last year." Whilst stating she did not believe she had been de-skilled, Danielle regretted lost learning opportunities. For some others, the experience of spending this period in practice gave them time to develop a greater sense of self as nurse-to-be, which helped develop confidence, which itself had a knock-on effect of increasing levels of competence (McSherry *et al.,* 2021).

Being in practice as a student/ employee did have some advantages though, which Danielle appreciated. This deployment was longer than all individual previous placement experiences through the programme, sometimes referred to as an Extended Clinical Placement (ECP) (Haslam, 2021). This meant a greater exposure to working with the same individual patients for a longer period:

> "So, I think some of our patients have been there since I've been there, some of them have gone (been discharged) and come back since I've been there… really unwell… and because you've been able to have worked with them so long, it's that, you know… and it's all of a sudden you can see that patient's mood lift and… which you don't get when you are a student on a short period of time, you know?"

In terms of understanding the patient journey and spending time with the same patients for therapeutic purposes, this presented an ideal opportunity, something students elsewhere found valuable (Godbold *et al*., 2021). Danielle did not think her extended period in the practice area had either positively or negatively affected the patient experience, and she was still seen as a student because of the colour of her uniform, "they (patients) will ask you and confide in you regardless, it's what relationship you have with that patient not what colour your uniform is (that matters)".

Additionally, Danielle was able to realise "what it's going to be like to work" as opposed to being a student in the workplace. In the same way that she did not think of herself as a student, she did not think she was on placement, "…. I've just thought of it as going to work...". McSherry *et al.,* (2021) identified professional practice as a benefit for students who opted in. They found students appreciated the "real world learning" (p 11) deployment offered them, although the removal of supernumerary status was equally cursed and blessed,

causing confusion (Godbold *et al*., 2021, Kane *et al.,* 2021). As Danielle explained, "yeah and we're in the numbers (counted on the rota) and they expect us to be there so when they're putting their rotas together… even though it says, you are a student... at the end of the day, you're in those numbers. So, how can you not be an employee rather than a student?" For Danielle, allowing herself to be an employee in the workplace was how she visualised and managed the situation.

When commenting on the work environment during one of the focus groups, Danielle had expressed her frustration at RNs who she considered spent time in the office when they did not need to, and so had reduced patient contact as a result. However, during this work placement Danielle acknowledged that as a registrant, it is likely she will be bound to the office to complete the administration that RNs need to. This extended period in practice had enabled Danielle to consider the nursing team from an employees' perspective, seeing things students were protected from. She concluded, whilst "bitching behind each other's backs (about, for example, the length of time some nurses spend in the office), goes with the territory, so does working together and "covering each other's backs, when it's needed." Being part of a supportive team was important to Danielle and added value to the experience for other students elsewhere (Griffin and Riley, 2022). Henshall *et al.,* (2023) found such relationships "were reported to be valuable in helping students feel part of a workplace community, … connected to the nursing profession and supported." (p 7). Belonging to the group in this way was an important supportive factor for Danielle, something others elsewhere also came to value.

The importance of personal and professional boundaries were highlighted for Danielle over this period, demonstrated by her stated intent to avoid a cliquey culture where personal friendships might try to influence non-clinical decisions, but decisions which affect the clinical environment. Having a "low need for affiliation" with others when in a leadership position, negates the need to pay special attention to personal relationships (Yukl, 2013, p 146), seemingly an ambition for Danielle.

Danielle was keen on discovering more about the process and practice of accountability whilst she was an employee; making clinical decisions and being responsible for the outcomes of these decisions is an integral part of the RN's role, professionally and legally

(NMC, 2018[b]). For some, feeling as if they had too much responsibility was overwhelming. Anticipating taking accountability in the midst of a chaotic clinical environment was alarming (Griffin and Riley, 2022).

For Danielle, holding accountability was easier to envisage as a student/ employee than as a student on placement. During the second focus group Danielle had recounted her experience of working with a newly qualified, anxious RN, worried about having to take accountability in clinical practice. In this interview it transpired this new role of student/ employee (although confusing) may have been a useful buffer for Danielle between the two stages on the practice continuum.

6.3.1 Summary: Danielle's story

For Danielle, deployment into practice as a paid employee was an inevitable next step in her studentship as she had been unable to opt-out. The most significant impact on Danielle was the distress caused during the period of waiting to go out to placement when she described loneliness and feeling lost. This was peppered with uncertainties leading to significant anxieties that had threatened to destabilise Danielle's ambition to be a mental health nurse. To counter these thoughts and feelings, Danielle had resolved to consider herself to be an employee, whilst ensuring that she addressed her requirements as a student. From this time, she was able to see herself in practice in the future and consider how she wanted to be.

6.4 Grace's story

Grace came into studying mental health nursing several years after she had left school. She thought she had started the programme with a good understanding of what mental health nursing could offer. In the first focus group, Grace had spoken about her parents who were both mental health nurses. Their work had impacted her childhood positively, and influenced her decision to work in mental health services, and her decision to study to become a mental health nurse.

During this interview, Grace commented on the unexpected impact the first focus group had on her. It was in the group that Grace had actively started to think about siting herself as a

mental health nursing student, who would soon progress and become a RN. Grace had come to realise her identity was important to her but it had not yet been defined, and thought other students were thinking and feeling the same. The concept of herself as an RN was something she had not thought about in depth: there had not been any real consideration of what that would mean to her, or how it might make her feel. She came to understand she had thought it would just happen, she would come to be an RN through time served, competence measured and assignments achieved. Grace then realised she needed to be present in this process, it would not be automatic.

The rapid and unexpected shift in status, from a supernumerary student beginning to think about her identity as an RN, to a student on paid deployment in practice, made the process of assimilation more complicated for Grace.

(i) Feeling lost

Grace described her speedy re-evaluation of her identity, as uncomfortable, "jarring…. at first we didn't know what we were". Conscious consideration of her identity at that point was not easy, "how do you identify yourself as something you were learning to identify yourself as, but in a hurricane? Everything is up in the air and unknown". In the period between the suspension of the programme and the deployment, Grace detailed her anxieties, when she felt as if she did not know what would happen next or when or how it would happen:

> "(it was) scary, pretty scary… for everyone, the newness of everything that was going on, my anxiety levels were going through the roof but at the same time I felt calm about it because it was so out of anyone's control. I was like, 'I'm following the guidelines, that's all I can do'".

Grace perceived a lack of meaningful communication between the university and the health board had fuelled levels of anxiety: "…a lot has been lost between uni and the health boards and everyone's been trying their best but it's just been so confusing", not an unusual situation for students in Grace's position (Henshall *et al*., 2023). As an example, Grace described erroneously receiving information telling her she was to be deployed to work in a clinical area specialising in treating the most unwell patients with COVID-19, "… I'm a mental

health nurse, I don't want to do that!". In the event, Grace felt she was not needed in practice, "…there was such a struggle placing us anywhere in the end, I was delayed going into practice by two weeks, I think during that time I got anxious again… (I thought) if it's such as struggle to place us, we're really not needed". When Grace started her deployment, there were five students, six patients and seven staff on the ward. Her fear that students were not needed to work as employees was quickly realised, "…I've never seen the ward so well staffed!". She felt superfluous to requirements.

Overstaffing was certainly not something experienced by all student nurses on deployment (Hayter and Jackson , 2020). Griffin and Riley (2022) described students who were happy with staffing levels and had access to a plentiful supply of PPE, as a clear minority. The phenomenon of overstaffing in specific clinical areas is not yet explored in depth in the literature, but could be explained when considering the management of mental health in-patient services at the time. If the physical health of patients could be reasonably assured, patients who did not present as acutely mentally unwell or in crisis could be discharged home, into the community. Villaseñor *et al.,* (2023) determined that in mental health services, in England at least, during the first three months of lockdown when Grace was on deployment, bed occupancy fell. This placed pressure on services elsewhere and raised separate issues around the (potential over) use of mental health legislation (Payne-Gill *et al.,* 2021) but, understandably, sought to ensure the primacy of acute physical health needs which were prioritised.

Grace acknowledged the decision to opt in, to put herself into the position of being an employee and to put her studentship on hold was hers, and she felt she was "always going to help…whether… paid, or not". Grace did consider that opting out could have helped her to focus on the academic elements of the programme but she knew for her this was not really an option, "I knew I never would, (opt out) ever". Grace noted the media focus on concerns about healthcare provision was influential, "…the news… made it sound like everyone was in dire straits…", reflecting a wider pressure that undoubtedly existed on students to go into practice (Godbold *et al.,* 2021). Although she was not frightened for herself (of being infected), like many other students (Barrett, 2022) she had concerns for others, "…I was only ever worried for my family", something of a common experience (Bogossian *et al.,* 2020). Students were aware that their families would be impacted by their choices (Townsend,

2020). For Grace, having a task to focus on and remain busy for personal and professional reasons in a difficult and very challenging world, helped her decide to opt in, "… we've come into this profession to help people…. (and there is) personal obligation…. based on… values, morals, I guess".

This sense of duty Grace experienced was widespread within the student nursing community (McSherry *et al.,* 2021, Hayter and Jackson, 2020). There was an emotional element to the decision-making process because of the nature of the risks and benefits involved, constantly fanned by uncertainty and fear of the unknown. Hayter and Jackson (2020) voiced concerns about whether students had been able to make properly informed choices, given the lack of information available and the need to make the decision quickly.

In the focus groups, Grace had bought up the concept of the anonymous, homogenous and ubiquitous student. At that time, she was clear nursing students should not be considered in this way and should not be referred to exclusively as "the student" by staff in clinical areas, as they often were, because they were seen as interchangeable, stayed for short periods of time and came and went often. She thought it was lazy and rude not to try and learn other peoples' names. During the interview, Grace considered the nature of being a student again.

Grace was one of a number of student/employees on the ward, all of whom wore the student's purple uniform and PPE, which covered their faces. In these circumstances, Grace was happy to be called "the student", knowing it was more difficult for others to quickly discern each of them as individuals because they were, literally, faceless. Indeed, later, Grace felt being easily identifiable as a student just by virtue of a purple uniform could be an advantage. As Grace pointed out, she was still a student and still needed to give the message to others, "please remember I am a student, I do still need to learn!". The purple uniform confirmed her identity as a learner. The single word label "student" was helpful in this context for Grace. Even though she was one of five people in purple, and it was difficult for others to know which of the five she was because her face was covered, she still stood out clearly as "student" but as she explained, this did not guarantee learning opportunities. Feeling unsupported as a learner was not an unusual situation for some students (McSherry *et al.,* 2021).

Initially, there were two students six months behind Grace on the programme, and two were six months in front. The latter were on their final placement, (PLO7), prior to completing the programme. Grace thought they had possibly been more entitled to the "student" status to help them achieve the competencies specific to PLO7. For them, undertaking this practice period as a student was fundamental to them completing the programme on time, which she would not be able to. Grace felt she had "disappeared in the middle section somewhere" between the two students behind her (who needed more support as they had less clinical experience) and the two in front . Due to the staff/ patient ratio, Grace thought there could have been scope for all of them to be supernumerary but realised this was not an option, as they were all paid employees who were equal. As she noted,

> "…don't get me wrong, it was great, I've never seen such good staffing levels but at the same time it was like 'wow, we are so not needed' (and now) it still doesn't feel like we're needed but we are definitely being utilised…".

(ii) The reality of deployment

Grace accepted that she should not expect to achieve clinical competencies as she would ordinarily have done on placement. This caused a great deal of anxiety, underpinned as it was, by the original confusing concept of the student/ employee. Grace and her mentor in clinical practice posed questions that remained unanswered about how the process (of being a student on deployment) should work. As Grace did not know what was expected of her and could not find answers to her questions from elsewhere, she determined that, in the end, she was just "trying to get on with it…".

> "….I've just been going through my portfolio at home and sticking stickies next to competencies I think I have. I saw my mentor briefly… so I thought I'd stay late which I'm not paid to do but … I haven't seen him in three weeks at all and I need to get this portfolio sorted out (quickly)… he seems very blasé about it all…'I'm happy that you're competent, I'm happy to sign'. Well, that makes one of us!"

On balance, if given the choice, Grace would rather not have been paid, and in return retained her full, supernumerary student status to be the student she wanted to be to prepare for PLO7, her next, and final, placement. This final placement before professional registration represents a robust test of knowledge and ability that requires careful preparation. This weighed heavily on Grace, and although she accepted this, "there is not the capacity for me to be that (student)" she was frustrated by the accompanying lack of agency:

> "…there's a lot of very nurse specific activities and roles and jobs I need to know or be confident and competent in… the stark lack of my ability to be able to do that on this placement is in my head, …I feel like that clock is really prominently ticking now and I have certain things I really need to work on… and occasionally there's been an opportunity to look at some things but it's just really…. it's not there…."

Grace did not often think of herself exclusively as a student, "…I work four shifts a week so I would maybe say that one of those shifts I feel a bit studenty…". Instead Grace thought of herself as employee who was seconded to work who needed to have to have "studenty experiences". However, she noted the "studenty experiences I have are few and far between". Although she tried to always "think like a student", it was difficult for Grace to practice as a student because she knew she was not doing activities or learning things she must achieve as a student, "…I feel like I'm always in-between", positioned as she was between the two other groups of two students which was a disadvantage.

Given her and her mentor's uncertainty about the role, how to balance employee/ student status, is was not a surprise to Grace that some other members of the clinical team did not understand the newly imagined student role either, "it feels like the health care support workers think we're health care support workers, management seem to think we're health care support workers, and the nurses don't know what we are!". Misperception by other staff on the scope of the role of students as employees on deployment was not unusual (Griffin and Riley 2022, Godbold *et al.,* 2021, McSherry *et al.,* 2021).

Grace was often asked to do work beyond her scope of practice as a student and she needed to be assertive, "I can't do that because I'm still a student". This could have been frustrating for Grace as well as other members of staff as Grace, like many of her contemporaries, had

also worked on the nurse bank in the green uniform of the HCSW, outside of her studentship. As such, she had been trained to carry out some duties she could not do as a student. Grace gave the example of being asked to spend time on close observations with a patient who was unwell and was known to hit out, and who would probably need to be prevented in some way to limit this behaviour, to keep them safe. As an HCSW she could have done this as she had been appropriately trained to restrain a person but as a student, she could not touch anyone to restrain them as that is outside of the students' role; physical restraint was not something she would learn as a student, nor would she expect to learn, so she could not complete the close observations on this occasion. Initially, being constrained in this way had caused some tension with the HCSWs on the ward with whom Grace worked most often, "oh she just doesn't want to go with this patient…" could be given as the reason for Grace turning down some of the jobs allocated to her. Some staff may resent the boundaries of practice imposed on Grace, interpreting her inability to carry out the tasks as laziness or being too choosy. Set into the general context of uncertainty at the organisational level, some HCSWs regarded the student employee differently and they were not always positively received (McSherry *et al.,* 2021).

Conversely, Grace perceived that some HCSWs on the ward welcomed the presence of the students as it reduced the pressure on them, and spread the workload. However, this was not universal, as working students like Grace meant fewer overtime opportunities for the HCSWs, some of whom were "not happy" about this. This resentment related to the fact the students appeared to be expected to do less for more pay, a sentiment that did not surprise her. Grace had been asked directly about how much she was paid, and found talking about this uncomfortable as she suspected she was getting paid more than some of the established HCSWs. She tried to overcome this by working hard, "I need to muck in more", to prove her mettle. She also found her work a welcome distraction. Even though negotiating her way through and into the team was anxiety provoking for her, Grace found she had to be adaptable and her "priority has been to first fit in and make this as easy as possible". Grace considered the importance of adapting and fitting in, and making sure others understood that she understood her place in the team. This form of "impression management" (Goffman, 1959) was especially important to Grace who was aware some members of the

team were wary of her and may have attributed their displacement to her. It is pertinent to remember that Grace, in line with her contemporaries, was not given a placement choice.

Working hard and being seen to do so was designed to give others less reason to be unhappy about her presence on the ward and to be seen to be part of the team. Grace thought later she might have "shot myself in the foot" as her student status seemed to erode further as she worked through her contract. However, on balance, she was glad to fit in as a worker not stick out as a student/ employee because it was equitable, "I was like, 'I don't want this to be uncomfortable' so I just need to fit in and … meet their expectations of what we should be bringing to the table because we're in the numbers, and we're being paid". Later, it transpired one of the benefits of working closely with the HCSWs was feeling like a member of the team, having a sense of permanency as opposed to the brief period on placement usually experienced by students. Grace thought she was perceived in a different way by these other team members who appreciated her endeavours and hard work.

However, in general, Grace was clear, for her, this deployment represented lost learning opportunities and "lost time", something she referred to on a number of occasions. This time in practice should have been the placement for Grace to assimilate knowledge and skills from previous placements, and develop them to carry forward to polish off in PLO7. This was especially significant as if successful, Grace would pass the whole practice element of the programme. This stress was compounded by her mentor's attitude towards her, as she felt he was happy to leave her to work alone, seemingly confident about her competence, something she felt was "flattery". This was a confidence Grace did not share, furthering her own insecurities about a lack of preparation for PLO7, adding to her "pile of worry". Grace's "pile of worry" was shored up by her thoughts about the outstanding academic assessments, "…I feel like I've probably better used the time to write my dissertation".

Some of Grace's worries were related to PPE, which was requisite for all ward staff. Grace considered there was a change in the attitude of some staff towards wearing it, although this was not across the board. It was clear some were more mindful than others of the significance of PPE, despite being weary of it, '…it is what it is, it's what we need to do to protect the patients and ourselves'. More worrying for Grace was her perception that some staff were becoming relaxed about using PPE correctly:

> "…other people are much more like blasé with it and … 'well everything's relaxing now and it's fine we don't have to do it as much, it's less risky'. I guess it's still invisible so we don't actually know how risky it is, and also if one person brings it onto the ward it could spread like wild fire really quickly…. that could go really bad, really fast".

This was underpinned by the concern about patients not wearing PPE (they were not required to) and highlighted the potential for patient-to-patient infection. This is something that was almost inevitable in some clinical environments, and infection control caused specific professional, ethical and legally sensitive problems for different mental health settings (Brown *et al.,* 2020).

The mental fatigue and physical effects of long-term use of PPE for staff are well recognised (for example, Jin *et al.,* 2022, Tume *et al.,* 2022) as is the stress experienced during shortages of PPE, and not being able to follow PPE best practice guidelines as a result (Hoernke *et al.,* 2021). The situation described by Grace, whereby some staff seemed to demonstrate a sort of nonchalant approach to infection control, is, as yet, less well explored.

Grace was clear that the wearing of PPE had negatively affected her ability to develop and manage relationships with patients. Haptic touch, including managing proximity and space between and around one another, in addition to physical contact, is considered fundamental to many social relationships (Katila *et al.,* 2020). In mental health nursing, appropriate and measured touch is integral to empathic responding and maintaining nurse/patient relationships (Gerace, 2022). Avoiding touch underpinned the practice of social distancing during the pandemic, as limiting skin to skin contact could prevent the spread of the virus (Katila *et al.,* 2020). However, maintaining social distancing proved difficult, if not impossible for mental health nurses in many clinical environments (Foye *et al.,* 2021). Having to consider using touch conditionally (pre-planned and with gloves on) affected Grace and she thought it impacted on people who she thought of as "so unwell". It was difficult to pre-plan when gloves needed to be worn, and taking away the skin-to-skin contact, such as touching someone's arm with a glove on, somehow made physical touch less meaningful.

6.4.1 Summary: Grace's story

Grace accepted the temporary transition from student to employee, describing it as a necessary obligation, with dutiful undertones. Whilst she did not fully understand her new identity and found others did not either, she was able to adapt to what she thought the role might be, and make the best of it through working hard and being seen to do so. However, being an employee came at personal cost. Initially Grace expressed the distress and fear caused by uncertainties, some of which she explained as being an expected part of a pandemic (limited ability to control infection societally, for example) and those which could have been avoided (such as the waiting period prior to deployment). There was also a professional cost to this period of employment; opportunities to practice and develop nursing skills were either lost or did not transpire. Therapeutic engagement with patients was more challenging, sometimes impossible. In terms of professional and personal development, being an employee had been, for Grace, "more of a hinderance than a help".

6.5 Summary: Danielle and Graces' stories

Grace and Danielle expressed similar thoughts and feelings related to their period of deployment. The distress and anxiety experienced during the lapse between the suspension of their studies and the beginning of their deployment was palpable. Some of this distress can reasonably be expected; rapid changes to wider social structure and increasingly negative effects of a pandemic on the population enhanced levels of distress for many. However, they both describe the source of their deepest distress as arising from the systems that appeared to cause the hiatus and left them feeling lost. They felt let down by the institution they thought would have supported them, the university. Being unsupported in an unfamiliar hinterland, they were both holding the identity of neither employee nor student.

Wenger (2009) maintains theories of social structure emphasise the significance of institutions, underpinned by rules for action and theories of situated experience, the individual driven meaning making, are the most significant elements of the STL. Individuals can identify and communicate their worth and competence and learn about themselves through a sense of belonging and an understanding of what they do and how they contribute as individuals, to the whole. Here, for both students, their expected progression of their

assimilation of nurse identity, through socialisation, immersed in the culture of registered practice was interrupted.

As students, Danielle and Grace had previously been able to move in and out of clinical areas through legitimate peripheral participation, understanding the rules and being sited within the bigger picture. This was an accepted and understood role as outsiders with special privileges, learning to be and to become mental health nurses, through engagement and interaction. They were also simultaneously legitimate members of a university community. When this role was removed, by default, the primacy of the institution was lost, involvement through engagement and interaction was gone. For Danielle especially, this fostered a sense of loneliness that was problematic for many students during this period (Henshall *et al.,* 2023).

As an individual without an institution to be anchored in and guided by, Danielle's conceptualization of her own identity was skewed, and she considered herself less favourably because of the unplanned and unforeseen change in status. Grace too, found herself thinking about what she was in context and later what she meant to others, as a professional. Individuals want to see themselves as valuable through the achievement of a specific group membership (Tajfel and Turner, 1986) but initially, both students realised they were not in a position to move towards group membership, as they had previously understood it, it was uncontrolled and uncontrollable by them.

The almost constantly evolving context required quick reappraisal as to how best negotiate themselves through the situation once in practice, and adapt as individuals to the changing boundaries of practice (which were not always understood). This was difficult, given the extraordinary circumstances of living and working through a pandemic, totally changing previously well understood social structures beyond recognition.

The STL (Wenger, 1998) suggests tensions can arise quite organically, as the individual starts to explore themselves through experience, set against the background of society expectations (social structure). Working through the pandemic made this a complex experience, and they inevitably found themselves in difficult situations, as they tried to

assimilate themselves into practice as individuals. This affected learning and of course impacted upon the development of their professional identities.

Later into the deployment, as Grace and Danielle settled into a new way of working, Wenger-Trayner *et al's* (2015[b]) three modes of identification, engagement, imagination and alignment, albeit somewhat vaguely, were evidenced. This encouraged them towards belonging and becoming although their status as student nurses had been changed. Danielle and Grace were both eventually able to identify themselves in a newly imagined CoP, making their experiences meaningful. They both found their own space in this new environment although this did not always feel like a good or particularly comfortable fit, they understood it.

6.6 Chapter Summary

In this chapter, I have presented the findings from the individual interviews. The interviewees provided information about themselves and their circumstances from the unique position of working through a pandemic in healthcare, as mental health nursing student-employees on deployment.

Although their stories were different and they managed their situations uniquely, they both expressed distress at being unsupported and not having enough information to understand the situation. However, they had to "get-on-with-it" and work their way through their contracts as best they could. Whilst the opportunities to work were eventually appreciated as positives in some ways, in terms of cementing a professional identity, the deployment was not especially useful.

In the next and final chapter, I answer the research questions and consider the strengths and limitations of the study. I then discuss the recommendations arising from the findings and the original contribution the study makes, before offering a conclusion. Finally, I share some of my thoughts on the process of my own journey.

Chapter 7

Purple, green, blue and beyond

7.0 Introduction

Having considered the findings in Chapters 5 and 6, here, I answer the research questions supported by the narrative of Wenger's (1998) STL. This incorporates the language of the framework, as referenced in the findings chapters.

I consider strengths and limitations, including those of myself as a researcher and those relating to the study. Following this, I set out recommendations generated from the findings and consider the original contribution this study offers. I submit an overarching conclusion for my thesis and then present my final thoughts on my experience as a researcher.

7.1 Answering the Research Questions

Initially, I determined to collect data from the participants through focus groups at different stages of their nursing programme journey. However, unavoidable changes to the methods of collection have yielded two sets of data, one gathered pre-pandemic in the two focus groups and one mid-pandemic, through individual interviews. I address the research questions separately for each set of data as, unsurprisingly, there is a change in tone and focus between the data gathered pre and data gathered mid-pandemic. As a result, as stated in Chapter 4, I have not addressed research question four relating to IPE in the second data set because the students were not exposed to university-based IPE during this period.

7.2 Pre-pandemic

Research Question 1 How do mental health nursing students narrate their own professional identity?

The significance of resilience and being - or learning to become - more resilient is integral to mental health nursing practice (Rees *et al*., 2015) and this resonated soundly across time through focus group discussions. Mirroring Curtis *et al.* (2017), the students determined the importance of having a "thick skin" (p 217) when they found themselves in challenging circumstances or working through adverse events. Adversity came from different quarters and drew attention to a vulnerability they all felt at some time, which, although it could be

negative, had encouraged self-awareness. Making meaning of these experiences though, was not easy, hampering assimilation in practice, sometimes interfering with development of identity. Negative experiences did, however, help to develop skills associated with face work (Goffman, 1967), reflected in the concept of emotional intelligence, something they were adept at, helping to build resilience.

Such experiences also helped students to develop the skills to facilitate good quality peer support, showing themselves to be empathic, something of prime importance to nursing students (Walsh, 2015). They were aware of the symbiosis of the support found in their own CoP, which had grown organically, acknowledging their shared histories and making meaning for themselves and each other. The attitudes they described are underpinned with compassion and kindness, for one another and for patients. This compassionate response to others was highlighted in their approach to patients through the protective language they used, as they described themselves as advocates who helped others when needed.

Nursing work can be onerous and requires a high level of commitment (Eckardt and Lindfelt, 2018). Working towards the blue of the RNs uniform, away from the purple student uniform they inhabited was demanding for the students, demonstrating their level of commitment and across time, their dedication. As Kelly (2020), Traynor and Buss (2016) and Keeling and Templeman (2013) previously determined, they thought not everyone could do what they do which gave them a feeling of specialness and distinctiveness. This included having the right attitude to work with mentally unwell or vulnerable people. Being a good fit themselves for mental health nursing, the students found self-worth and self-satisfaction when engaged in what they considered to be worthy activities. The students found an interdependence in their work with patients, they found it fulfilling and considered patients, generally, found them to be helpful. Participating and engaging, learning as doing, both supported and led the development of their professional identity although this was not straightforward.

As seen elsewhere (Galvin *et al.,* 2015), narrating their present identity as mental health nursing students was not a simple task, and directly reflected their thoughts about the difficulties of defining mental health nursing. This led to some frustration because they subsequently found the professional identity of mental health nurses difficult to define, a widely observed phenomenon (Hurley *et al*., 2022, Terry, 2020, Holt, 2014). Identity was sometimes referenced in terms of the role of the nurse but this tended to be specific to the

individual clinical area, and so was not widely applicable. For them, this was complicated by the need to be both university student and nursing student in practice, simultaneously. Moving between the two did not feel particularly well joined and for some, straddling this divide was uncomfortable, hard work (Crigger and Godfrey, 2014).

These students articulated ways of thinking, being and behaving that enabled them to narrate their own identities as resilient, supportive, compassionate and dedicated individuals. There was almost an assumption of the ability to hold onto hope for others who could not hold it for themselves, something Fisher (2023) described as "… the true value of a mental health nurse" (p 2).

Despite the lack of clarity of the context they worked in, they were sure their present identity, imbued by the value they added to their work, was suitable. They confidently narrated their way through an uncertain landscape. They identified themselves as becoming mental health nurses, regardless of the occasional difficulties in negotiating their belonging in legitimate peripheral positions, in different CoPs.

Research Question 2: What influences do these students perceive as impactful on the development of their professional identity in clinical practice?

The impact of clinical practice upon their professional identity development, of learning to become, was multifactorial. Spending time in the company of unwell patients (especially for the first time), working alongside nursing staff, and their insight into their sense of self were most significant.

Being exposed to, what they described as people (patients) in situations that they thought others would not experience, was a tremendous influence, working with very unwell people who presented with an intensity of distress they had not witnessed before. Whilst this was described as a privilege, it also highlighted the need to depersonalise in order to avoid own distress. This could be hard, necessitating again, the use of face work (Goffman, 1967). It was useful in terms of facilitating the development of their personal resources, developing their own line (Goffman, 1967), making meaning from experience, that could be transferred elsewhere.

This became an important part of being chameleon-like, able to fit into different situations as they regularly moved through the landscape. This enabled them to learn and to develop their skill set, engaging through participation and helping them to become student mental health nurses. Moving successfully around and between clinical areas as legitimate outsiders on the peripheries of different CoPs, underlined their ability to be flexible.

Nursing staff were great influencers on them. They were aware of the power differential between nursing staff and themselves, as the most junior individuals in the clinical area, as one described themselves, "the lowest of the low" (Grealish and Trevitt, 2005, p 143). They needed these others to guide them and help them develop clinical skills, to move towards competence. Most often their nurse mentors were helpful and interested in them and their progression, but unfortunately this was not always the case. Mentors could be dismissive or rude and students had to develop their own ways of negotiating when the path to competence was rocky, meaning they often had to take the initiative in order to achieve. This affected confidence negatively but it also bolstered confidence when they worked hard and achieved, regardless of whether or not they were supported and accepted into the community. Achievement in challenging circumstances imbued them with a sense of both what they wanted to be as RNs (competent and confident) and what they did not want to be (rude or dismissive). They could clearly see their identity development through these experiences.

The students started to realise through their experience and the knowledge held and skills assimilated, they could trust themselves, and they could take the trust offered by others, to make decisions and complete nursing interventions. This trust was part of the nurturing and encouragement they received from "good" mentors. They were able to begin the interpersonal process of developing therapeutic relationships, the crux of mental health nursing (Peplau, 1997) and recognise this for themselves, acknowledging their personal and professional development. For the majority, there was an understanding that through their achievements they would be worthy of becoming an RN, and their success would validate their claim to their own blue uniform, the reification of these achievements. Elements of the complexities of Carper's (1978) ways of knowing can be heard in their voices as they create their own personae based on achievements in clinical practice.

Professional identity for these students was significantly influenced by nursing staff, patients they worked with and themselves through the agency they held in the diverse landscape they inhabited. The significance of belonging to the community, the collective of nursing within the familiar structure, that nurtured and encouraged their identity development, their becoming, was writ large. They recognised that their own development was ultimately their responsibility and having faith in themselves was part of this process, they needed to trust themselves and believe in their own abilities.

Research Question 3: How do these students describe their experience of professional socialisation in clinical practice?

The process of professional socialisation is sometimes described as a frustrating, challenging and difficult one that can be unpleasant for students (Walsh, 2015). Reflecting the students' own experience, the incivility of RNs towards students causing them to feel awkward and "in the way" is widely recognised (Clements *et al.,* 2016, Rees *et al.,* 2015, Walker *et al.,* 2014). Although, most of the time, for these students, socialisation was not a negative process, it was the negative experiences that were easily recalled.

Students in this study reported sometimes being made to feel unwelcome in clinical areas by nurses, treated as if their presence was a burden on nursing staff. Sometimes they felt like staff regarded them carelessly, without much thought, rather than with targeted hostility. Whether this was personal or not, the outcome was the same, being regarded as someone who had to be tolerated rather than as a student who needed to be guided and encouraged, was deflating. Such dissonance between reality and expectation is not uncommon, but it comes as a shock for students (Lundell Rudberg *et al*., 2022). The incongruity between what they thought their experiences should be and what it was actually like, disappointed the students all of whom considered being in practice was the best part of being a student nurse. In these situations, not being able to negotiate legitimate peripheral membership of these communities meant that they did not feel a sense of belonging.

For the majority of the students, most of the time, placements were welcoming, with nursing staff who understood what they needed to do to succeed and would help them. Having a good mentor, one who offered time and shared their expertise was invaluable, allowing the

student to become part of the nursing team and directly facilitate their learning. Joining the community relied on nursing staff to accommodate them and they appreciated this when it happened. They were able to continue with their progression through the hidden curriculum, towards assimilation and internalisation of norms and values. This brought with it a comforting sense of belonging to the community. These were pleasurable experiences that kept them interested in nursing and fortified their ambitions to register.

The students recognised that through their studentship there had been subtle changes in them as they went through a process of professional socialisation, helping them to assimilate into practice. They largely ascribed this to clinical practice experience as classroom-based learning was not always considered useful to practice. It was through their ability to negotiate and renegotiate their place in practice that they developed their professional personae. It was difficult to identify exactly how and when this had happened. This seemed to focus on tacit learning, which, as an immeasurable entity, must not be stand-alone (Benner, 1984) although it is a powerful and well recognised phenomenon in the socialisation of student nurses (Adamson, 2018).

The students found that the quality of professional socialisation they enjoyed, initially relied on others, and the level of support could vary between clinical areas. Despite this, they found they had enough agency to help themselves to socialise successfully, albeit sometimes implicitly.

Research Question 4: What are these students' perceptions of Interprofessional Education?

IPE is commonly recognised as an enjoyable experience for students (North *et al.,* 2023, Jorm *et al.,* 2016). IPE was new to most of the students and had not been an integral part of their studentship to date, but they welcomed the focus towards overtly engaging and participating in the learning process at university, with students from other professions. They enjoyed the informal approach to teaching and learning IPE gave them. As final year students they were in a good position to benefit from IPE (Stephens and Ormandy,2018).

Although being on placement was considered the most enjoyable and beneficial element of the programme, the students thought the process of IPE could potentially create a link between theory, which some found to be dry and uninspiring, and practice. They considered

it could be a useful mock-up of interprofessional collaboration in the clinical environment, opening opportunities to practice this with students of other professions, in a safe place; there was no risk to a real patient as a result of their decision making.

The students reported time spent with these other students was useful for a number of reasons. Learning more about what other professions do and recognising different responsibilities and scope of practice was illuminating (McGuire *et al.,* 2020). This also helped them to identify their own scope of practice and they were pleased that they could share their knowledge, this was confidence boosting. Through this sharing and negotiating their place in a temporary team, IPE allowed them to showcase both their own expertise, but also the potential contribution of mental health nursing to clinical team working more generally. They were able to demonstrate their development into interprofessional practitioners, an important element in the process of IPE (Stephens and Ormandy, 2018).

Working alongside students from other professions helped them to challenge themselves and the decisions they made, as well as being challenged, and questioning others' decision-making processes. This was not felt to be confrontational but professional curiosity, which led to discussions about decisions made, when the answer (if there was a solution) to the problem was complex.

Nicholl and Tracey (2007) underline the importance of networking for clinical staff and students found IPE was a good opportunity to do this. In addition to enjoying the process of networking, they realised the usefulness of relationships they could make now with other students who they were quite likely to encounter in practice, post-registration.

Despite their unfamiliarity with the process, these students thought IPE was a useful platform to meet others and share their knowledge and expertise. The experiences they described met the CAIPE requirements for IPE, as they learnt with, from and about each other (Barr and Lowe, 2013). This also upholds the STL tenet that engagement and active participation is critical to learning, and therefore, to identity development. IPE facilitated the process of making meaning from experience clearly and quickly.

7.2.1 Summary: pre-pandemic

To summarise, in reviewing the research questions, it was clear the students held an affinity to mental health nursing. They identified composite characteristics of themselves, such as resilience, compassion and determination, which they narrated articulately.

Despite feeling they were "fit for purpose", and that their development of identity was strongly linked to, and firmly embedded in practice, the complexity of being mental health nursing students required their full attention. Ultimately, there was a symbiosis in what they did; working with vulnerable people was good for those people, it was also good for them. The students were clear that mental health nursing is niche and not suitable for everyone. It demanded resilience and a high tolerance threshold for uncertainty which most do not have.

They could not find a ubiquitous definition for mental health nursing which was irritating to them and obfuscated the landscape. However, it was clear that patient need and specific environment dictated their role which was primarily more important to the students. They captured a sense of "becoming", despite working in uncertainty with abstraction and intangibility.

Although their work was sometimes difficult, influenced and driven by those over whom they had no agency, they were generally able to nurture their own development. They needed to be adaptable to fit into different environments and multiple teams, something that could be made more difficult by staff who were not always welcoming or accommodating. However, most of the time they found socialisation, even if it was not always easy, to be an invaluable step in the process that saw them move towards belonging to the individual community. Tacit understanding and the dynamism of the process of professional socialisation was integral to their experience, although difficult to pinpoint, but as the students became more confident and attracted the confidence of others, they started to demonstrate professional and personal change.

IPE was a useful way to link theory to practice and a suitable conduit to work with other students. Students found it exposed them to different ways of thinking about patient care, encouraging reflection. It also allowed them to share their own knowledge and expertise which boosted confidence, and potentially to make connections with others that would be useful, post-registration. The students described being the mental health nursing

representative during IPE activities as a source of professional honour and demonstrated evidence of themselves as developing interprofessional practitioners. They described their pride in being able to demonstrate their belonging to the collective of mental health nursing in this forum, positioning themselves as knowledgeable patient advocates.

The students' articulations of themselves and their identities are reflected by the composite elements of the STL (Wenger, 1998). Engagement and participation, demonstrated in dedication and commitment, were pre-requisites to successful integration into different CoPs, although the landscape was not always conducive to their learning and development. Never-the-less, they all described their affinity for learning as doing and learning as experience (practice and making meaning), as integral to their growing sense of holding an identity and being part of a community (becoming and belonging).

7.3 Mid-pandemic

Research Question 1: How do mental health nursing students narrate their own professional identity?

The changes to the context unsurprisingly sent their understanding of themselves, how they narrated their identity, into a spin for Grace and Danielle. This started in the pre-deployment period of waiting to go into the workplace. Both of them thought, and they were not alone in this (Henshall *et al.,* 2023) that their transfer to practice had been clumsily managed by the university, and they did not know what they were going to do when they finally got into the workplace. Kane *et al.,* (2022) considered that students were not well prepared for this practice period. This time evoked self-doubt for Danielle and Grace, which was distressing for them. From a position of relative stability pre-pandemic, doubts crept in as to whether they wanted to continue.

When they were eventually deployed, they described themselves as unsure of who they were and what their purpose was, finding it hard to place themselves in the clinical environment. They were still in their purple uniforms but were carrying out the duties of HCSWs (but were not wearing green). For many students in the UK, initially working out who they were and how they fitted in, was difficult.

Hayter and Jackson (2020) voiced concerns about whether students where needed in practice. Once in practice, it became clear to Danielle and Grace that they were superfluous to requirements, they were not needed, and they felt this keenly. There were too many staff and too many students. The limited availability to practice initially stifled identity development. This was in stark contrast to students elsewhere who plugged gaps for and worked alongside RNs in chaotic clinical areas, and for whom staff shortages were real and seemed to put the care of patients into jeopardy (Griffin and Riley, 2022, Godbold *et al.,* 2021).

Feeling like by-standers was uncomfortable and Danielle and Grace had to work hard to stake their claims to a legitimate position in the team. However, this legitimacy was questionable, given a widespread lack of understanding of their role and responsibilities as a student/ employee. This feeling of awkward hybridity is described elsewhere (Griffin and Riley 2022, Godbold *et al.,* 2021, McSherry *et al.,* 2021).

Trying to understand whether they were students or employees presented a chronic source of worry and anxiety and fuelled their self-doubt. As time progressed this lessened, both found a niche, describing a space to occupy that helped them feel more comfortable, working hard, trying to fit into the team. However, they could not have all of their needs met; they identified as employees, not the students they were supposed to still have been.

Narrating their identity during this period was difficult and contradictory for both Danielle and Grace, confusing and confused. Although they wanted to be students in order to achieve competencies, ultimately, this was purely nominal.

<u>Research Question 2: What influences do these students perceive as impactful on the development of their professional identity in clinical practice?</u>

Being on deployment had its uses for Grace and Danielle. Being able to spend more time with patients across a longer period of time was a bonus. Seeing patients through an episode of care because of the length of time they were deployed for, was satisfying.

It did help them to recognise what it would be like to be in professional practice, with little mentor support, going to work and occupying the space of paid employee. Some students have similarly reported this as a positive (Griffin and Riley, 2022, Godbold *et al*, 2021). Seeing

working life through a different lens, from the other side, was interesting. Being an insider gave them insight into how different team members operated when students were not obviously presenting as students. This was helpful in thinking about the future, what it could be like to legitimately belong to the collective.

For Grace and Danielle, the purple of the student uniform they wore should have impacted significantly on their professional identity development. It should have made them stand out as students, as they had both previously observed in the focus groups. However, this was not the case because they were "counted in the numbers", and they were both one of several students in their clinical area. As a result, they thought they were used to do the jobs of the HCSWs, which they would not ordinarily have been asked to do as students, pre-pandemic, something noted elsewhere (McSherry *et al.,* 2021). Staff often held misperceptions of what they were and what they were supposed to be doing so what they should and should not be asked to do, because of their status as a student/ employee. Still clad in purple but no longer supernumerary and, instead, "on the books", they often found they were unable to engage staff with the administrative tasks of recording their achievements, which they found very frustrating. Through this period, students regularly reported being unable to engage purely as students and felt they had missed out as a result (Henshall *et al.*, 2023, McSherry *et al.,* 2021).

The consensus for Grace and Danielle was that even though they both determined to "get-on-with-it" and manage their deployment in the best way they could, it was not a useful exercise in terms of helping them develop their professional identity. Making meaning from experience to feedforward to their developing professional identity was not possible because they were not students. They thought they should have been on placement, continuing their journey towards the blue of registration. On balance, the impact on them, at a time when they needed to practice being registrants, was negative.

<u>Research Question 3: How do these students describe their experience of professional socialisation in clinical practice?</u>

The students described their professional socialisation as being underpinned by a lack of support and understanding. This was largely because nobody seemed to understand the role

of the deployed student. To others, as to themselves, they were unidentifiable either as a full student (in purple) or a full employee (in green). Their identities seemed interchangeable.

Whilst they knew they should not do the work of the HCSWs, doing so helped them to fit in. Being adept at blending in was to their advantage, practising their chameleon-like skills once again. A sense of belonging to the in-group beckoned and becoming a team member was relatively simple. If they worked hard and committed themselves they could win the trust of the team. This helped to develop their negotiating skills, outwardly assuring their place in a team in a newly imagined role, something that took time and energy and which they thought could help them in the future, post-registration.

Getting attention from mentors in order to discuss practice achievements was not easy. The anxiety it provoked highlighted the lost opportunities of deployment versus studentship. Managing this as part of their professional socialisation was very much up to them. Socialisation, whilst working in a pandemic as a paid student, being vaguely and inconsistently supported was a challenging and often frustrating process.

7.3.1 Summary

Pre-pandemic the students were generally aware of their place in the clinical arena, they were usually confident in engaging and participating. Danielle had occasional doubts, but these were set within a context she understood. Grace found herself sometimes irritated by processes and people but understood these were only distractions and that they would be resolved in time, as she continued on the nursing programme. By comparison, this hinterland of deployment without supernumerary status was strange and, initially, frightening. It was at odds with their thoughts that they should be developing their professional identity, so very close were they, at this point, to belonging to the collective of mental health nursing.

From the same research questions addressed pre-pandemic, there were, quite unsurprisingly, differences in their perceptions of themselves mid-pandemic. Neither Grace or Danielle fully understood an identity they were comfortable with initially, and they were not alone in this, as neither did many of their colleagues. Waiting to go into practice was a distressing period, made worse by a lack of information and support from the university. At the beginning of the third and final year of the programme, their hopes and expectations for

their development were dashed, and initially jeopardised their position as nurse-in-waiting. They did not know what they would be expected to do or how they should be. This was anxiety provoking.

At the beginning of deployment they found themselves surplus to requirements and were often unsupported as students. As others found it challenging to understand their role, working hard helped them to gain acceptance and respect from the team, working as employees rather than students. Being students was not really an option, but seeing working life from another perspective was useful when thinking about their future practice.

For Danielle and Grace, there was limited opportunity to belong to the CoP in the way that they wished to. Making meaning from experience as students, in anticipation of furthering and understanding their professional identity was restricted. Ultimately, being a student on deployment as an employee was disruptive, challenging and represented lost opportunities to practice the nursing skills they needed to, in order to pave the way towards registration.

Pre-pandemic, it is easier to discern Wenger's (1998) STL in the students' narratives in terms of learning and developing an identity. During the pandemic, Danielle and Grace describe a sort of stasis, during which they spent significant periods of their time treading water.

7.4 Conclusion: Research Questions

The research questions have been addressed and unsurprisingly, pre-pandemic and mid-pandemic responses were very different. Findings from the focus groups indicate these students, despite some concerns they held, were aware of their place in the landscape, they mostly understood their roles and responsibilities, knew what they needed to do and how to support themselves to do it. They knew what was expected of them (in purple and sometimes green) by others, and even though this could be challenging, they continued on with their goal of registering as nurses (to be in blue). As demonstrated, they were able to articulate their growth and development as seen through Wenger's (1998) STL. The assimilation and internalisation of professional values and norms was clearly discernible.

This was thrown into chaos during the pandemic. The student/ employee role in deployment was confusing and misunderstood. It seemed anchorless to the students, although it was not a wholly negative experience and learning and development did occur. Their experiences as,

fundamentally, employees, gave them a glimpse into what it could be like to belong to the community of mental health nursing. However, deployment could not replace the status of a pre-pandemic, supernumerary student and did not offer such a valuable and valued experience, working towards becoming, for these students and their identity development. They needed to practice, to make meaning, to work towards becoming in ways they understood (and ways they knew worked), which was not possible; uncertainty was the only certainty. Ordinarily, mental health services are subject to uncertainty in different ways: of professional role (such as scope of practice), of clinical decision making (when considering care choices) and external factors (wider influences felt on an episode of care) (Pomare *et al.,* 2018). These were magnified during the pandemic and these participants have demonstrated resilience and a remarkable ability to overcome and manage troubling uncertainty.

7.5 Strengths and limitations

(i) Researcher issues

Mason (2018) maintains that researchers must be interested in the world they wish to study and engage with it accordingly. My curiosity was stimulated by my prior understanding of the significance of identity to the group of students I worked with. My engagement, however, could have been problematic. Cohen *et al.,* (2018) are mindful that however aware the interviewer is of the need to be objective, "the constraints of everyday life will be a part of whatever interpersonal transactions she initiates" (p 507). As I knew these students relatively well, I was aware objectivity could not be achieved. Familiarity is an issue for insider researchers (Delamont, 2014), which needed managing through careful reflexivity.

Equally, my immersion and understanding of the situation was useful during the focus groups. I was already familiar with the technical language used and the soft architecture the students referred to, in addition to understanding the substantive content, and I had fairly easy access to them. Being "culturally literate" (Trowler, 2011, p 12) is beneficial to the insider researcher.

On another positive note, Comer (2009) suggests seeing their lecturer as researcher can have a positive role modelling effect on students. They can be left with the lasting impression that

research is valuable and it is needed, and, by implication is something they might be able to do in the future.

Overcoming the potential inhibitory effects of myself as researcher depended on my ability to engage with the students early on, and I was able to assure confidence and engender trust, particularly in the time period between the focus groups. It also tested my integrity, one element of the research process I had not expected.

I had been instrumental in managing the COVID-19 deployment at a micro level for these students. During the interviews, there were times when I was very uncomfortable hearing them narrate their experiences of distress and fear. This led me back to thinking about whether I should have acquiesced with the process and made me question my own actions.

Looking back through the immense email trails I had sent and received during this period, ploughing through the documents of advice and guidance and reading and re-reading my own journal entries persuaded me that, on balance "we" (the university) did what was thought best at the time. We took the guidance and interpreted it to our best ability for the students and for patients. However, the management of this vicarious risk taking is not something I will so readily accept as mandated policy, should such a situation ever occur again, acknowledging that recurrence is likely (WHO, 2024, Williams *et al.,* 2023).

I have developed my ability to be reflexive and keeping a journal helped me to formulate my own thoughts, whilst simultaneously trying to manage my own emotional responses to my work, something I did throughout my research. I could not share my understanding with the students of why and how changes were made to their programme, even though it is likely my explanations would have helped them to understand the decision-making processes and the context within which the decisions were made. This was difficult for me, and writing my thoughts and feelings down was cathartic.

(ii) Study strengths and limitations

The students in this study were exposed to two university-based IPE sessions. It is generally agreed that frequency of IPE is important, and it needs to be facilitated as part of a process, set within an organised programme, rather than an ad hoc or occasional occurrence (Reeves *et al.,* 2012), as Clark (2006) suggested "titrating the dose" (p 585). Having more

opportunities to work regularly with a wider group of students from other professions could have enriched student experiences of pre-registration, undergraduate education, offering opportunities for internalising a professional identity.

The number of students and focus groups recruited was smaller than originally planned. Being able to recruit more students and conduct further focus groups would have enabled wider exploration of identity and development with this student group, and I had to rethink my data collection methods after the first focus group.

However, the effects of the pandemic were to prove more challenging to manage. I had planned to present my research to a group of my "disinterested" peers at a doctoral conference. This would have given me an important opportunity to expose my research and justify my work to others (Shenton, 2004), none of whom had a vested interest in my study. This was prevented by the pandemic.

As previously noted, the first national lockdown started a few days after the second focus group in March 2020, meaning a further change to data collection methods and drastically reduced access to students. This also led to a lesser focus on IPE and my plans for developing a theory informed framework to develop the process of IPE for this student group were scuppered. Data from the mid-pandemic individual interviews were much less relevant to the student experience of university-based IPE as students had become employees of the NHS. Effectively, the study was bisected by the pandemic: narrations of student identity and IPE experience before the pandemic, and narrations of student/ employee identity, mid-pandemic. As a result, it is not possible to consider this the case study I set out to use, as defined in Chapter 4, whereby the case was to be IPE as stimulus to explore the development of professional identity. The case for the individual interviews became the student deployment to practice.

However, undertaking this study at this point in time, fortuitously gave me access to mental health nursing students who were working during the pandemic, something that was, I believe, quite a rare opportunity. I was able to present their individual narratives. This has facilitated complex and unique first-hand, contemporaneous accounts of two mental health nursing students from one university in Wales, deployed to NHS mental health hospitals, at the beginning of the COVID-19 pandemic.

7.6 Recommendations

From the data, there are four clear recommendations. Facilitating the development of identity, embedding this in theory that needs to be relatable and can be translated into practice; ensuring IPE is embedded in theory and clearly linked to practice and professional development; acknowledging staff incivility and addressing this; ensuring robust pre-planning for future student involvement in public health crises.

- Students are stakeholders in the future of mental health nursing. Students' frustrations at understanding mental health nursing identity, as seen in Chapter 5, are to be considered. A one-size-fits-all definition seems less important than curating the professional profile of the individual who delivers individualised mental health nursing care. Lecturers in HEIs, as advocates for students, and, therefore, vicarious patient advocates, must uphold the ethos and philosophy of mental health nursing for students. Their education and preparation must continue to focus on developing intrapersonal and interpersonal skills to facilitate therapeutic relationships, in ways that students find accessible, something the students were clear was their primary consideration throughout Chapter 5. This needs to include the promotion and acknowledgement of the relevance of nursing theory. If there is a theory-practice gap, students are well placed to advise on this. Further research and co-production at a local level, can be facilitated to engage students in developing ways of making theory more interesting and more relevant for them, both mode and content, encouraging engagement and participation.

- The students reported that IPE is useful to their learning and professional identity development through Chapter 5. This underscores the importance of ensuring IPE is robustly cited in undergraduate curricula, underpinned by theory to support, guide and justify resources. IPE must be part of the whole pedagogic approach set within a mental health nursing curriculum, that is meaningful and addresses the issue of internalisation. Students, once they are comfortable with their own roles, responsibilities and professional identity, must be signposted, through IPE, to expect themselves to be interprofessional collaborators. The position of the mental health

nurse, as a stakeholder within a multi-professional team should be celebrated and highlighted as crucial to team working and the provision of quality patient care. Locally, lecturers can take responsibility for innovations in IPE for mental health nursing students.

- Mental health nursing students must learn and develop in a suitable nurturing and inclusive environment that allows them to thrive, in practice and at university. They hold hope for others which must be respected. This should be a matter of routine, rather than a matter of fortune, not always the case as reported by students in this study in Chapter 5. Bullying and incivility is a chronic problem in practice and must not be tolerated. At a time when student nurse recruitment and retention are poor, this should be taken seriously, student nurses need to be able to assimilate and internalise the values and norms of registered professional nursing practice. There is enough evidence to suggest that there is research to be undertaken with RNs to explore this further. It is a sensitive issue, and it is reasonable to assume that nurses will not want to publicly consider incivility towards students from themselves, or from colleagues. It might be better approached in considering the preparation RNs have for supporting students and how they perceive the support they receive for guiding and supervising them; what do they think would make it easier, what makes it harder, what works and what does not work? This requires co-production between HEIs and service provision.

  Initially, incivility needs to be acknowledged as a problem across the community, in academia and in practice. It can be included early on in discussions with neophyte students about professionalism and socialisation. Students must be made aware that they could experience incivility, that it is an unacceptable but recognised phenomenon. Of course it must be balanced with the knowledge that this is nowhere near the whole experience. The theory and practice of whistleblowing, or truth telling, in these circumstances must be an integral part of their socialisation, acknowledging that this may be difficult but it is an expected element of professional practice and will be supported. This requires the establishment of a clear and

unambiguous framework of reporting for students to use. Co-production of this at a local level can be facilitated.

- In Chapter 6, Danielle and Grace's mid-pandemic testimonies revealed the unnecessary levels of distress and anxiety they both experienced, directly linked to widespread unpreparedness in already challenging circumstances. Preparedness for future public health crises, which are a distinct possibility, must be addressed. This affects the nursing community at all levels. Deployment must be justifiable, and, if required, an acceptable alternative can be determined prior to the need to deploy. The purpose of deploying mental health nursing students in these circumstances must be determined and the scope of the student/employee role must be clearly defined. From a micro perspective, lecturers in HEIs can develop local protocols for managing future deployment. This must take into account national and local need and mandates and therefore, will be flexible but principles remain the same. Lecturers must be prepared to engage in meaningful dialogue with authorities and regulatory bodies at all levels, identifying their role as student advocate, addressing issues of wellbeing.

7.7 What this study contributes

This study adds the narration of their own experiences, in their own words, of a group of underrepresented students to a particular body of literature. Detailing what it is like to be part of a CoP, and their thoughts and feelings about being a mental health nursing student in Wales at different times and in different circumstances, their voices have been captured and can be heard. This evidence concerns mental health nursing student experience of both engaging in clinical practice and with IPE, and how their developing professional identities are influenced as a result. This informs ways of working and processes that can be considered to address some of the challenges future students may be faced with.

The participants can be heard articulating their appreciation of the uniqueness of mental health nursing in interprofessional teams. They talk of the importance of building and managing relationships with vulnerable people and "holding hope" for those who cannot hold it for themselves. These relationships are central to their practice, they are the reason

they want to be mental health nurses. The participants, bolstered by one another and drawing on their own resources, demonstrate a high tolerance for managing uncertainty and negotiating through challenging situations. On placement, uncertainty seems to be the default position and the participants are adept at successfully manoeuvring the complicated and complex landscapes of clinical practice.

Hearing the voices of these mental health nursing students during the pandemic deployment is of great interest. This group at this point in time had rarely been heard and their stories are important. These students' accounts have demonstrated the importance of preparedness and support for students during public health crises. Their first-hand, real time accounts of deployment in healthcare provision during a pandemic, have been captured.

7.8 Conclusion

Firstly to summarise, in this chapter, I have answered the research questions in turn and from both sets of findings separately, summarised each and offered a conclusion. I have addressed strengths and limitations of myself as researcher and of the study and set out my recommendations generated from the findings. I have been able to suggest that there is evidence to undertake future actions, in co-production with students and others, to address ways of working and engage in further research. I have identified the study's original contribution to the existing body of knowledge.

The aim of my thesis was to explore how pre-registration undergraduate mental health nursing students at one university narrate their own professional identity and how this develops, using IPE as a platform to explore this. As previously discussed, there were significant pandemic-related changes and I was not able to use IPE as a platform to gather all data and I had to change methods of data collection. Never-the-less, professional identity has been explored, as planned, through the lens of Wenger's STL (1998). This has involved exploring making meaning of situated experience, understanding own practice and the intricacies of becoming and belonging for mental health student nurses in clinical practice at different times, working from "purple" towards "blue", most often via "green". I conclude that the aim of the study has been realised.

7.9 Final thoughts on the study

This study took me on a very different path to the one I had mapped. This was not always comfortable and has affected my perspective on the nature of the education I am responsible for managing. Exploring how students think and feel about their experiences and the impact people like me can have on them, was eye opening and sometimes jaw dropping. I hope that having their voices listened to and heard is of value to them as they charter their own journeys as RNs. I believe that the careers of current mental health nursing students, who will become Registered Mental Health Nurses, will be politically and professionally scrutinised as mental health nursing may be threatened with dilution or even dissolution. I believe that they will have to make their own voices heard to counter this, and taking part in research may be of some assurance that, sometimes, others will hear what they have to say.

Completing this study has impacted my life. In terms of professional and probably more so personal development, this has been a long journey, navigated concurrently with my own unfolding story. Although this is a small-scale project, for me it is the largest project I have been wholly responsible for. I know I have fallen clumsily down some distracting rabbit holes along the way as a result of my inexperience, the source of great frustration. However, for me, this remains a worthwhile pursuit, offering a useful contribution to the collective of mental health nurse education.

References

Abbott A (1988) *The System of Professions: An Essay on the Division of Expert Labor*. Chicago. The University of Chicago Press.

Abbott P, Meerabeau L (1998) "Professionals, Professionalization and the Caring Professions". In Abbott P, Meerabeau L (eds) *The Sociology of the Caring Professions* (2nd edition). London. UCL Press. 1-19

Adams K, Hean S, Sturgis P, Macleod Clark J (2006) Investigating the factors influencing professional identity of first year health and social care students. *Learning in Health and Social Care* 5 (2) 55 – 68

Adamson E (2018) Helping Student Nurses Learn the Craft of Compassionate Care: A Relational Model. *Journal of Perspectives in Applied Academic Practice* 91 – 96

Alexander VD, Thomas H, Cronin A, Fielding F, Moran-Ellis J (2016) *"*Mixed Methods*"*. In Gilbert N, Stoneman P (eds) *Researching Social Life* (4th edition). London. Sage Publications Ltd. 119 – 138

Andrew N (2012) Professional Identity in Nursing: are we there yet? *Nurse Education Today.* 32 (8) 846 – 849

Andrew N, Robb Y (2011) The duality of professional practice in nursing: Academics for the 21st century. *Nurse Education Today* 31 (5) 429-433

Andrews J, Butler M (2014) *Trusted to Care: an independent review of the Princess of Wales Hospital and Neath Port Talbot Hospital at Abertawe Bro Morgannwg University Health Board.* Microsoft Word - Trusted to Care - 20140506 - FINAL eng (gov.wales)

Attenborough J, Abbott S (2018) Building a professional identity: views of pre-registration students. *Nursing Times* 114 (8) 52 – 55

Ayala RC, Vanderstraeten R, Bracke P (2014) Promoting professional prerogatives: New insights to reopen an old debate about nursing. *Nursing and Health Sciences* 16 506 – 513

Bainbridge L, Wood VI (2012) The power of prepositions: Learning with, from and about others in the context of interprofessional education. *Journal of Interprofessional Care* 26 (6) 452 – 458

Barbagallo MS (2021) Nursing students' perceptions and experiences of reflective practice: A qualitative meta-synthesis. *Teaching and Learning in Nursing* 16 (1) 24 – 31

Barker P, Buchanan-Barker P (2011) Myth of mental health nursing and the challenge of recovery. *International Journal of Mental Health Nursing* 20 (5) 337 – 344

Barr H, Gray R, Helme M, Hutchings M, Low H, Machin A, Reeves S (2017) *Interprofessional Education Guidelines.* Fareham. Centre for the Advancement of Interprofessional Education.

Barr H, Helme M, D-Avray L (2014) *Review of Interprofessional Education in the UK 1997 – 2013*. Fareham. Centre for the Advancement of Interprofessional Education.

Barr H, Low, H (2013) *Introducing Interprofessional Education*. Fareham. Centre for the Advancement of Interprofessional Education.

Barratt D (2022) Impact of COVID-19 on nursing students: what does the evidence tell us? *Evidence Based Nursing* 25 (2) 37–38

Bates L, Stickley T (2013) Confronting Goffman: how can mental health nurses effectively challenge stigma? A critical review of the literature. *Journal of Psychiatric and Mental Health Nursing* 20 (7) 569 – 575

Benner P (1984) *From novice to expert: Excellence and power in clinical nursing practice*. California. Addison-Wesley.

Benner P, Tanner CA, Chesla CA (1996) *Expertise in Nursing Practice: Caring, clinical judgement and ethics*. New York. Springer.

Benwell B, Stokeo E (2006) *Discourse and Identity*. Edinburgh. Edinburgh University Press.

Bladon HJ (2018) Clear Skies Ahead: The Way Out of Identity Confusion. *Issues in Mental Health Nursing* 39 (3) 259 – 263

Bogossian F, McKenna L, Levett-Jones T (2020) Mobilising the nursing student workforce in COVID-19: The value proposition. *Collegian* 27 147–149

Bradshaw, A (2001) *The Project 2000 Nurse*. London. Whurr Publishers Ltd.

Brashers V, Erickson JM, Blackhall L, Owen JA, Thomas SM, Conaway MR (2016) Measuring the impact of clinically relevant interprofessional education on undergraduate medical and nursing student competencies: A longitudinal mixed methods approach. *Journal of Interprofessional Care* 30 (4) 448 – 457

Braun V, Clarke V (2022) *Thematic Analysis. A Practical Guide*. London. Sage Publications Ltd

Brennan D, Timmins F (2012) Changing institutional identities of the student nurse. *Nurse Education Today* 32 747 – 751

Brown E, *et al.,* (2020) The potential impact of COVID-19 on psychosis: A rapid review of contemporary epidemic and pandemic research. *Schizophrenia Research* 222 79 – 87

Browne C, Wall P, Batt S, Bennett R (2018) Understanding perceptions of nursing professional identity in students entering an Australian undergraduate nursing degree. *Nurse Education in Practice* 32 90 – 96

Buescher T, McGugan S (2022) Standing Out on the Margins: Using Dialogical Narrative Analysis to Explore Mental Health Student Nurse Identity Construction and Core Modules. *Issues in Mental Health Nursing* 43 (8) 737 – 747

Butterworth T, Shaw T (2017) *Playing our Part. The work of graduate and registered mental health nurses.* An independent review by the Foundation of Nursing Studies. London. Foundation of Nursing Studies.

Cardiff University (2018) Research Integrity and Governance Code of Practice. Available at: https://www.cardiff.ac.uk/ data/assets/pdf file/0011/1391942/20172018 Annual Statement on Research Integrity.pdf accessed 10.03.19

Care Council for Wales (2013) *The Social Work Degree in Wales: Practice Guidance*. Cardiff. Care Council for Wales.

Carper B (1978) Fundamental Patterns of Knowing in Nursing. *Advances in Nursing Science.* 1 13 – 24

Centre for the Advancement of Interprofessional Education and Department of Health (2007) *Creating an Interprofessional Workforce – An Education and Training Framework for Health and Social Care.* London. Department of Health

Centre for Advancement of Interprofessional Education (2016) Statement of Purpose. CAIPE-Statement-of-Purpose-2016.pdf accessed 07.02.23

Centre for Mental Health (2020) Commission for Equality in Mental Health. Commission_FinalReport_updated.pdf (centreformentalhealth.org.uk) accessed 14.02.23

Charmaz K (1995) "Grounded theory". In Smith J, Harre R, Van Langenhove L (eds*) Rethinking Methods in Psychology*. London. Sage Publications Ltd. 27 – 49

Cinoğlu H, Arıkan Y (2012) Self, identity and identity formation: From the perspectives of three major theories. *International Journal of Human Sciences* 9 (2) 1114 – 1131

Clark PG (2006) What would a theory of interprofessional education look like? Some suggestions for developing a theoretical framework for teamwork training. *Journal of Interprofessional Care* 20 (6) 575 – 589

Cleary E, Bloomfield J, Frotjold A, Schneider C (2023) A realist synthesis of interprofessional patient safety activities and healthcare student attitudes towards patient safety. *Journal of Interprofessional Care*. 38 (2) 346 – 376

Cleary M, Dean S, Sayers JM, Jackson D (2018) Nursing and Stereotypes. *Issues in Mental Health Nursing*. 39 (2) 192 – 194

Clements AJ, Kinman G, Leggetter S, Teoh K, Guppy A (2016) Exploring commitment, professional identity, and support for student nurses. *Nurse Education in Practice.* 16 20 – 26.

Coffey M, Pryjmachuk S, Duxbury J (2015) The shape of caring review: what does it mean for mental health nursing? *Journal of Psychiatric and Mental Health Nursing*. 22 738 – 741

Cohen L, Manion L, Morrison K (2018) *Research Methods in Education* (8th edition) Abingdon. Routledge.

Collier-Sewell, Monteux S (2024) What is the purpose of nurse education (and what *should* it be)? *Nursing Inquiry* doi.org.10.1111/nin.12640

Comer SK (2009) The Ethics of Conducting Education Research on Your Own Students. *Journal of Nursing Law.* 13 (4) 100 – 105

Connell C, Jones E, Haslam M, Firestone J, Pope G, Thompson C (2022) Mental health nursing identity: a critical analysis of the UK's Nursing and Midwifery Council's pre-registration syllabus change and subsequent move towards genericism. *Mental Health Review Journal* 27 (4) 472 – 483

Connor K (2019) Student perceptions of knowledge development and consolidation in a clinical community of practice. *Nurse Education Practice*. 39 90- 95

Cootes H, Heinsch M (2022) 'Jack of All Trades and Master of None'? Exploring Social Work's Epistemic Contribution to Team-Based Health Care. *British Journal of Social Work* 52 (1) 256 – 273

Cottam C, Dillon A, Painter J (2023) An Exploration of Student Nurses' Experiences of Burnout during the COVID-19 Pandemic Using the Copenhagen Burnout Inventory (CBI). *Healthcare* 11 2576. doi: 10.3390/healthcare11182576

Council of Deans of Health (2016) *Educating the Future Nurse – a paper for discussion*. Council of Deans Shape of Caring Advisory Body available at http://www.councilofdeans.org.uk/wp-content/uploads/2016/08/Educating-the-Future-Nurse-FINAL-1.pdf accessed 27.04.19

Cranage K, Foster K (2022) Mental health nurses' experience of challenging workplace situations: A qualitative descriptive study. *International Journal of Mental Health Nursing* 31 (3) 665 – 676

Crawford P, Brown B, Majomi P (2008) Professional identity in community mental health nursing: a thematic analysis. *International Journal of Nursing Studies* 45 1055 – 1063

Cresswell JW, Cresswell JD (2018) *Research Design. Qualitative, Quantitative and Mixed Method Approaches* (5th edition). Lincoln. Sage Publications Ltd.

Crigger N, Godfrey N (2014) From the Inside Out: A New Approach to Teaching Professional Identity Formation and Professional Ethics. *Journal of Professional Nursing* (30) 5 376 – 382

Cronin A (2016) "Focus Groups" in Gilbert N, Stoneman P (eds) *Research Social Life*. (4th ed). London. Sage Publications Ltd. 302 – 317

Crook D (2008) Some historical perspectives on professionalism. In Cunningham B (ed.) *Exploring professionalism*. 10 – 27. London Institute of Education, University of London.

Curtis K (2014) Learning the requirements for compassionate practice: Student vulnerability and courage. *Nursing Ethics* 21 (2) 210 – 223

Cyr J (2019) *Focus Groups for the Social Science Researcher*. Cambridge, Cambridge University Press.

Delamont S (2014) *Key Themes in the Ethnography of Education. Achievement and agendas.* London. Sage Publications Ltd.

Denscombe M (2014) *The Good Research Guide* (5th edition). Maidenhead. Open University Press.

Department of Health (2001) *Working together, learning together : a framework for lifelong learning for the NHS*. London. Department of Health.

Dinmohammadi D, Peyrovi H, Mehrdad N (2013) Concept Analysis of Professional Socialization in Nursing. *Nursing Forum* 43 (1) 26 – 34

Doody O, Slevin E, Taggart L (2013[a]) Focus group interviews in nursing research: part 1. *British Journal of Nursing* 21 (1) 16 – 19 (1)

Doody O, Slevin E, Taggart L (2013[b]) Focus group interviews part 3: Analysis. *British Journal of Nursing* 22 (5) 266 – 269

Eckardt M, Lindfelt M (2018) An analysis of nursing students' ethical conflicts in a hospital. *Nursing Ethics* 26 7 – 8 doi: 10.1177/0969733018784730

Edge D, Gladstone N (2022) Exploring support strategies for improving nursing student retention. *Nursing Standard* 37 (9) 28 – 33

Ely J, Stephenson J (2021) Standardised nursing uniforms: what do you want to wear to work? *Nursing Standard* 36 (6) 14 – 17

Eraut M (2004) Informal learning in the workplace. *Studies in Continuing Education* 26 (2) 247 – 273

Erikson E (1950) *Childhood and Society*. New York. Norton

Evans N (2023) Do NMC proficiency standards undermine mental health nursing? *Mental Health Practice* 26 (3) 6 – 8

Evetts J (2012) Professionalism in turbulent times: Changes, challenges and opportunities. Proceedings of the Propel International Conference. Stirling, Scotland

Evetts J (2014) "The Concept of Professionalism: Professional Work, Professional Practice and Learning". In Billett S, Harteis C, Gruber H (eds) *International Handbook of Research in Professional and Practice-based Learning* New York. Springer 29 – 56

Ewertsson M, Bagga-Gupta S, Allvin R, Blomberg K (2017) Tensions in learning professional identities – nursing students' narratives and participation in practical skills during their clinical practice: an ethnographic study. *BMC Nursing* 16:48

Farnsworth V, Kleanthous I, Wenger-Trayner E (2016) Communities of Practice as a Social Theory of Learning. A conversation with Etienne Wenger. *British Journal of Educational Studies* 64 (2) 139 – 160

Fielding N, Thomas H (2016) "Qualitative Interviewing". In Gilbert N, Stoneman P (eds) *Researching Social Life* (4th edition). London. Sage Publications Ltd. 282 – 300

Findlow S (2012) Higher education change and professional academic identity in newly "academic" disciplines: the case of nurse education. *Higher Education* 63 117 – 133

Fisher J (2023) The true value of a mental health nurse: the lessons that I learned by becoming a mental health service user. *British Journal of Mental Health Nursing* doi.org/10.12968/ bjmh.2023.0001

Fitzgerald A, Clukey L (2022) Factors influencing nursing professional identity development: A qualitative study. *Nursing Forum* 57 1346 – 1353

Floyd A, Arthur L (2012) Researching from within: external and internal ethical engagement. *International Journal of Research and Method in Education.* 35 (2) 171 – 180

Foye U *et al.,* (2021) How has COVID-19 affected mental health nurses and the delivery of mental health nursing care in the UK? Results of a mixed-methods study. *Journal of Psychiatric and Mental Health Nursing* 28 (2) 126 – 137

Francis R (2013) *Independent inquiry into care provided by mid –Staffordshire NHS Foundation Trust June 2005* – March 2009. London. The Stationery Office.

Friedson E (2001) *Professionalism: The Third Logic*. Cambridge. Blackwell.

Galvin J, E Suominen, Morgan C, E-J, O'Connell E-J, Smith AP (2015) Mental health nursing students' experiences of stress during training: a thematic analysis of qualitative interviews. *Journal of Psychiatric and Mental Health Nursing* 22 773 – 783

General Medical Council (2009) *Tomorrow's Doctors: Outcomes and Standards for Undergraduate Medical Education*. London. General Medical Council.

Gerace A (2022) Gentle gloves: The importance of self-compassion for mental health nurses during COVID-19. *International Journal of Mental Health Nursing* 31 3 – 7

Gibbon B, Crane J (2018) The impact of "missed care" on the professional socialisation of nursing: A qualitative research study. *Nurse Education Today* 66 19 – 24

Gill P, Stewart K, Treasure E, Chadwick B (2008) Methods of data collection in qualitative research: interviews and focus groups. *British Dental Journal* 204 291 – 295

Glaser BG, Strauss AL (1967) *Discovery of Grounded Theory: Strategies for Qualitative Research.* Chicago. Aldine Publishing Company.

Godbold R, Whiting L, Adams C, Naidu Y, Pattison N (2021) The experiences of student nurses in a pandemic: A qualitative study. *Nurse Education in Practice* 56 e 1 – 8

Godfrey N, Young E (2017) "Professional Identity". In Giddens J *Conceptions of Nursing Practice* 2nd edition. St Louis Elsevier Publishing 379 – 386

Goffman E (1959) *The Presentation of Self in Everyday Life. New* York. Anchor Books Publishing Company

Goffman E (1963) *Stigma: Notes on the Management of Spoiled Identity*. New York. Simon and Schuster

Goffman E (1967*) Interaction ritual: Essays in face-to-face behaviour*. Chicago. Aldine.

Goodolf DM, Godfrey N (2021) A think tank in action: Building new knowledge about professional identity in nursing. *Journal of Professional Nursing* 37 493 – 499

Goodwin J (2021) Acknowledging the resilience of student nurses during COVID-19. *Teaching and Learning in Nursing* doi: 10.1016/j.teln.2021.05.006

Gourlay S (2002) Tacit knowledge, tacit knowing, or behaving? Available at: (PDF) Tacit knowledge, tacit knowing, or behaving? (researchgate.net) accessed 20.02.24

Grealish L, Trevitt C (2005) Developing a professional identity in the workplace. *Contemporary Nurse* 19 (1 – 2) 137 – 150

Green BN, Johnson CD (2015) Editorial: Interprofessional collaboration in research, education, and clinical practice: working together for a better future. *Journal of Chiropractic Education* 29 (1) 1 – 10

Greenway K, Butt G, Walthall H (2019) What is a theory-practice gap? An exploration of the concept. *Nurse Education in Practice* 34 1 – 6

Griffin L, Riley R (2022) Exploring the psychological impact of working during COVID-19 on medical and nursing students: a qualitative study. *BMJ Open* 12 doi: 10.1136/bmjopen-2021-055804

Guba EG (1981) Criteria for assessing the trustworthiness of naturalistic inquiries. *Educational Communication and Technology Journal* 29 (2) 75 – 91.

Guba EG, Lincoln Y (1989) *Fourth Generation Evaluation*. California. Sage Publications Ltd.

Guraya SY, Barr H (2018) The effectiveness of interprofessional education in healthcare: A systematic review and meta-analysis. *Kaohsiung Journal of Medical Sciences* 34 160 – 165

Halverson K, Tregunno D, Vidjen I (2022) Professional Identity Formation: A Concept Analysis. *Quality Advancement in Nursing Education* 8 (4) 1 – 16

Hamilton L, Corbett-Whittier C (2013) *Using Case Study in Education Research (Qualitative Research Kit)*. London. Sage Publications Ltd.

Handley K, Sturdy A, Fincham R, Clark TAR (2006) Within and beyond communities of practice: making sense of learning through participation, identity and practice. *Journal of Management Studies* 43 (3) 641 – 653

Harris BA, Panozzo G (2019) Therapeutic alliance, relationship building, and communication strategies-for the schizophrenia population: An integrative review. *Archives of Psychiatric Nursing* 33 (1) 104 – 111

Haslam MB (2021) What might COVID-19 have taught us about the delivery of Nurse Education, in a post-COVID-19 world? *Nurse Education Today* doi: 10.1016/j.nedt.2020.104707

Hayter M, Jackson D (2020) Pre-registration undergraduate nurses and the COVID-19 pandemic: Students or workers? Journal of Clinical Nursing 29 3115 – 3116

Health and Care Professions Council (2014) *Standards of Education and Training*. London. HCPC.

Hean S, O'Halloran C, Craddock D, Hammick M, Pitt R (2013) Testing theory in interprofessional education: social capital as a case study. *Journal of Interprofessional Care* 27 10 – 17

Henshall C *et al*. (2023) The impact of the COVID-19 pandemic on nursing students' navigation of their nursing programmes and experiences of resilience. A qualitative study.

International Journal of Nursing Studies Advances 5 100146
doi: 10.1016/j.ijnsa.2023.100146

Hoernke K, *et al.,* (2021) Frontline healthcare workers' experiences with personal protective equipment during the COVID-19 pandemic in the UK: a rapid qualitative appraisal. *BMJ Open*
doi: 10.1136/bmjopen-2020-046199

ten Hoeve Y, Jansen, G Roodbol P (2014) The nursing profession: public image, self-concept and professional identify. A discussion paper. *Journal of Advanced Nursing* 70 (2) 295 – 309

Holt J (2014) Nursing in the twenty first century: is there a place for nursing philosophy? *Nursing Philosophy* 15 (1) 1 -3

Hopton J (1996) Reconceptualizing the theory-practice gap in mental health nursing. *Nurse Education Today* 16 (3) 227 – 232

Hovland C, Milliken B, Niederriter J (2021) Interprofessional Simulation Education and Nursing Students: Assessing and Understanding Empathy. *Clinical Simulation in Nursing* 60 25 – 31

Hurley J (2009) A qualitative study of mental health nurse identities: Many roles, one profession. *International Journal of Mental Health Nursing* 18 383 – 390

Hurley J, Lakeman R, Linsley P, Ramsay M, McKenna-Lawson S (2022) Utilizing the mental health nursing workforce: A scoping review of mental health nursing clinical roles and identities. *International Journal of Mental Health Nursing* 31 (4) 796-822

Ion R, Olivier S, Darbyshire P (2019) Failure to report poor care as a breach of moral and professional expectation. *Nursing Inquiry*. 26 (3) e12299 doi: 10.1111/nin.12299

Ipsos Veracity Index (2023) available at https://www.ipsos.com/en-uk/ipsos-trust-in-professions-veracity-index-2023 accessed 22.06.24

Jack K, Hamshire C, Chambers C (2017) The influence of role models in undergraduate nurse education. *Journal of Clinical Nursing* 26 4707 – 4715

Jackson D, Bradbury-Jones D, Gelling L, Morin KH, Neville S, Smith GD (2020) International Nurses Day 2020: Remembering nurses who have died in the COVID-19 pandemic. *Journal of Clinical Nursing* 29 (13-14) 2050-2052

Jackson S, Steven A (2020) Discourse tensions: Professional socialisation into nursing within the university education system. *Nurse Education Today* doi: 10.1016/j.nedt.2020.104478

Jin H, Xiao M, Gong Z, Zhao Y *(*2022) Influence of Different Protection States on the Mental Fatigue of Nurses During the COVID-19 Pandemic. *Risk Management and Healthcare Policy* 15 1917 – 1929

Jones-Berry C (2020[a]) Student attrition: why do nursing students leave their course before completion? *Nursing Standard* https://rcni.com/nursing-standard/newsroom/news/student-attrition-why-do-nursing-students-leave-their-course-completetion-169446

Jones-Berry S (2020[b]) Patients are confused by nurses' uniforms - and they're not alone. *Nursing Standard* 35 (4) 8 – 10

Jorm C, Nisbet G, Roberts C, Gordon C, Gentilcore S, Chen TF (2016) Using complexity theory to develop a student-directed interprofessional learning activity for 1220 healthcare students. *BMC Med Education* 16, 199 doi: 10.1186/s12909-016-0717-y

Joseph RA, Turner T, Chansoon L, Akers SW, Whorley E, Goodrich C (2022) Impact of COVID-19 on Nursing Students: FACTORS ASSOCIATED WITH PTSD RISK. *Journal of Christian Nursing* 39 (4) 250 - 257

Kalin M, Sambanis N (2018) How to think about social identity. *Annual Review of Political Science* 21 239 – 257

Kane C, Rintakorpi E, Wareing M, Hewson D (2021) The psychological effects of working in the NHS during a pandemic on final-year students: part 1. *British Journal of Nursing* 30 (22) 1303 – 1307

Kane C, Wareing M, Rintakorpi E (2022) The psychological effects of working in the NHS during a pandemic on final-year students: part 2. *British Journal of Nursing* 31 (2) 96 – 100

Katila J, Gan Y, Goodwin MH (2020) Interaction rituals and 'social distancing': New haptic trajectories and touching from a distance in the time of COVID-19. *Discourse Studies* 22 4 doi: 10.1177/1461445620928213

Keeling J, Templeman J (2013) An exploratory study: Student nurses' perceptions of professionalism. *Nurse Education in Practice* 13 18 – 22

Kelly SH (2020) The hidden curriculum: Undergraduate nursing students' perspectives of socialization and professionalism. *Nursing Ethics* 27 (5) 1250 – 1260

Kerno SJ (2008) Limitations of Communities of Practices. A Consideration of Unresolved Issues and Difficulties in the Approach. *Journal of Leadership and Organisational Studies* 15 (1) 69 – 78

Kevern J, Webb C (2003) Mature women's experiences of preregistration nurse education. Journal of Advanced Nursing 45 (3) 397 – 306

Kilbourn, B (2006) The qualitative doctoral dissertation proposal. *Teachers College Record* 108 (4) 529 – 576

Kim SH (2015) *The Essence of Nursing Practice: Philosophy and Perspective*. New York. Springer Publishing.

King S *et al.,* (2016) Launching first-year health sciences students into collaborative practice: Highlighting institutional enablers and barriers to success. *Journal of Interprofessional Care*. 17 (3) 386 – 393

King's Fund (2021) Assessing England's response to Covid-19: A framework (kingsfund.org.uk) accessed 09.12.21

King's Fund (2023) NHS Workforce Nutshell | The King's Fund (kingsfund.org.uk) accessed 16.02.24

Kitzinger J (2005) "Focus group research: using group dynamics to explore perceptions, experiences and understandings". In Holloway I (ed) *Qualitative Research in Health Care*. Berkshire. Open University Press 56 – 69

Kivunja C, Kuyini AB (2017) Understanding and Applying Research Paradigms in Educational Contexts. *International Journal of Higher Education* 6 (5) 26 – 41

Knight J, Corbett A, Smith C, Watkins B, Hardy R, Jones G (2012) "What made me stay?" A Review of the reasons student nurses enrolled in a Bachelor of Nursing programme completed their students: A descriptive phenomenological study. *Nurse Education Today* 32 (8) 62 – 65

Koliba C, Gajda R (2009) "Communities of Practice" as an Analytical Construct: Implications for Theory and Practice. *International Journal of Public Administration* 32 (2) 97 - 135

Korstjens I, Moser A (2018) Practical guidance to qualitative research. Part 4. Trustworthiness and publishing. *European Journal of General Practice* 24 (1) 120 – 124

Kotera Y, Cockerill V, Chircop J, Kaluzeviciute G, Dyson S (2021) Predicting self-compassion in UK nursing students: Relationships with resilience, engagement, motivation, and mental wellbeing. *Nurse Education in Practice* 51 e 1 – 7

La Guardia JG, Ryan RM (2007) Why Identities Fluctuate: Variability in Traits as a Function of Situational Variations in Autonomy Support. *Journal of Personality* 75 (6) 1205 – 1228

Larson MS (1977) Professionalism: Rise and Fall. *International Journal of Health Services* 9 (4) 607 – 627

Lave J, Wenger E (1991) *Situated Learning: Legitimate Peripheral Participation*. Cambridge. Cambridge University Press

LeCompte, M, Preissle Goetz J (1982) Problems of Reliability and Validity in Ethnographic Research. *Review of Educational Research* 52 (1) 31 – 60

Lee J, Yang S (2019) Professional socialisation of nursing students in a collectivist culture: a qualitative study. *BMC Medical Education* 19, 254 (2019) doi: 10.1186/s12909-019-1690-z

Lees C, Keane P, Porritt B, Cleary JP (2023) Exploring nursing students' understanding and experiences of academic resilience. A qualitative study. *Teaching and Learning in Nursing* 18 2 276 – 280

Levers MJD (2013) *Philosophical Paradigms, Grounded Theory, and Perspectives on Emergence*. Sage Open 1 –6 doi: 10.1177/2158244013517243

Lewis J, Bartlett S (2015) How UK psychiatric geneticists understand and talk about engaging the public. *New Genetics and Society* 34 (1) 89 – 111

Lundell Rudberg S, Westerbotn M, Sormumen T, Scheja M, Lachmann H (2022) Undergraduate nursing students' experiences of becoming a professional nurse: a longitudinal study. *BMC Nursing* 21 (1) 219 doi: 10.1186/s12912-022-01002-0

Mancini T, Caricati L, Panari C, Tonarelli A (2015) Personal and social aspects of professional identity. An extension of Marcia's identity status model applied to a sample of university students. *Journal of Vocational Behavior*. 89 140 – 150

Marcia JE (1966) Development and validation of ego-identity status. *Journal of Personality and Social Psychology*. 3 551 – 558

Martin-Delgado et al., (2021) Nursing students on the frontline: impact and personal and professional gains during the COVID-19 pandemic in Spain. *Journal of Professional Nursing*. 37 (3) 588 – 597

Mason J (2018) *Qualitative Researching* (3rd edition). London. Sage Publications Ltd.

Mayer JD, Salovey, P (1997) *"What is emotional intelligence?"* In Salovey P and Sluyter DJ (eds) *Emotional development and emotional intelligence: Educational implications*. New York. Basic Books. 3 – 34

McGuire LE, Stewart AL, Akerson EK, Gloeckner JW (2020) Developing an integrated interprofessional identity for collaborative practice: Qualitative evaluation of an undergraduate IPE course. *Journal of Interprofessional Education and Practice* 20 e1 – e8

McKeown M, White J (2015) The future of mental health nursing: are we barking up the wrong tree? *Journal of Psychiatric and Mental Health Nursing* 22 (9) 724 – 730

McKeown M, Wright KW, Gadsby J (2018) "Introduction" in Wright KM, McKeown M (eds) *Essentials of Mental Health Nursing*. London. Sage Publications Ltd.

McSherry R, Eost-Telling C, Stevens D, Bailey J, Crompton R, Taylor L, Kingston P, Simpson A (2021) Student Nurses Undertaking Acute Hospital Paid Placements during COVID-19: Rationale for Opting-In? A Qualitative Inquiry. *Healthcare* 9 (8) 1001 doi: /10.3390/healthcare9081001

Michalec B, Giordano C, Pugh B, Arenson C, Speakman E (2017) Health Professions Students' Perceptions of Their IPE Program. *Journal of Allied Health* 46 (1) 10 – 19

Mitchell KM, Baxter CE, Gural DM, Chorney MA, Simmons-Swiden JM, Queau ML, Nayak N (2021) Strategies for retention of nursing students: A scoping review. *Nurse Education in Practice* 50 doi: 10.1016/j.nepr.2020.102956

Morris AH, Faulk DR (2012) *"The Road to Professionalism: Transformative Learning for Professional Role Development".* In Morris AH, Faulk DR (eds) *Transformative Learning in Nursing: A Guide for Nurse Educators*. New York. Springer Publishing Company. 57 – 63

Myin E, Zahnoun F (2018) Reincarnating the Identity Theory. *Frontiers in Psychology* 9 (2044) 1 – 9

National Health Service Confederation (2021[a]) https://www.nhsconfed.org/publications/under-pressure accessed 09.12.21

National Health Service Confederation (2021[b]) https://www.nhsconfed.org/news/nhs-staff-continue-be-under-enormous-pressure accessed 09.12.21

Nibbelink CW, Brewer BB (2017) Decision Making in Nursing Practice: An integrative literature review. *Journal of Clinical Nursing* 27 5- 6

Nicholl H, Tracey C (2007) Networking for nurses. *Nursing Management* 13 (9) 26 – 29

North SE, Lafky R, Porta C, Sick, B (2023) Interprofessional students' insights into the experiential learning environment: Values, impacts, and alignment with interprofessional collaborative practice competencies and the triple aim. *Journal of Interprofessional Education and Practice* 32 available at: https://www.sciencedirect.com/science/article/pii/S2405452623000411?via%3Dihub accessed 15.05.23

Nowell LS, Norris JM, White DE, Moules NJ (2017) Thematic Analysis: Striving to Meet the Trustworthiness Criteria. *International Journal of Qualitative Methods* 16 1 doi: 10.1177/1609406917733847

Nursing and Midwifery Council (2018[a]) *Future nurse: Standards of proficiency for registered nurses*. London. Nursing and Midwifery Council. future-nurse-proficiencies.pdf(nmc.org.uk) accessed 30.06.23

Nursing and Midwifery Council (2018[b]) *The Code. Professional standards of practice and behaviour for nurses, midwives and nursing associates.* London. Nursing and Midwifery Council.

Nursing and Midwifery Council (2023[a]) *Standards for Education and Training: Standards framework for nursing and midwifery education.* London. Nursing and Midwifery Council.

Nursing and Midwifery Council (2023[b]) *Standards For Education and Training: Standards for pre-registration nursing programmes.* London. Nursing and Midwifery Council.

Ó Lúanaigh P (2015) Becoming a professional: What is the influence of registered nurses on nursing students' learning in the clinical environment? *Nurse Education in Practice* 15 450 – 456

Orazietti B, Peniston S, Mohammed Z, Duldulao JF, Rao M (2023) Nursing Students and Faculty Narratives During COVID-19 Pandemic: Challenges and Recommendations From a Canadian Perspective. *SAGE Open Nursing* 9 doi: 10.1177/23779608231179553

Orsmond P, McMillan H, Zvauya R (2022) Its how we practice that matters: professional identity formation and legitimate peripheral participation in medical students: a qualitative study. *BMC Medical Education* 22, 91 doi.org/10.1186/s12909-022-03107-1

Ousey K (2011) The changing face of student nurse education and training programmes. *Wound UK.* 7 (1) 70 – 75

Park WB *et al.,* (2020) Virus Isolation from the First Patient with SARS-CoV-2 in Korea. *Journal of Korean Medical Science* 35 7 e84 doi: 10.3346/jkms.2020.35.e84.

Pascale CM (2011*) Cartographies of Knowledge. Exploring Qualitative Epistemologies*. California. Sage Publications Ltd.

Payne-Gill J, Whitfield C, Beck A (2021) The effect of rapidly discharging psychiatric inpatients from Mental Health Act section during COVID-19: a cohort study. *Epidemiology and Psychiatric Sciences* doi:10.1017/S2045796021000226

Peplau HE (1988) *Interpersonal Relations in Nursing*. Hampshire. MacMillan Education.

Peplau HE (1997) Peplau's Theory of Interpersonal Relations. *Nursing Science Quarterly*. 10 (4) 162 – 167

Perksy AM, Robinson JD (2017) Moving from Novice to Expertise and Its Implications for Instruction. *American Journal of Pharmaceutical Education* 81 (9) 6065 doi: 10.5688/ajpe6065

Pescosolido BA, Martin JK (2015) The Stigma Complex. *Annual Review of Sociology* 41 87 – 116

Pomare C, Ellis LA, Churruca K, Long JC, Braithwaite J (2018) The Reality of Uncertainty in Mental Health Care Settings Seeking Professional Integration: A Mixed-Methods Approach. *International Journal of Integrated Care* 18 (4) 1 – 9

Ponterotto JG (2005) Qualitative Research in Counselling Psychology: A Primer on Research Paradigms and Philosophy of Science. *Journal of Counselling Psychology*. 52 (2) 126 -136

Porter S (1992) The poverty of professionalism: a critical analysis of the strategies for the occupational advancement of nursing. *Journal of Advanced Nursing*. 17 720 – 726

Priest H, Roberts P, Dent H, Hunt T, Weston D, Chell A, Blincoe C, Armstrong C (2011) Preparing for collaborative working in mental health: an interprofessional education project with clinical psychology trainees and nursing students. *Journal of Mental Health, Training and Education in Practice* 6 (1) 47 – 57

Pugsley L (2012) "Walk this way, talk this way: qualitative research on professional education". In Delamont S (ed) *Handbook of Qualitative Research in Education*. Cheltenham. Edward Elgar. 157 – 169

Pyrko I, Dorfler V, Eden C (2017) Thinking together: What makes Communities of Practice work? *Human Relations* 70 (4) 389 – 409

Quinn BG, McLaughlin C, Bunting A, McLaughlin L, Scales S, Craig S, Copeland S (2021) Exploring the role of effective nurse leadership during COVID-19. *Nursing Management* doi: 10.7748/nm.2021.e198

Ranjbar H, Joolaee S, Vedadhir A, Abbaszadeh A, Bernstein C (2017) Becoming a nurse as a moral journey: A constructivist grounded theory. *Nursing Ethics* 24 (5) 583 – 597

Rees CE, Monrouxe LV, McDonald LA (2015) "My mentor kicked a dying woman's bed …." Analysing UK nursing students "most memorable" professionalism dilemmas. *Journal of Advanced Nursing* 71 (1) 169 – 180

Reeves S, Perrier L, Goldman J, Freeth D, Swarenstein M (2013*) Interprofessional Education: effects on professional practice and healthcare outcomes* (update). Cochrane Database Systematic Review

Reeves S, Tassone M, Parker K, Wagner SJ, Simmons B (2012) Interprofessional education: An overview of key developments in the past three decades. *Work* 41 233 – 24

Roberts BW, Viechtbauer W (2006) Patterns of Mean-Level Change in Personality Traits Across the Life Course: A Meta-Analysis of Longitudinal Studies. *Psychological Bulletin* 132 (1) 1 – 25

Roberts J (2006) Limits to Communities of Practice. *Journal of Management Studies*. 43 (3) 623 – 639

Rodríguez-Pérez M, Mena-Navarro F, Domínguez-Pichardo A, Teresa-Morales C (2022) Current Social Perception of Value Attached to Nursing Professionals' Competences: An Integrative Review. *International Journal of Environmental Research and Public Health* 19 3 doi: 10.3390/ijerph19031817.

Rohde G, Johannessen B, Maaseide M, Flateland S, Skisland AV, Moi EB, Haraldstad K (2022) Baccalaureate nursing students' experiences of how the COVID-19 pandemic influenced learning experiences: a mixed method study. *BMC Nursing* 21 172 doi: 10.1186/s12912-022-00955-6

Rood L, Tanzillo T, Madsen N (2022) Student nurses' educational experiences during COVID-19: A qualitative study. *Nurse Education Today* 119 doi: 10.1016/j.nedt.2022.105562

Rosenberg JP Yates PM (2007) Schematic representation of case study research designs. *Journal of Advanced Nursing*. 60 (4) 447 – 452

Royal College of Nursing (2007) *Policy Briefing 14/2007 Pre-registration Nurse Education. The NMC review and the issues*. London. Royal College of Nursing

Royal College of Nursing (2019[a]) Advice: Terrified of Being Newly Qualified? Available at Terrified of being newly qualified | Students | Royal College of Nursing (rcn.org.uk) accessed 23.03.23

Royal College of Nursing (2019[b]) Wake up Slackers! The great nursing registration controversy. Available at: Wake up, slackers! | Royal College of Nursing (rcn.org.uk) accessed 31.03.23

Royal College of Nursing (2020) Uniform and Workwear Guidance. https://www.rcn.org.uk/professional-development/publications/rcn-uniform-and-workwear-guidance-covid-19-uk-pub-009245#orderTab accessed 10.12.21

Royal College of Nursing (2023[b]) https://www.rcn.org.uk/news-and-events/news/uk-falling-nursing-student-applications-deeply-concerning-for-future-of-profession-130723#:~:text=The%20data%20reports%20on%20the,show%20there%20were%204%2C860%20applicants. accessed 14.09.23

Saks M (2016) A review of theories of professions, organizations and society: The case for neo-Weberianism, neo-institutionalism and eclecticism. J*ournal of Professions and Organization* 3 (2) 170 – 187

Saldana J (2015) *The Coding Manual for Qualitative Researchers* (3rd Edition) London. Sage Publications Ltd.

Santry C (2010) Nurse training is "too academic" says Cameron. https://www.nursingtimes.net/nurse-training-too-academic-says-cameron/5010291.article accessed 15.04.19

Sapolsky RM (2017) *Behave. The Biology of Humans at Our Best and Worst.* New York. Penguin Press.

Scotland J (2012) Exploring the Philosophical Underpinning of Research: Relating Ontology and Epistemology to the Methodology and Methods of the Scientific, Interpretive and Critical Research Paradigm. *English Language Teaching* 5 (9) 9 – 16

Scully NJ (2011) The theory-practice gap and skill acquisition: an issue for nursing education. *Collegian* 18 (2) 93 – 98

Seawright J, Gerring J (2008) Case Selection Techniques in Case Study Research: A Menu of Qualitative and Quantitative Options. *Political Research Quarterly* 61 (2) 294 – 308

Severinsson E, Sand S (2010) Evaluation of the clinical supervision and professional development of student nurses. *Journal of Nursing Management* 18 669 – 677

Shaw K, Timmons S (2010) Exploring how nursing uniform influence self-image and professional identity. *Nursing Times* 106 (10) 21 – 23

Shenton AK (2004) Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information* 22 63 – 75

Sikes P (2006) On dodgy ground? Problematics and ethics in educational research. *International Journal of Research and Method in Education* 29 (1) 105 – 117

Silverman D (2014) *Interpreting Qualitative Data*. London. Sage Publications Ltd.

Simons H (2009) *Case Study Research in Practice*. London. Sage Publications Ltd.

Simons H (2014) "Case Study Research: In-Depth Understanding in Context". In Leary P (ed) *The Oxford Handbook of Qualitative Research*. Oxford. Oxford University Press, 455 – 470

Skidmore D, Warne T, Stark S (2004) Mental health practice and the rhetoric–reality gap. *Journal of Psychiatric and Mental Health Nursing* 11 348 – 356

Smith SU, Hayes S, Shea P (2017) A Critical Review of the Use of Wenger's Community of Practice (CoP) Theoretical Framework in Online and Blended Learning. *Online Learning* 21 (1) 209 – 239

Smithson A (2000) Using and analysing focus groups: limitations and possibilities. *Journal of Social Research Methodology* 3 (2) 103 – 119

Sollami A, Caricati L, Mancini T (2018) Does the readiness for Interprofessional Education reflect students' dominance orientation and professional commitment? Evidence from a sample of nursing students. *Nurse Education Today* 68 141 – 145

Spears R (2011) "Group identities: The social identity perspective". In Schwartz SJ, Luyckx K, Vignoles LV (eds) *Handbook of identity theory and research*. New York. Springer. 201 – 224

Spencer JA, Taff SD, Chen L (2019) Interprofessional education: A controlled trial of a shared-learning skills simulation between RN and OT students. *Journal of Interprofessional Education and Practice* 15 75 – 81

Spragley F, Francis K (2006) Nursing uniforms: professional symbol or outdated relic? *Nursing Management* 37 (10) 55 – 58

Stacey A (2022) Student attrition: what's happening with the COVID-19 cohort? Briefing on a Nursing Standard investigation. *Nursing Standard* 37 10 10 – 12

Stacey G, Pollock K, Crawford P (2015) A case study exploring the experience of graduate entry nursing students when learning in practice. *Journal of Advanced Nursing* 71 (9) 2084 – 2095

Stake RE (2005) "*Qualitative Case Studies*". In Denzin NK, Lincoln Y (eds) *The Sage Handbook of Qualitative Research*. California. Sage Publications Ltd. 443 – 466

Stake RD (1995) *The Art of Case Study Research*. California. Sage Publications Ltd.

Stanley N (2021) Associative Stigma Against Mental Health Nursing: Ways Forward. *Creative Nursing.* 27 (3) doi: 10.1891/CRNR-D-20-00040

Stephens M, Ormandy P (2018) Extending conceptual understanding: How interprofessional education influences affective domain development. *Journal of Interprofessional Care* 32 (3) 248 – 357

Stone R (2016) Self-development and earning that staff nurse uniform. *British Journal of Nursing* 25 (15) 882

Strachan S, Stadig G, Jung M, Semenchuk B (2018) Affective and self-presentational responses to an exercise identity challenge: Investigating identity theory and the role of others. *Psychology of Sport and Exercise* 36 132 – 138

Stull CL, Blue CM (2016) Examining the influence of professional identity formation on the attitudes of students towards interprofessional collaboration. *Journal of Interprofessional Care* 30 (1) 90 – 96

de Swardt HC, van Rensburg GH, Ooosthuizen MJ (2017) Supporting students in professional socialisation: Guidelines for professional nurses and educators. *International Journal of Africa Nursing Sciences* 6 1 – 7

Swift A *et al.,* (2020) Editorial. COVID 19 and student nurses: A view from England. *Journal of Clinical Nursing* 29 17 – 18

Tajfel H, Turner JC (1986) "The Social Identity Theory of Intergroup Behaviour". In Worchel S, Austin WG (eds) *Psychology of Intergroup Relation*. Chicago. Hall Publishers. 7 – 14

Taylor C (1989) *Sources of the Self: The Making of Modern Identity*. Cambridge, Massachusetts. Harvard University Press.

Teresa-Morales C, Rodríguez-Pérez M, Araujo-Hernández M, Feria-Ramírez C (2022) Current Stereotypes Associated with Nursing and Nursing Professionals: An Integrative Review. *International Journal of Environmental Research and Public Health* 19 (13) 7640

Terry J (2020) 'In the middle': A qualitative study of talk about mental health nursing roles and work. *International Journal of Mental Health Nursing* 29 414 – 426

Teskereci G, Boz I (2019) "I try to act like a nurse": a phenomenological qualitative study. *Nurse Education in Practice* 37 39 – 44

Tholen G (2017) *The Changing Opportunities of Professionalization for Graduate Occupations*. Comparative Sociology 16 613 – 633

Thomas L, Hovdhaughen E, Sweetman R (2023) Professional or student identity and commitment? Comparing the experiences of nursing students with literature of student success. *Journal of Tertiary Education and Management* 29 93 – 106

Thomas J, Jinks A, Jack B (2015) Finessing incivility: The professional socialisation experiences of student nurses' first clinical placement, a grounded theory. *Nurse Education Today* 35 e4 – e9

Thomas G, Myers K (2015) *The Anatomy of the Case Study*. Abingdon. Sage Publications Ltd.

Townsend MJ (2020) Learning to nurse during the pandemic: a student's reflections. *British Journal of Nursing* 29 16 doi: 10.12968/bjon.2020.29.16.972

Traynor M, Buss (2016) N Professional identity in nursing: UK students' explanations for poor standards of care. *Social Science and Medicine* 166 186- 194

Treloar AE, Bleus K (2021) Conceptualising Recovery in Mental Health Nursing: A Word, A Journey or A Philosophy of Nursing Care? *Journal of Problem-Based Learning* 2 87 – 93

Trowler P (2011) Researching your own institution. British Educational Research Association on-line resource. https://www.bera.ac.uk/researchers-resources/publications/researching-your-own-institution-higher-education accessed 22.02.19

Tume LN, Ungari D, Bannerman F, Cuddihy S, Gnanalingham C, Phillips *H* (2022) The physical effects of wearing personal protective equipment: a scoping review. *International Journal of Infection Control* 18 doi: 10.3396/ijic.v18.22415

Ulenaers D, Grosemans J, Schrooten W , Jochen B (2021) Clinical placement experience of nursing students during the COVID-19 pandemic: A cross-sectional study. *Nurse Education Today* 99 1 – 6

Varjus SL, Leino-Kilpi H, Suominen T (2011) Professional autonomy of nurses in hospital settings – a review of the literature. Scandinavian Journal of Caring Sciences 25 201–207

Villaseñor A *et al*., (2023) The impact of COVID-19 on mental health service utilisation in England. *SSM Mental Health* doi: 10.1016/j.ssmmh.2023.100227

Walker CR *et al.,* (2023) Ethnic inequalities during clinical placement: A qualitative study of student nurses' experiences within the London National Health Service. *Journal of Advanced Nursing* (80) 1497 – 1510

Walker S, Dwyer T, Broadbent M, Moxham L, Sander T, Edwards K (2014) Constructing a nursing identity within the clinical environment: The student nurse experience. *Contemporary Nurse* 49 103 – 112

Walsh A (2015) The effect of social interaction on mental health nurse student learning. *Nurse Education in Practice*. 15 (1) 7 – 12

Warrender D, Connell C, Jones E, Monteux, Colwell L, Laker C, Cromer-Hayes M (2023) Mental health deserves better: Resisting the dilution of specialist pre-registration mental health nurse education in the United Kingdom. *International Journal of Mental Health Nursing*. 33 (7) 202 – 212

Weeks KW, Coben D, O'Neill D, Jones A, Weeks A, Brown M, Pontin D (2019) Developing and integrating nursing competence through authentic technology-enhanced clinical simulation education: Pedagogies for reconceptualising the theory-practice gap. *Nurse Education in Practice.* 37 29 – 38

Welsh Assembly Government (2009) New all-Wales nurses uniforms showcased https://www.wired-gov.net/wg/wg-news-1.nsf/0/64FBC3C7B3B00D4F802575AF00410D7D?OpenDocument accessed 30.03.23

Welsh Government, NHS Wales, Health Education and Improvement Wales (2020) Nursing and Midwifery Student Support Guidance during COVID-19 Outbreak. Cardiff. Welsh Government, NHS Wales, Health Education Improvement Wales

Wenger E (1998) *Communities of Practice. Learning, Meaning and Identity*. Cambridge. Cambridge University Press

Wenger E (2009) "A social theory of learning". In Illeris K (ed) *Contemporary Theories of Learning. Learning Theorists in Their Own Words*. Abingdon. Routledge. 209 – 218

Wenger-Trayner E, Wenger-Trayner B (2015[a]) *Communities of practice – a brief introduction*. http://wenger-trayner.com/introduction-to-communities-of-practice accessed 12.09.22

Wenger-Trayner E, Wenger-Trayner B (2015[b]) "Learning in a Landscape of Practice". In Wenger-Trayner B, Fenton-O'Creevy M, Hutchinson S, Kubiak C, Wenger-Trayner B (eds) *Learning in Landscapes of Practice. Boundaries, identity and knowledgeability in practice-based learning*. London. Routledge 13 – 29

Willetts G, Clarke D (2014) Constructing nurses' professional identity through Social Identity Theory. *International Journal of Nursing Practice* 20 164 – 169

Williams BA, Jones CH, Welch V, True JM (2023) Outlook of pandemic preparedness in a post-COVID-19 world. *npj Vaccines* 8 178 doi.org/10.1038/s41541-023-0073-0

Williams MG, Burke LL (2015) Doing Learning Knowing Speaking: How Beginning Nursing Students Develop Their Identity as Nurses. *Nursing Education Perspectives* 36 (1) 50 – 52.

Willis P (2015) *Raising the bar: shape of caring: a review of the future education and training of registered nurses and care assistants*. London. Health Education England.

Woods A, Cashin A, Stockhausen L (2016) Communities of Practice in the construction of the professional identities of nurse educators: A review of the literature. *Nurse Education Today* 37 164 - 169

World Health Organisation (1988) *Learning together to work together for health. Report of a WHO study group on multi-professional education of Health Personnel: the team approach*. Geneva. World Health Organisation.

World Health Organisation (2010) *Framework for Action on Interprofessional Education & Collaborative Practice.* Geneva. World Health Organisation.

World Health Organisation (2019) *The International Year of the Nurse and the Midwife Taking stock of outcomes and commitment.* Geneva. World Health Organisation. Available at 9789240081925-eng.pdf (who.int) accessed 30.06.20

World Health Organisation (2020[a]) https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020 accessed 09.12.21

World Health Organisation (2020[b]) https://www.who.int/news-room/spotlight/a-year-without-precedent-who-s-covid-19-response accessed 09.12.21

World Health Organisation (2020[c]) https://www.who.int/publications/m/item/weekly-epidemiological-update---31-august-2020 accessed 21.09.20

World Health Organisation (2021) https://www.who.int/publications/m/item/weekly-epidemiological-update-on-covid-19---7-december-2021 accessed 09.12.21

World Health Organisation (2023) https://www.who.int/publications/m/item/weekly-epidemiological-update-on-covid-19---1-september-2023 accessed 09.09.23

World Health Organisation (2024) WHO Member States agree to resume negotiations aimed at finalizing the world's first pandemic agreement
https://WHO Member States agree to resume negotiations aimed at finalizing the world's first pandemic agreement accessed 24.04.24

Yin RK (2014) *Case Study Research. Design and Methods* (5th edition) California. Sage Publications Ltd.

Yukl G (2013) *Leadership in Organizations* (8th edition). New York. Pearson Education Limited.

Zelditch M Jr. (1962) Some methodological problems of field studies. *The American Journal of Sociology* 67 566- 576

APPENDIX 1

School of Social Sciences
Ysgol y Gwyddorau Cymdeithasol

Cardiff University
Glamorgan Building
King Edwards VII Avenue, Cardiff
CF10 3WT, Wales, UK
Tel +44(0)29 2087 5179
Fax +44(0)29 2087 4175
www.cardiff.ac.uk/social-sciences

Prifysgol Caerdydd
Adeilad Morgannwg
Rhodfa'r Brenin Edward VII, Caerdydd
Ffon +44(0)29 2087 5179
Ffacs +44(0)29 2087 4175
www.cardiff.ac.uk/social-sciences

04 March 2019

Our ref: SREC/3186

Elizabeth Bowring Lossock
Professional Doctorate Programme
SOCSI

Dear Elizabeth,

Your project entitled *'Does Interprofessional Education facilitated at pre-registration level benefit the learning and practice of mental health nursing students?'* has now been approved by the School of Social Sciences Research Ethics Committee of Cardiff University and you can now commence the project should all necessary forms of approval been received.

If you make any substantial changes with ethical implications to the project as it progresses you need to inform the SREC about the nature of these changes. Such changes could be: 1) changes in the type of participants recruited (e.g. inclusion of a group of potentially vulnerable participants), 2) changes to questionnaires, interview guides etc. (e.g. including new questions on sensitive issues), 3) changes to the way data are handled (e.g. sharing of non-anonymised data with other researchers).

In addition, if anything occurs in your project from which you think the SREC might usefully learn, then please do share this information with us.

All ongoing projects will be monitored and you will be obliged periodically to complete and return a SREC monitoring form.

Please inform the SREC when the project has ended.

Please use the SREC's project reference number above in any future correspondence.

Yours sincerely

[redacted]

Professor Emma Renold
Chair of School of Social Sciences Research Ethics Committee
Cc: Alison Bullock

APPENDIX 2

CARDIFF UNIVERSITY
PRIFYSGOL CAERDYDD
School of Social Sciences
Ysgol y Gwyddorau Cymdeithasol

Cardiff University
Glamorgan Building
King Edwards VII Avenue, Cardiff
CF10 3WT, Wales, UK
Tel +44(0)29 2087 5179
Fax +44(0)29 2087 4175
www.cardiff.ac.uk/social-sciences

Prifysgol Caerdydd
Adeilad Morgannwg
Rhodfa'r Brenin Edward VII, Caerdydd
Ffon +44(0)29 2087 5179
Ffacs +44(0)29 2087 4175
www.cardiff.ac.uk/social-sciences

03 October 2019

Our ref: SREC/3186

Elizabeth Bowring Lossock
Professional Doctorate Programme
SOCSI

Dear Elizabeth,

Many thanks for advising the committee of the changes to your project entitled *'Does Interprofessional Education facilitated at pre-registration level benefit the learning and practice of mental health nursing students?'* has now been approved by the School of Social Sciences Research Ethics Committee of Cardiff University and you can now commence the project should all necessary forms of approval been received.

If you make any substantial changes with ethical implications to the project as it progresses you need to inform the SREC about the nature of these changes. Such changes could be: 1) changes in the type of participants recruited (e.g. inclusion of a group of potentially vulnerable participants), 2) changes to questionnaires, interview guides etc. (e.g. including new questions on sensitive issues), 3) changes to the way data are handled (e.g. sharing of non-anonymised data with other researchers).

In addition, if anything occurs in your project from which you think the SREC might usefully learn, then please do share this information with us.

All ongoing projects will be monitored and you will be obliged periodically to complete and return a SREC monitoring form.

Please inform the SREC when the project has ended.

Please use the SREC's project reference number above in any future correspondence.

Yours sincerely

[redacted]

Professor Emma Renold
Chair of School of Social Sciences Research Ethics Committee
Cc: Alison Bullock, Jamie Lewis

APPENDIX 3

School of Social Sciences
Ysgol y Gwyddorau Cymdeithasol

Cardiff University
Glamorgan Building
King Edwards VII Avenue, Cardiff
CF10 3WT, Wales, UK
Tel +44(0)29 2087 5179
Fax +44(0)29 2087 4175
www.cardiff.ac.uk/social-sciences

Prifysgol Caerdydd
Adeilad Morgannwg
Rhodfa'r Brenin Edward VII, Caerdydd
Ffon +44(0)29 2087 5179
Ffacs +44(0)29 2087 4175
www.cardiff.ac.uk/social-sciences

4th February 2020

Our ref: SREC/3186

Elizabeth Bowring Lossock
Professional Doctorate Programme
SOCSI

Dear Elizabeth,

Many thanks for advising the committee of the changes to your project entitled '*How does the development of identity for mental health nursing students benefit from Interprofessional Education facilitated at pre-registration level?'* has now been approved by the School of Social Sciences Research Ethics Committee of Cardiff University and you can now commence the project should all necessary forms of approval been received.

If you make any substantial changes with ethical implications to the project as it progresses you need to inform the SREC about the nature of these changes. Such changes could be: 1) changes in the type of participants recruited (e.g. inclusion of a group of potentially vulnerable participants), 2) changes to questionnaires, interview guides etc. (e.g. including new questions on sensitive issues), 3) changes to the way data are handled (e.g. sharing of non-anonymised data with other researchers).

In addition, if anything occurs in your project from which you think the SREC might usefully learn, then please do share this information with us.

All ongoing projects will be monitored and you will be obliged periodically to complete and return a SREC monitoring form.

Please inform the SREC when the project has ended.

Please use the SREC's project reference number above in any future correspondence.

Yours sincerely

[redacted]

Professor Emma Renold
Chair of School of Social Sciences Research Ethics Committee
Cc: Alison Bullock, Jamie Lewis

APPENDIX 4

RE: Ref: SREC 3186

socsi-ethics <socsi-ethics@cardiff.ac.uk>
Fri 29/05/2020 11:59
To: Elizabeth Bowring-Lossock <Bowring-LossockEG@cardiff.ac.uk>

Hi Liz,

Thank you for letting us know of the below changes. I have run this past the ethics committee and they are happy to approve your amendments.

Many thanks,
James

James Griffiths
Research Administrator | Gweinyddwr Ymchwil
Cardiff University | Prifysgol Caerdydd
School of Social Sciences | Ysgol Gwyddorau Cymdeithasol
Glamorgan Building | Adeilad Morgannwg
King Edward VII Avenue | Rhodfa Brenin Edward VII
Cardiff | Caerdydd
CF10 3WT
Phone | Ffon: +44 (0)29 20874294
E-mail | Ebost: griffithsj39@cardiff.ac.uk
http://www.cardiff.ac.uk/social-sciences

From: Elizabeth Bowring-Lossock <Bowring-LossockEG@cardiff.ac.uk>
Sent: 27 May 2020 18:08
To: socsi-ethics <socsi-ethics@cardiff.ac.uk>
Subject: Ref: SREC 3186

Dear SOCSI Research Ethics Team

Re: SREC 3186

In light of changes related to the coronavirus pandemic I need to make some amendments to my data collection method. Earlier this year, I was given approval to include face to face individual interviews in addition to the agreed focus groups. The pandemic has changed the students' journey, they have become NHS employees with a unique student status. Carrying out interviews would be appropriate but I cannot physically meet them at the moment. I am seeking permission to carry out individuals via video link. I would only take a voice recording. I can make very minor changes to the information sheet to reflect this.
I have discussed and negotiated these changes with Professor Bullock and Dr Lewis.

Thank you.

Kind Regards

Liz

Elizabeth Bowring-Lossock

APPENDIX 5

Interprofessional Education and the Development of Identity

PARTICIPANT INFORMATION SHEET: Mental Health Nursing Students 26.09.19

You are invited to take part in a study of Interprofessional Education (IPE) and identity for mental health nursing students. Before you decide whether or not to take part, please read the following information carefully. If you have any questions, please contact Elizabeth Bowring-Lossock, whose contact details are provided at the end.

What is the purpose of the research?

The aim of this research is to explore the effect of IPE on the development of identity for mental health nursing students.

Who is organising and funding this research?

The research is being carried out by Elizabeth Bowring-Lossock as part of a Doctoral study. It is being supervised by Professor Alison Bullock and Dr Jamie Lewis at the School of Social Sciences at Cardiff University.

Why have I been invited to take part in the study?

You have been invited to participate due to your experience as a mental health nursing student.

Do I have to take part in the study?

No, your participation is entirely voluntary. If you *do* decide to participate in the study, you will be asked to sign a consent form. You will be free to withdraw from participation in the study at any time, without giving reason and any data previously collected from you will not be included in the study.

If you decide you *do not* wish to participate, you do not have to provide a reason.

What will taking part involve?

Taking part in the study will involve participating in two focus groups with other mental health nursing students. Here you will be asked about your views on what identity means to you, how you think your professional identity develops and how IPE can influence professional identity. You are not expected to provide any information or opinion which you do not feel comfortable sharing.

The first focus groups will be held on 23rd and 30th October 2019 and you will only need to attend one of these. The second focus groups will be held on 4th March and 10th March 2020 and again you will only need to attend one of these. Each group will last approximately one hour.

Should you provide permission freely, the focus group discussion will be recorded for later transcription at which point all data will be anonymised. If you agree to participate in the focus

group but do not give permission for recording, any input you provide will not be transcribed for data analysis.

Will I be paid anything for taking part?

No, there are no payments for taking part in this study.

What are the possible benefits of taking part?

Your participation in this study will involve sharing your views on the development of professional identity and IPE for mental health nursing students. Although there are no direct benefits to you as a result of your participation, this information will be used to help understand how students develop their identity and how IPE influences this. This can inform recommendations for mental health nursing curriculum development and changes to programme structure.

What are the possible risks of taking part?

The only foreseeable potential risk of participation in this study is some discomfort you may feel in sharing your views on the development of professional identity and/or IPE in the presence of other focus group participants. There is no intent to cause discomfort and you are encouraged to only contribute opinions you feel comfortable sharing.

Will my taking part in this study be kept confidential?

Should you grant permission for the focus group discussion to be recorded, all data provided by you and your fellow participants will be anonymised on transcription and you will not be personally identifiable. However, you should understand the limits in confidentiality of focus group discussions in that any information you share will be known to other focus group participants. All focus group participants will be asked to respect the confidentiality of the discussion. Data collected during the study will be kept strictly confidential and any personal information you provide will be managed in accordance with data protection legislation.

What will happen to my personal data?

The only personally identifiable data collected from you and retained will be your consent form (should you provide it), which will include your name and signature. This information is only collected so I know who has consented to participate in the study. All information provided by you will be anonymous and will not be matched to the information in your consent form. Your consent form will be retained in accordance with Cardiff University research ethics requirements and may be accessed by my supervisors and, where necessary, by members of the University's governance and audit teams. Anonymised data will be kept for a minimum of 5 years, or at least 2 years post-publication.

Cardiff University is the Data Controller and is committed to respecting and protecting your personal data in accordance with your expectations and Data Protection legislation. The University Data Protection Officer can be contacted at inforequest@cardiff.ac.uk. Further information about Data Protection can be found at: https://www.cardiff.ac.uk/public-information/policies-and-procedures/data-protection

APPENDIX 5

In providing data for this research, I will process it on the basis that it is part of our public task as a university established to advance knowledge and education through its teaching and research activities.

What will happen to the results of the study?

The principal output of the study will be a thesis documenting findings about the development of student nurses' identity, what is deemed to be important and how IPE may influence this. It is expected that this will be available in July 2021, though this is subject to change.

It is also my intention to report the results in academic journals and at relevant conferences. All data will remain anonymous and participants will not be personally identified in any report, publication or presentation.

What if there is a problem?

Elizabeth Bowring-Lossock will be available to answer any questions or queries regarding any aspects of the research study. If you wish to complain or have concerns about the way you have been approached or treated during the course of this study, please contact the research ethics committee at:

socsi-ethics@cardiff.ac.uk.

Who has reviewed this study?

This study has been reviewed and given a favourable opinion by the School of Social Sciences' Research Ethics Committee at Cardiff University.

Further information and contact details

Should you have any questions or queries relating to this study, please contact:

Elizabeth Bowring-Lossock Telephone: 02920 687748 Email: bowring-lossockeg@cf.ac.uk

Cardiff University, College of Biomedical and Life Sciences, School of Healthcare Sciences, Room 2F20, Cardigan House, Heath Hospital, Cardiff, CF144XN.

Thank you for considering participation in this study.

APPENDIX 6

PARTICIPANT CONSENT FORM: Mental Health Nursing Students

Interprofessional Education and the Development of Identity

Title of study: **How does the development of identity for mental health nursing students benefit from Interprofessional Education, facilitated at pre-registration level?**

Name of Researcher: **Elizabeth Bowring-Lossock**

This has been considered through the lens of Wenger's STL (1998).	Please initial box
I confirm that I have read and understood the Information Sheet dated 26.09.19 for the above study and have had the opportunity to ask questions and these have been answered satisfactorily.	
I understand that my participation is voluntary, and I am free to withdraw the study at any time without giving a reason and without any adverse consequences.	
I consent to the processing of my personal data provided in this consent form. I understand that such information will be held in accordance with all applicable data protection legislation and in strict confidence unless disclosure is required by law or professional obligation.	
I understand who will have access to the personal information I provide, how the data will be stored and what will happen to the data at the end of the project.	
I understand that the focus group discussion will be audio recorded and that anonymised excerpts and/or verbatim quotes from my focus group may be used as part of the research report.	
I understand how the findings and results of this study will be written up and disseminated.	
I give consent freely to my participation in this study.	

Name of participant (print)	Date	Signature
Name of person taking consent (print)	Date	Signature

THANK YOU FOR PARTICIPATING IN THIS RESEARCH.

APPENDIX 7

Interprofessional Education and the Development of Identity

PARTICIPANT INFORMATION SHEET: Mental Health Nursing Students

26.09.19 amended 08.06.20 to reflect additional data collection

You are invited to take part in a study of Interprofessional Education (IPE) and identity for mental health nursing students. Before you decide whether or not to take part, please read the following information carefully. If you have any questions, please contact Elizabeth Bowring-Lossock, whose contact details are provided at the end.

What is the purpose of the research?

The aim of this research is to explore the effect of IPE on the development of identity for mental health nursing students.

Who is organising and funding this research?

The research is being carried out by Elizabeth Bowring-Lossock as part of a Doctoral study. It is being supervised by Professor Alison Bullock and Dr Jamie Lewis at the School of Social Sciences at Cardiff University.

Why have I been invited to take part in the study?

You have been invited to participate due to your experience as a mental health nursing student.

Do I have to take part in the study?

No, your participation is entirely voluntary. If you *do* decide to participate in the study, you will be asked to sign a consent form. You will be free to withdraw from participation in the study at any time, without giving reason and any data previously collected from you will not be included in the study.

If you decide you *do not* wish to participate, you do not have to provide a reason.

What will taking part involve?

Taking part in this part of the study will involve participating in one individual interview. This will be held remotely via Skype (or similar). This will only be audio recorded. Here you will be asked about your views on what identity means to you and how you think your professional identity develops and how IPE can influence professional identity. You are not expected to provide any information or opinion which you do not feel comfortable sharing.

The interview will last approximately one hour.

Should you provide permission freely, the interview will be recorded for later transcription at which point all data will be anonymised. If you agree to participate but do not give permission for recording, any input you provide will not be transcribed for data analysis.

APPENDIX 7

Will I be paid anything for taking part?

No, there are no payments for taking part in this study.

What are the possible benefits of taking part?

Your participation in this study will involve sharing your views on the development of professional identity and IPE for mental health nursing students. Although there are no direct benefits to you as a result of your participation, this information will be used to help understand how students develop their identity and how IPE influences this. This can inform recommendations for mental health nursing curriculum development and changes to programme structure.

What are the possible risks of taking part?

The only foreseeable potential risk of participation in this study is some discomfort you may feel in sharing your views on the development of professional identity and/or IPE. There is no intent to cause discomfort and you are encouraged to only contribute opinions you feel comfortable sharing.

Will my taking part in this study be kept confidential?

Should you grant permission for the interview to be recorded, all data provided by you will be anonymised on transcription and you will not be personally identifiable. Data collected during the study will be kept strictly confidential and any personal information you provide will be managed in accordance with data protection legislation.

What will happen to my personal data?

The only personally identifiable data collected from you and retained will be your consent form (should you provide it), which will include your name and signature. This information is only collected so I know who has consented to participate in the study. All information provided by you will be anonymous and will not be matched to the information in your consent form. Your consent form will be retained in accordance with Cardiff University research ethics requirements and may be accessed by my supervisors and, where necessary, by members of the University's governance and audit teams. Anonymised data will be kept for a minimum of 5 years, or at least 2 years post-publication.

Cardiff University is the Data Controller and is committed to respecting and protecting your personal data in accordance with your expectations and Data Protection legislation. The University Data Protection Officer can be contacted at inforequest@cardiff.ac.uk. Further information about Data Protection can be found at: https://www.cardiff.ac.uk/public-information/policies-and-procedures/data-protection

In providing data for this research, I will process it on the basis that it is part of our public task as a university established to advance knowledge and education through its teaching and research activities.

APPENDIX 7

What will happen to the results of the study?

The principal output of the study will be a thesis documenting findings about the development of student nurses' identity, what is deemed to be important and how IPE may influence this. It is expected that this will be available in July 2021, though this is subject to change.

It is also my intention to report the results in academic journals and at relevant conferences. All data will remain anonymous and participants will not be personally identified in any report, publication or presentation.

What if there is a problem?

Elizabeth Bowring-Lossock will be available to answer any questions or queries regarding any aspects of the research study. If you wish to complain or have concerns about the way you have been approached or treated during the course of this study, please contact the research ethics committee at:

socsi-ethics@cardiff.ac.uk.

Who has reviewed this study?

This study has been reviewed and given a favourable opinion by the School of Social Sciences' Research Ethics Committee at Cardiff University.

Further information and contact details

Should you have any questions or queries relating to this study, please contact:

Elizabeth Bowring-Lossock Telephone: 02920 687748 Email: bowring-lossockeg@cf.ac.uk

Cardiff University, College of Biomedical and Life Sciences, School of Healthcare Sciences, Room 2F20, Cardigan House, Heath Hospital, Cardiff, CF144XN.

Thank you for considering participation in this study.

APPENDIX 8

PARTICIPANT CONSENT FORM: Mental Health Nursing Students

Interprofessional Education and the Development of Identity

Title of study: **How does the development of identity for mental health nursing students benefit from Interprofessional Education, facilitated at pre-registration level?**

Name of Researcher: **Elizabeth Bowring-Lossock**

	Please initial box
I confirm that I have read and understood the Information Sheet dated 26.09.19 updated 08.06.20 for the above study and have had the opportunity to ask questions and these have been answered satisfactorily.	
I understand that my participation is voluntary, and I am free to withdraw the study at any time without giving a reason and without any adverse consequences.	
I consent to the processing of my personal data provided in this consent form. I understand that such information will be held in accordance with all applicable data protection legislation and in strict confidence unless disclosure is required by law or professional obligation.	
I understand who will have access to the personal information I provide, how the data will be stored and what will happen to the data at the end of the project.	
I understand that the individual interview will be audio recorded and that anonymised excerpts and/or verbatim quotes may be used as part of the research report.	
I understand how the findings and results of this study will be written up and disseminated.	
I give consent freely to my participation in this study.	

Name of participant (print)	Date	Signature
Name of person taking consent (print)	Date	Signature

THANK YOU FOR PARTICIPATING IN THIS RESEARCH.

APPENDIX 9

Interview Guide Questions: Focus Group 1

Column 1	Column 2	Column 3
Research Question 1 How do mental health nursing students narrate their own professional identity?	What do you think your role as a mental health nursing student is? What do you do as a mental health nursing student that others (professions) do not? Are you proud to be a mental health nursing student? Why is that? How would you explain to somebody who didn't know, what a mental health nurse is?	**Practice** **Identity** **Meaning** **Community**
Research Question 2 What influences do these students perceive as impactful on the development of their professional identity in clinical practice?	Please can you tell me what you think are the biggest influences on you when you are on placement? How does this make you feel?	**Meaning** **Identity**
Research Question 3 How do these students describe their experience of professional socialisation in clinical practice?	Please can you tell me about your experience of working in clinical practice as a student nurse. What is it like for you in clinical practice? I didn't get to ask this question because the students led the discussion to this position themselves, so, I followed up with supplementary questions: Has anyone else had any similar experiences? Why do you think that is? How does that make you feel as a student? (being treated poorly) And that's just because you're a student, do you think? What things do you enjoy doing? Why? What do you least enjoy? Why is that?	**Meaning** **Practice/ Meaning** **Practice/ Meaning**
Research Question 4 What are these students' perceptions of Interprofessional Education?	What did you think about this IPE session? Please can you tell me more about what it was like, how you felt about it? How can you apply skills of IPE to your own clinical practice?	**Meaning** **Identity** **Practice**

APPENDIX 10

Interview Guide Questions: Focus Group 2

Column 1	Column 2	Column 3
Research Question 1 How do mental health nursing students narrate their own professional identity?	What makes you most proud to be a mental health student nurse? Have you got different attitudes, do you think, from students in other fields of nursing? How do they differ? (D) Standing at the beginning of year 3, you are "stepping over a line". How does that make you feel? What is your greatest achievement to date (as a student nurse)?	**Meaning** **Identity** **Identity** **Community**
Research Question 2 What influences do these students perceive as impactful on the development of their professional identity in clinical practice?	What do you like best about being a mental health nursing student? What values are important to you? Please can you give me an example of other people's perceptions (of mental health nursing)? (D) Why do you think she tells people? (participant's Mum tells strangers that her daughter is a nurse)	**Practice** **Community** **Meaning**
Research Question 3 How do these students describe their experience of professional socialisation in clinical practice?	Thinking back to your last placement, please can you tell you tell me a bit about what it was like? How was it for you? What was good about it? What was not so positive?	**Identity** **Meaning/ Practice** **Meaning/ Practice**
Research Question 4 What are these students' perceptions of Interprofessional Education?	What did you think about this IPE session? Please can you tell me more about what it was like, how you felt about it? How can you apply skills of IPE to your own clinical practice?	**Meaning** **Identity** **Practice**

APPENDIX 11

Interview Guide Questions: Individual Interviews

Column 1	Column 2
Research Question 1 How do mental health nursing students narrate their own professional identity?	**Early days** Do you think you made the right decision to opt in? Can you tell me how that feels? Why wouldn't you "opt-out? Why was it a struggle to (find a clinical) place you? How do you feel about all of these things happening to you? So that period of uncertainty was extremely unsettling? Do you think you have been looked after? What do you think your role as a mental health nursing student is now? You are a student but you are you also a health care support worker. Please can you tell me how that feels? Do you see yourself as a student? Do you feel like a student? How does it feel? Do you see yourself as an employee? What is the difference between the role of the student and the support worker? How has this clinical experience hindered your development then?
Research Question 2 What influences do these students perceive as impactful on the development of their professional identity in clinical practice?	**Relationships in practice** How do you think your mentor sees you? When you say a "good" mentor, what does that mean? What makes a "good" mentor? Has your mentor been clear (to others) that you are a student? How do other people perceive you? What do the RNs feel about working with you, do you think? What about other members of the MDT? Have you learned from others? What is the difference then in role because you said that sometimes HCSWs will let you do what they're supposed to be doing, is that what you mean? How are other people, health care support workers, different with you? What about patients, because you're in a different colour (uniform), does that matter to them, do you think? What are your relationships with patients like now?
Research Question 3 How do these students describe their experience of professional socialisation in clinical practice?	**Being a student on deployment** If you're in the position of not having a mentor, how does that affect your experience? Ok, why not, what happens? (response to statement "I don't know who I am in purple") Do you have thoughts about the differences, does colour (of uniform) matter to other people, do they treat you differently? Has it been more a hinderance that a help in terms of professional development? So, do you mean there could have been a bit of resentment from the people who were already doing the job and that you hard to work harder to justify your position? You describe yourself has having "fallen down in the middle". Why is that? What does that mean? Has having that contract been quite valuable and quite helpful then? So, from that, do you think that this has not been preparation for practice? You said you "do the green" even when you're in purple, do you become the HCSW (Health Care Support Worker)? What is that like?

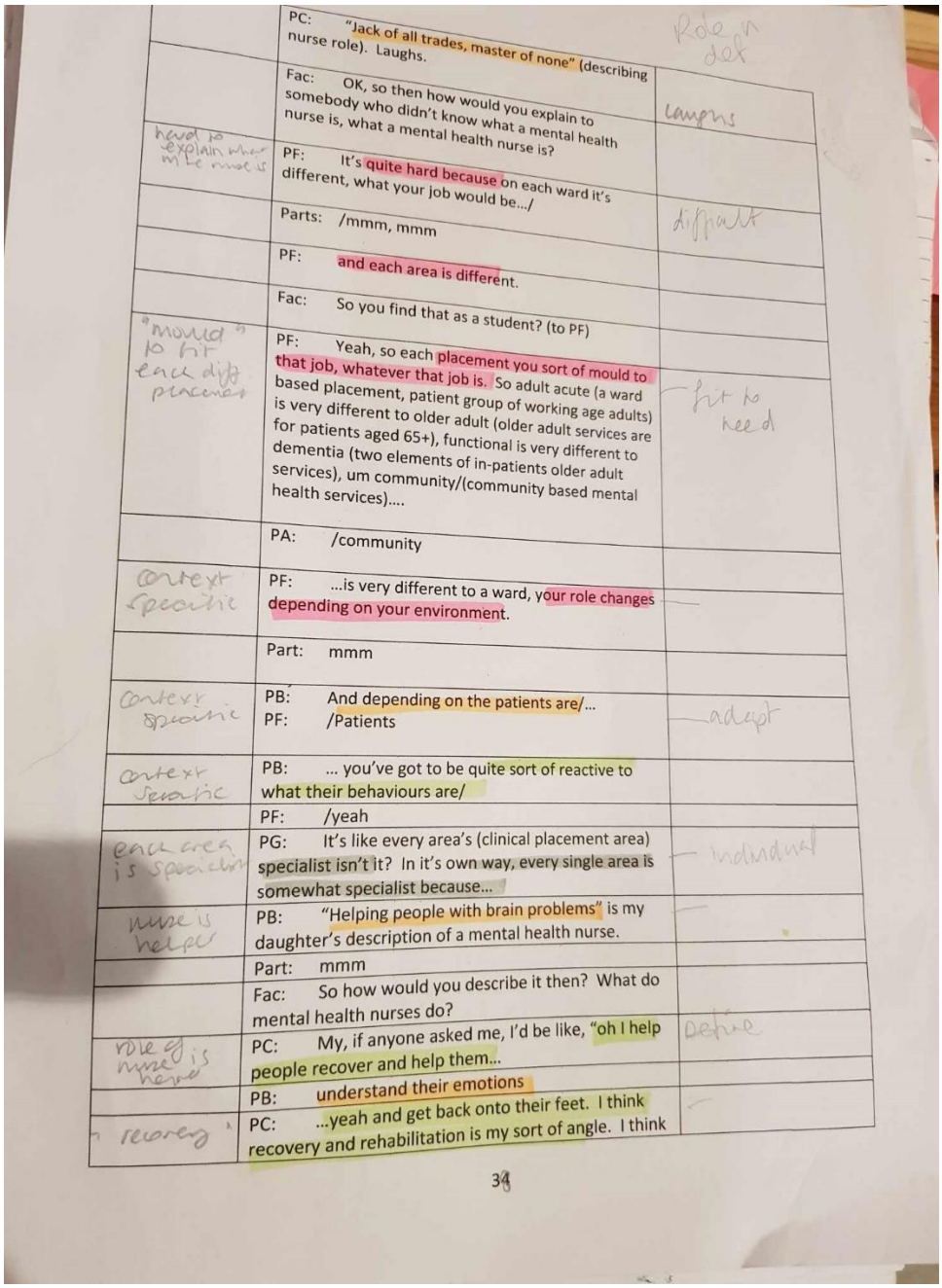
APPENDIX 12

The Participants

Alice	Caring for her family, working on the nurse bank, mental health nursing student
Bridie	Prior experience of working in public services, caring for her family, working on the nurse bank, mental health nursing student
Carly	Mental health nursing student
Danielle	Prior experience of working in different services, caring for her family, working on the nurse bank, mental health nursing student
Emma	Prior retail experience, mental health nursing student
Ffion	Working on the nurse bank, mental health nursing student
Grace	Working on the nurse bank, mental health nursing student

APPENDIX 13

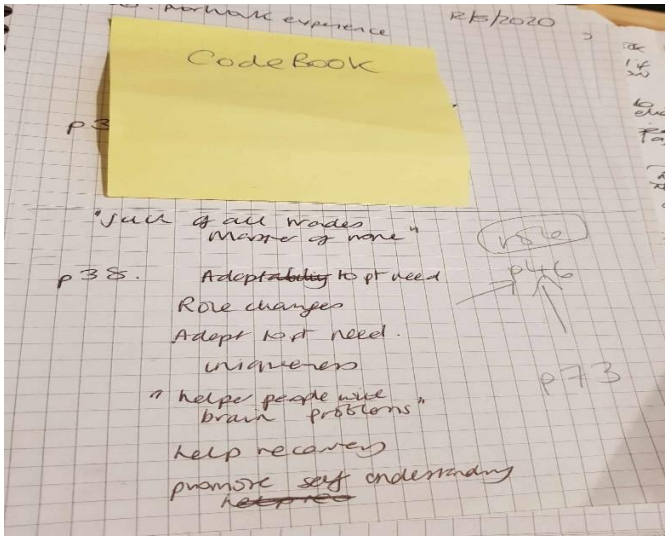
Line by line coding example

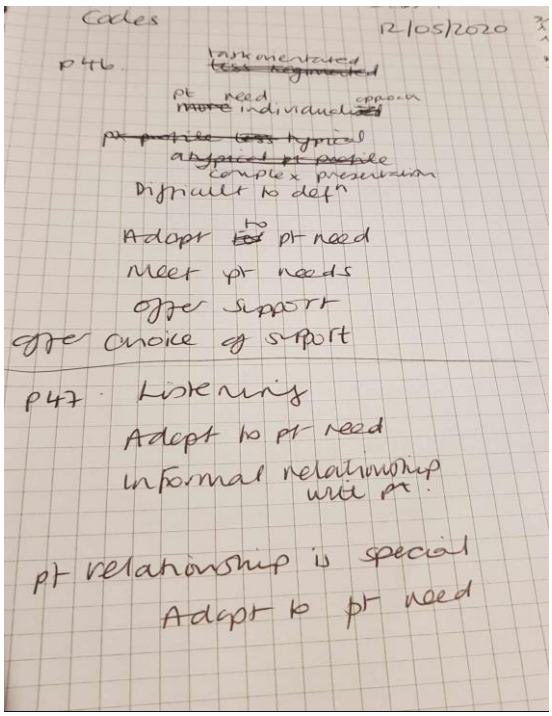


	PC: "Jack of all trades, master of none" (describing nurse role). Laughs.
	Fac: OK, so then how would you explain to somebody who didn't know what a mental health nurse is, what a mental health nurse is?
hard to explain what mh nurse is	PF: It's quite hard because on each ward it's different, what your job would be.../
	Parts: /mmm, mmm
	PF: and each area is different.
	Fac: So you find that as a student? (to PF)
"mould" to fit each diff placem	PF: Yeah, so each placement you sort of mould to that job, whatever that job is. So adult acute (a ward based placement, patient group of working age adults) is very different to older adult (older adult services are for patients aged 65+), functional is very different to dementia (two elements of in-patients older adult services), um community/(community based mental health services)....
	PA: /community
context specific	PF: ...is very different to a ward, your role changes depending on your environment.
	Part: mmm
context specific	PB: And depending on the patients are/... PF: /Patients
context specific	PB: ... you've got to be quite sort of reactive to what their behaviours are/
	PF: /yeah
each area is specialist	PG: It's like every area's (clinical placement area) specialist isn't it? In it's own way, every single area is somewhat specialist because...
nurse is helper	PB: "Helping people with brain problems" is my daughter's description of a mental health nurse.
	Part: mmm
	Fac: So how would you describe it then? What do mental health nurses do?
role of mhn is helper	PC: My, if anyone asked me, I'd be like, "oh I help people recover and help them...
	PB: understand their emotions
recovery	PC: ...yeah and get back onto their feet. I think recovery and rehabilitation is my sort of angle. I think

APPENDIX 14

Code Book examples





APPENDIX 15

Spider Diagram example