The lived experience of Higher Education for Irish post-registration nursing students: A phenomenological study.

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Thesis submitted in part fulfilment for the Degree of EdD

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June 2015
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Glossary of Terms

ACCS - Accumulation of Credits and Certification of Subjects.

ACCS Degree - the general degree (Level 8) developed for registered nurses who did not have a degree.

An Bord Altranais - the Irish Nursing Board and regulatory body.

CNM – Clinical Nurse Manager. This is a clinical management role. This manager works on the wards with staff nurses coordinating the care of patients.

CPC – Clinical Placement Coordinator. The clinical person whose role it is to coordinate the education of undergraduate student nurses in terms of ensuring that the clinical learning environment is conducive to their learning.

Director of Nursing – a more senior nurse manager. This nurse directs the overall nursing services in a health care facility.

Higher Diploma - the specialist nursing programme of study (Level 8) developed for registered nurses who wanted to study a specialty subject.

Post-registration Nurse - a nurse who has qualified and is registered as a nurse with An Bord Altranais.

Preceptor - a staff nurse who is designated to supervise student nurses who are undertaking a Degree in Nursing.

Staff Nurse - the first level of employment on the nursing career ladder.

CNS – Clinical Nurse Specialist. This nurse is qualified in a specialty area. He or she would be called upon to advise on care of patients with special needs for example a patient with diabetes.
Acknowledgements

I would like to thank my supervisor Gareth Parry for his kindness, patience and advice throughout this study.

Thank you to the post-registration nurses who took part in this study. Their generosity with sharing their stories at a time when they were so busy was much appreciated.

The support I received from my friends and work colleagues helped me to keep going. I would also like to acknowledge the financial support I received from Dundalk Institute of Technology for the programme fees.

Finally, I would like to say a big thank you to my family, especially my sister Elaine, for all the words of encouragement throughout this process.
Abstract

The aim of this study was to explore Irish post-registration nurses’ experiences of higher education nursing programmes in terms of influences on their motives to engage and their participation in such programmes. The study is set against a backdrop of change to the entry level education for nurses in Ireland in 2002. The conceptual framework to inform this study was drawn from the community of practice theory described by Lave and Wenger (1991) and Wenger (1998) which provided a new perspective on the experiences of post-registration nurses’ engagement in higher education.

Using a descriptive phenomenological approach, 17 post-registered nurses undertaking two different higher education programmes at one Institute of Technology in the North East of Ireland were interviewed using one-to-one semi-structured interviews. Two focus group interviews were also conducted comprising of nine post-registration nursing students in two Institutes of Technology in the North West and the West of Ireland by way of triangulating the findings. Giorgi’s (1985) framework of data analysis was used to extract the natural meaning units from the data.

The findings in this study revealed that post-registration nurses’ motives to engage in higher education included: educational equality, knowledge acquisition, career advancement and morale enhancement. These motives were influenced by attitudes towards higher education for nurses, resources and supports. While the nurses engaged in higher education they experienced two main challenges: lack of time and lack of confidence to do the academic work. The nurses were resourceful in terms of implementing coping strategies to deal with these challenges. These experiences were influenced by practical college and clinical supports. The findings are discussed in light of the cited literature and concepts from the communities of practice theory. The findings in this study have implications for nursing education, practice, policy and research.
Chapter One: Introduction and Context

Introduction

The aim of this study was to explore Irish post-registration nurses’ experiences of higher education nursing programmes in terms of influences on their motives to engage and their participation in such programmes. This chapter gives an account of the context to the study. There is an introduction to the rationale for using the community of practice theory as a conceptual framework for the study. The approach used to address the research question is outlined followed by the significance of the study. The chapter ends with an outline of the main chapters in the thesis.

The Study Context

Nurse education in Ireland has developed over the years for both pre-registration nurses and post-registration nurses. Pre-registration nursing education has gone through major changes spanning from the 1980s to 2002 with the introduction of a 4-year degree in nursing as the sole route of entry to nursing practice in Ireland. In many ways it was these changes that set the stage for current advances in nurse education for post-registration nurses. This chapter provides an account of the changes that took place in pre-registration nursing education in Ireland followed by an account of the advances in post-registration nursing education. These advances provide a context for the current study.

Irish Pre-registration Nursing Education Reform

In Ireland a nurse must register as a nurse with the Irish Nursing Board which is the regulatory body for nurses and midwives. This board is currently known as An Bord Altranais agus Cnáimhseachais na hÉireann or the Nursing and Midwifery Board of Ireland. At the time of this study it was known as An Bord Altranais, The Nursing Board. Nurses and midwives who were registered with this board must have
attained a recognised entry level qualification. In Ireland that entry level has changed over the years from a Certificate level to the current requirement of a Degree in Nursing or Midwifery.

**The Apprenticeship Model (the Certificate in Nursing)**

The history of pre-registration nurse education in Ireland can be classified as a mirror image of what was taking place in the United Kingdom and elsewhere internationally. The primary stages included a shift from an apprenticeship model (Certificate) to a semi-higher education model (Diploma) and finally a fully integrated higher education model of nurse education (Degree) leading to registration as a nurse. Keeping up with international trends meant that Irish nurse education and registration could maintain its currency abroad (Fealy et al., 2007). The first education system of pre-registration nurse education in Ireland began in the 1880s, and was known as the Apprenticeship model. In Ireland, up to that point, religious orders of nuns cared for the sick. Out of this grew a professional role for women in health care. However, because of women’s position in society at the time this role was dictated by others, particularly the medical profession (Treacy and Hyde, 2003). The religious order of nuns set up and ran voluntary hospitals in the 1880s and subsequently the first nurse training schools in Ireland. The nurse training scheme that emerged was based on the apprenticeship model. The apprenticeship model was a form of employment for young educated middle and lower-middle class women (Fealy, 2006). The apprenticeship model entailed a three year paid apprenticeship in a School of Nursing which had links with the clinical area, in the health service, for practical experience (Fealy et al., 2007). Graduates of this model exited with a Certificate in Nursing and were then eligible to register as a nurse with the regulatory body, An Bord Altranais. The apprenticeship model meant that student nurses, outside of a 40-week theoretical element in a school of nursing, were part of the workforce and rostered for service (Treacy and Hyde, 2003). In other words, they were paid members of staff. An advantage of this was that student nurses, from early on in their training, were fully immersed in the clinical aspect of nursing. On the other hand, the learning opportunities available to students in the clinical area were solely service driven thus this limited their exposure to other varied learning experiences. Student nurses found themselves responding to specific service demands rather than having the freedom to explore the application of theory they had learned in the
School of Nursing. In other words, they did what they were told. This situation had a
disempowering influence on student nurses. It limited their learning and had a
limiting impact on their practice as registered nurses and their perception of nursing
(Treacy and Hyde, 2003).

The apprenticeship model of nurse education perpetuated the notion that nurses did
not require an academic background in order to work as a nurse. From the time of
the apprenticeship model of nurse training there has been an enduring debate about
the need for nurses to have an academic background (McNamara, 2005). This
debate is related to the fact that the nature of nursing work is primarily manual work
(McNamara, 2005). Fealy (2004), exploring discourses about nurse education,
found that nurses continually have to justify their place in academia because nursing
is generally viewed as a practical and common sense occupation which does not
merit an academic education. At the time of the apprenticeship model, the public
image of the nurse was that of the work of women in a caring role as the doctors’
assistant. Fealy et al. (2007) postulated that it was this branding that generated the
idea that nurses did not require an academic background like in other professions
i.e. medical profession. He also suggested that nurses themselves believed and
bought into the idea of not needing an academic background because they placed a
high value themselves on the practical, hands-on aspect of nursing.

The view that nurses do not require an academic background is reflected in the
international medical and nursing community alike. According to Fealy et al. (2007)
prominent discourses in the literature have emphasised doctors’ belief that a nurse’s
place is at the bedside and that higher educational achievements for nurses would
dilute the vocational and practical skills of nurses at the coal face of the ward
environment. Fealy et al. (2007) also uncovered discourses that saw nurses
themselves resent the idea of an academic background favouring practical skills
over thinking skills. Many nurses have been of the opinion that the practice of
nursing should only be learned at the bedside. This view placed a high value on the
apprenticeship model of nurse training. Thus a drawback to the Irish
apprenticeship model of training for nurses was that it perpetuated this image of
nursing which emphasised a tension between the intellectual and the practical and
generated a disagreeable identity for nurses within the multidisciplinary team and the health service.

The debate concerning the need for an academic background for nurses highlighted the lack of a unique identity for nursing. The knowledge base for nurses in the apprenticeship model was primarily based on medical knowledge. According to Fealy (2006) this dependence on medical scientific evidenced-based knowledge left nursing with no distinct scientific knowledge base of its own. A scientific knowledge base was seen as the symbol of a true profession, power and status predominantly enjoyed by the medical profession but for the nurse it was seen as unnecessary. This situation perpetuated a nurse identity of servant to doctors (Fealy, 2006). To rectify this situation early nurse theorists set about developing a distinct knowledge base for nursing so that nursing could develop a distinct identity, status and authority within the health care team (Allen, 2000; Henkel, 2004; Fealy et al., 2007).

It was envisaged that a unique knowledge base for nursing would facilitate a different attitude towards the position of the nurse in the health care team, namely not as a handmaiden to doctors, but as a legitimate contributor to the care of patients based on nursing scientific evidence based knowledge. Therefore, the demise of the apprenticeship model in 1994 was fuelled by a number of issues. Firstly, Irish nurse education, leading to registration as a nurse, needed to keep up with UK and international reforms in nurse education in order to allow Irish nurses to work abroad. Secondly, the philosophy behind the apprenticeship model was not education driven but service driven. Finally, as pivotal members embedded in a multidisciplinary team of other professionals working to care for patients, the apprenticeship model only served to perpetuate the image of the nurse as handmaidens to doctors with no unique scientific knowledge base. Consequently this did nothing for the advancement of nursing as a profession in its own right.

However, McNamara (2005) cautions that debates about nurse education and its integration into higher education have exposed the profession to accusations of wanting higher education for self-serving reasons, i.e. status, recognition and more pay, rather than to enhance the knowledge base to improve standards of care for patients. Nonetheless, by 1994 the Certificate in Nursing came to an end in Ireland and was replaced by the Diploma in Nursing. This debate will be further explored in the literature review.
The Diploma in Nursing

In 1994 the first three year pre-registration nursing programme linked with a higher education institution commenced in the National University of Ireland Galway leading to a Diploma in Nursing and was termed the “Galway Model”. Nurse education in Ireland had finally gained entry to higher education joining the other graduate professions in health care like doctors, physiotherapists, occupational therapists, and dieticians who required a degree as an entry level qualification to their profession (Fealy et al., 2007). Two reports were instrumental in driving that agenda. Firstly, the Working Party Report on General Nursing (Department of Health, 1980) identified the apprenticeship model of training as unsuitable to meet the training needs of Irish nurses. Secondly, the Report: The Future of Nurse Education and Training in Ireland published by An Bord Altranais (An Bord Altranais 1994) led to the establishment of the first links with higher education for pre-registration education for Irish nurses.

The transition from Certificate to Diploma was initiated and strictly controlled by the Irish Department of Health, thus nurse educators were not able to influence the programme as they would have wanted (Chavasse, 1996; Hyde & Treacy, 1999). Even before the Diploma in Nursing (the Galway Model) could be evaluated, in 1998, the Department of Health wasted no time in producing guidelines on the implementation of the “Galway Model” for other health boards and third level institutions (universities and institutes of technology alike). By 1998 all pre-registration nursing programmes were at diploma level, delivered in higher education intuitions (universities and institutes of technology) linked with their respective health boards based on the “Galway Model” (Dundalk Institute of Technology, 1998). The transition into higher education for nurses was still under fire from even nurses themselves because some nurses were worried about the clinical abilities of the Diploma nursing graduates (Fealy et al., 2004).

The Diploma in Nursing changed the method of entry level education for Irish nurses from vocational to a professional education. It was a three year programme delivered as a combined effort through the old hospital schools of nursing which were now linked with a University or Institute of Technology. Students still utilized the
health board clinical placements for work experience (Treacy and Hyde, 2003). The nursing theoretical aspect of the programme was delivered in the schools of nursing. The sciences and research content were delivered in the universities or institutes of technology. In terms of learning, greater emphasis was placed on in-depth exploration of content and a focus on critical thinking, research and evidence-based practice. In the clinical placements student nurses were classed as supernumerary to the staff complement and were no longer paid members of staff apart from 16 weeks of rostered placement towards the end of the programme (Treacy and Hyde, 2003). This was pivotal to freeing student nurses up to focus on learning rather than service. On the other hand, this was criticised for creating a shortage of staff on the ground in the health service (Treacy and Hyde, 2003).

In 1998, the Diploma in Nursing was independently evaluated by the University of Southampton, commissioned by An Bord Altranais and the Department of Health (Simons et al., 1998). The evaluation found that in terms of providing an educational background for nurses, fostering efficient and effective professionals, the diploma seemed to fall short. The diploma programme turned out to be an unsatisfactory compromise to the apprenticeship model. In 1998 the Irish government published the Report of the Commission on Nursing which reviewed the state of nursing in Ireland at the time. This Commission was set up to respond to unrest among Irish nurses over work structures, educational and promotion issues (Government of Ireland 1998). The Diploma in Nursing also came under fire by the Commission on Nursing which recommended that it be replaced as soon as possible (from September 2002) with a 4-year Bachelor of Science (Nursing) programme (Government of Ireland, 1998).

The Pre-registration Nursing Degree
The Commission on Nursing (1998) made recommendations which were anticipated to ensure that future Irish nurses would measure up to the following standard:

“Professional nurses who were safe, caring competent decision makers, willing to accept personal and professional accountability for evidence-based practice. They should be able to promote and maintain health as well as be able to give care during illness, rehabilitation and dying. Nurse graduates should be flexible, adaptable and reflective practitioners, integral members of the multidisciplinary team and should adapt a life-long approach to learning” (Government of Ireland 2000, p.31).
To satisfy this definition of the role of a nurse, one of the recommendations made by the Commission on Nursing (1998) was to move from diploma to degree level education as an entry-level background for the Irish nursing profession. Other countries, like Australia and America, already had a degree level pre-registration qualification for nurses and Canada and the United Kingdom were working towards the same goal. The Royal College of Nursing (RCN) in the United Kingdom advocated that it would take this type of education to prepare nurses in today’s changing health care system (Government of Ireland, 1998). There was general consensus that health services internationally and in Ireland were becoming more complex environments, mainly due to technological developments. Therefore, in order for the nurse of the future to function effectively, a degree in nursing was a minimum requirement. This view was echoed in the report published by An Bord Altranais 1994 titled the *Report on the Future of Nurse Education and Training*. This report highlighted that nurses needed different knowledge and skills for their changing role as a nurse including critical thinking and creative thinking skills.

The Commission on Nursing (1998) also argued that nurse entry level education should change to a degree because nurses working alongside other health care professionals were still at odds in terms of their educational level. In the interdisciplinary team, nurses were the lowest qualified members. For nurses, to raise the bar on their entry level qualification, this would ensure that all members of the team would have equal status, at least educationally at entry level (Government of Ireland, 1998). This argument pointed towards the need for nurses to move forward in terms of legitimising nursing as a profession in Ireland.

The debate continued about whether nursing education should be conducted in higher education. Watson (2006) writing about the preparation of nurses posed the question: is there a role for higher education in preparing nurses? Watson (2006) argued that the answer to that question depended on whether or not the preparation of nurses was viewed as training or as education and that this hinged upon whether or not nursing was a profession. Watson (2006) emphasised that the purpose of a university education was not just for training people but also to enhance the formation of character and to prepare people who are accountable for their actions.
Watson (2006) also stated that since accountability is one of the hallmarks of a profession, a higher education preparation for nurses is warranted in order to achieve the type of nurse outlined by the Commission on Nursing. This view is echoed in the writings of Treacy and Hyde (2003) who highlight the need for nurses to carve out their uniqueness on the multidisciplinary team, among other qualities, as promoters of health and comfort of patients, developing therapeutic relationships with patients and acting as patient advocates. These writers also stress that the professional route of study is:

“increasingly necessary to hold the elemental caring values of nursing, to articulate these in the public arena, and retain public support and acknowledgement of the importance of nursing, especially in economic terms” (Treacy and Hyde 2003, p.92).

Nurses can enhance their professional identity by being responsible and accountable practitioners, continuing to learn, earning credentials and working towards integrating their professional and personal identities (Muscari and Archer, 1994). Thus a degree level education was deemed necessary as an entry level qualification to address all these issues.

In 2002, the 4-year degree in nursing (General, Psychiatric and Intellectual Disability) became the sole route of entry to nursing practice in Ireland. Now graduates of the new nursing degree were educated as professional nurses in full-time study availing of student grants instead of a salary (Treacy and Hyde, 2003). Students no longer attended the old Schools of Nursing. They were fully integrated into the higher education system, universities and institutes of technology. There they received all their theory input yet still utilising the clinical placements with the health service. Again the sciences and research appreciation, critical thinking and evidence-based practice elements were emphasised in the degree. Students continued to be supernumerary to the staff complement while on clinical placement apart from 36 weeks of rostered placement in the final year of the programme (Treacy and Hyde, 2003). The education of pre-registration nurses in Ireland was now provided by both the University and Institute of Technology sectors. This binary system of education, had no bearing on where nurse education was taught because both systems could effectively deliver programmes up to PhD level, albeit that the universities lead the way on Masters and PhD nursing programmes. The nursing programmes delivered by these higher
education institutions were guided by An Bord Altranais’s (based on European Directives) *Requirements and Standards for Nurse Registration Education Programmes* (An Bord Altranais, 2005). Furthermore, degree level learning outcomes for nursing programmes had to meet the Higher Education and Training Awards Council (HETAC) standards related to level 8 Programmes (Higher Education and Training Awards Council, Ireland, 2004). An Bord Altranais (the nursing regulatory body), the Department of Health (the funding body and health care provider for student placements) and the Department of Education shared the responsibility for nurse education. By 2006 the first nursing undergraduates emerged from these honours degree programmes.

**Irish Post-registration Education Reform**

**The General Degree for Post-registration Nurses**
While pre-registration nurse education in Ireland was evolving from certificate to degree level, the existing workforce of registered nurses had varied minimum educational backgrounds, mainly certificate and diploma level education. According to Treacy and Hyde (2003) up to 2002, there were effectively few nurses in Ireland with baccalaureate and masters degrees and less than 10 registered nurses held a doctoral degree. Of the nurses who did undertake degrees these were only taken up by managers and teachers, not clinical nurses (staff nurses) (Fealy et al., 2007). Furthermore, only a few universities offered a degree in nursing to post-registered nurses (Treacy and Hyde, 2003).

To address this shortfall, the Commission on Nursing (1998) recommended that all post-registered nurses should have the opportunity to upskill to degree level. To this end, the Commission recommended that educational programmes of study and funding should be made available to these nurses in order to gain a minimum educational level to a level 8 degree (Government of Ireland, 1998).

Anticipating these changes, in 1992, University College Dublin rolled out a Bachelor of Nursing Studies programme for clinical nurses (staff nurses) on a part-time basis. Other higher education institutions, for example the Institute of Technology in the
North East, followed suit by providing degree programmes of study for post-registration nurses (Treacy and Hyde, 2003). Thus, a General Nursing Degree was put in place nationally to facilitate post-registration nurses on the ground who desired to catch up with the minimum educational requirements for entry to the profession due to commence in 2002. However, it had also emerged that there was a need for specialist degrees to be made available to Irish post-registered nurses.

The Specialist Degree level Education for Post-registration Nurses
In the latter part of the 1990s, and around the time of the Commission on Nursing, there was a lot of unrest among the nursing community in Ireland. This unrest culminated in an all-out national strike for 9 days in October 1999. The main concern for nurses was the need for salary increases. But other concerns that the nurses aired were the need for them to be better able to respond to changes in the health service, the need for the development of new clinical career pathways and the need to address the development of specialist roles and specialist career pathways in nursing (Government of Ireland, 1998). Thus post-registration nurses already recognised the need for change and the need for advanced education in order to keep up with service needs. The Commission on Nursing (1998) helped to respond to these needs by recommending major changes not only to pre-registration nurse education but also to post-registration nurse education and career pathways for nurses. The Commission found that some nurses in the health service had developed specialist roles in an unstructured way and, in some cases, without educational support. Frequently these roles crossed boundaries into medical specialties and other speciality areas like education, research and administration. Irish nurses were not getting recognition for undertaking these roles. Even though there were some specialist nursing education programmes available in Ireland for post-registration nurses, they were ad hoc and uncoordinated. There was a need to develop more coordinated educational structures for registered nurses in conjunction with career advice (Government of Ireland, 1998).

To address this issue, the Commission on Nursing (1998) recommended the development of two new roles for registered nurses namely the Clinical Nurse Specialist (CNS) and the Advanced Nurse Practitioner (ANS) roles which would provide avenues for nurses to clinically progress in their careers outside of the more
conventional progression routes of education and management (Government of Ireland, 1998).

The Commission on Nursing also found that the Irish Nursing community fell short in terms of the creation of research and the implementation of research in practice. The majority of post-registration nurses at the time were certificate trained and did not have a background in research appreciation. This could be seen as one of the reasons for the lack of enthusiasm in research in the broader Irish nursing community. It has been shown by Phillips, Schostak, Bedford and Leamon (1996) that graduates from nursing degree programmes can adopt a critical perspective on their practice. These authors found that graduate midwives were better equipped to use their skills in research appreciation and looked at their practice in a more enquiring manner after taking a degree (Phillips, Schostak, Bedford and Leamon, 1996). Writers like DeBourgh (2001) suggested that specialist roles like that of the Advanced Nurse Practitioner can promote leadership in the profession of nursing affording nurses the power to promote evidence-based practice and measure outcomes of practice. The aforementioned new specialty roles incorporated job descriptions that addressed the deficit in nurses’ lack of enthusiasm for research.

The Nursing Education Forum was the body responsible for rolling out the pre-registration degree (Government of Ireland, 2000). Post-registration education and the professional development of nurses and midwives became the responsibility of the National Council for the Professional Development of Nursing and Midwifery (NCPDNM, 2003). The Council set about developing guidelines for the educational pre-requisites and job descriptions for the CNS and Advanced Nurse Practitioner roles.

In 2008, the Office of the Nursing Services Director in the Health Services Executive published the Report of the Post-Registration Nursing and Midwifery Education Review Group (Collins, 2008) which outlined recommendations related to the development of organised structures and processes for post-registration nursing and midwifery education in Ireland. The review group stated that changes in the education of registered nurses were necessary in light of the radical reforms taking place in the Irish Health Service as a result of priorities set out in the Transformation
Programme of 2006 and changes which had taken place in pre-registration nurse education nationally. The Health Service Executive’s Transformation Programme 2007-2010 proposed six priorities of health care reform in Ireland:

1. “Develop integrated services across all stages of the care journey
2. Configure primary community and continuing care services so that they deliver optimal and cost effective results
3. Configure hospital services so that they deliver optimal and cost effective results
4. Implement a model for the provision and management of chronic illness
5. Implement standards-based performance measurement and management throughout the Health Service Executive
6. Ensure that all staff engage in transforming health and social care in Ireland” (Health Service Executive, 2006, p.11)

Registered nurses would play a pivotal role in the implementation of the Transformation Programme reforms. Therefore, the nursing roles and educational supports to upskill nurses to degree level were essential to ensure the provision of a working workforce that could address these reforms. The recommendation of the Report of the Post-Registration Nursing and Midwifery Education Review Group outlined how educational programmes should be developed, structured, evaluated and funded to support nurses in this endeavour.

Working as a Nurse in Ireland
The majority of Irish nurses work in acute care hospital settings which are known to operate within hierarchal structures. This environment for post-registration nurses makes it difficult for them to develop their unique identity as nurses. Treacy and Hyde (2003) acknowledge that:

“Nurses work within very bureaucratic and hierarchic structures that are not conducive to professional development and do not assist the articulation of the value of nursing. Within these structures the direction of nursing has been determined by medicine” (p.72).
However, Irish nurses are cognisant of the need to develop and illuminate their unique contribution to care within the multidisciplinary team. Therefore, post-registration nurses see that a route to this end is the availability of general and specialty degree level education for Irish nurses. Treacy and Hyde (2003) suggest that Irish nurses:

“appear to have a vision of what their role can and should be, and are aware of the need to articulate their contribution to care in the current climate of change. They see the articulation of this conceptualization as important and recognize the need for their future development and education to further articulate the role and value of the professional nurse and to overcome the factors that are interfering with their practice role” (p.79).

Treacy and Hyde (2003) suggest that nurses find it difficult to implement change and to exert their nursing perspective on practice issues given that structures are hierarchical and management practices are non-consultative (Treacy and Hyde 2003). Thus, in Ireland, the introduction of the degree in nursing as an entry level education for nurses and the availability of general and speciality degree level programmes for post-registration nurses were seen as a major step forward in terms of advancing the status of nursing within the health care team. A desired knock on effect of this was expected to be better nursing care for patients.

Local Implementation of the National Nursing Educational Developments.

The Diploma in Nursing for Pre-registration Nurses in the North East (1997)

The national nursing educational developments previously described were reflected in all the regions and in all the higher education institutions in Ireland (Dundalk Institute of Technology DkIT, 1998). Thus in the Institute of Technology, which serves the North East Health region of Ireland, the Diploma in Nursing was developed. In April 1996, the Institute of Technology in the North East became affiliated with the local Schools of Nursing already providing certificates in General, Psychiatric and Intellectual Disability nurse training for nursing students in the North East region. The purpose of this affiliation was to develop and implement a Diploma in Nursing based on the Galway Model. In addition to this collaboration, the Institute
of Technology in the North East joined a working group comprised of representatives from the National Council for Educational Awards (NCEA), the North West and South East Institutes of Technology, An Bord Altranais and the University of Ulster. This working group was set up by the NCEA to coordinate the development of Diploma programmes for the Institutes of Technology to ensure that they were comparable with the same programmes being developed and implemented in the university sector. The Department of Health, the driving force behind these developments, provided funding for the implementation of the Diploma programme. The Diploma in Nursing in the North East was validated by the NECA and commenced in October of 1997 in partnership with the North Eastern Health Board. By 1998 nationally, all pre-registration nursing programmes were at diploma level, (general, psychiatric, intellectual disability) and all were linked with higher education institutions and their respective health boards (Dundalk Institute of Technology, 1998). The Diploma in Nursing was no sooner off the ground in the North East when in 1998 the Galway Model was the subject of a major evaluation (Simons et al., 1998) and it was also scrutinised by the Commission on Nursing. As previously discussed it was recommended that the Diploma be scrapped for a 4-year Bachelor of Science (Nursing) programme from September 2002 (Government of Ireland, 1998).

**The Pre-registration Bachelor of Science (Nursing) Programme in the North East (2002)**

The pre-registration nursing degree for nursing students at the North East Institute of Technology, like the Diploma, was developed in collaboration with five other Institutes of Technology known as the National Pre-registration Nursing Education Group. The institutes involved were the North East Institute of Technology, the Midlands, Western, North Western, South Western and South Eastern Institutes of Technology and their associated health care partners (Dundalk Institute of Technology & the North Eastern Health Board, 2002).

In 2000 the Nursing Education Forum, charged with rolling out the degree nationally, advocated an approach to curriculum design of the pre-registration degree in nursing that reflected the principles of: flexibility (responsive to local needs), eclecticism (diverse sources of knowledge and teaching methodologies),
transferability and progression (between Institutes), utility (knowledge obtained applicable to practice), evidence base (all aspects of the programme evidence based), and shared learning (draw on other disciplines for knowledge) (Government of Ireland, 2000). The development group was therefore guided by these principles. The programme was validated in 2002 by the Higher Education Training and Awards Council (HETAC) (successor to the NCEA qualifications awarding body for third level institutions) and Bord Altranis (ABA). In light of these developments and as was the case nationally, the North East Institute of Technology also set out to respond to local educational needs for post-registration nurses.

**Post-registration Nursing education in the North East**

By 1997 at the North East Institute of Technology the Diploma in Nursing was underway for the pre-registration nurses in the locality. The next year, in 1998, the institute had already developed and implemented a bridging Diploma programme and a general degree in nursing - Bachelor of Science in Nursing (ACCS) - for local post-registration nurses to avail of in the region. These programmes gave local registered nurses a head start on the inevitable implementation of the pre-registration degree in nursing which was to come on board in 2002. Subsequent to this, in 2003, the North East Institute of Technology implemented a specialist nursing education programme for local post-registration nurses, the Higher Diploma in Nursing. These post-registration programmes of study were developed in response to the national and local developments and demand in relation to nurse education at the time in Ireland.

**The Characteristics of the ACCS General Degree**

The two post-registration programmes of study on offer at the North East Institute of Technology were the Bachelor of Science in Nursing (ACCS) (General degree) (1998) and the Higher Diploma in Nursing (Specialist programme) (2003). This current study is an exploration of the lived experience of post-registration nurses who engaged in these two programmes of study in the years 2006-2007.
**BSc (Hons) in Nursing (ACCS) (General Degree)**

The BSc (Hons) in Nursing (ACCS) was an honours degree in nursing designed for post-registration nurses. It was titled ACCS (Accumulation of Credits and Certification of Subjects) because participants were assessed for prior learning and credits that they could use to be eligible to enter the programme. It was rolled out in the North East Institute of Technology in the autumn of 1998 (Dundalk Institute of Technology, 1998).

The reason for the development of this programme was in response to the changes in pre-registration nurse education in Ireland. This programme addressed the need for nurses with a Certificate in Nursing or a Diploma in Nursing to measure up to the level of basic nursing education that the pre-registration nurses enjoyed (Dundalk Institute of Technology, 1998).

There was a Programme Development Team which conducted an extensive consultation process on the development of this degree. Input was sought from a number of health boards and their respective Institutes of Technology: the North Eastern Health Board, the North Western Health Board, the Western Health Board, the Midlands Health Board, also the National Council for Educational Awards (NCEA), An Bord Altranais and the University of Ulster. Three of the consulted Institutes of Technology worked collaboratively to develop the degree namely the Institutes of Technology in the North East, the North West and the Midlands. Thus BSc (Hons) in Nursing (ACCS) was delivered in these three institutions (Dundalk Institute of Technology, 1998).

To be eligible to apply for the BSc (Hons) in Nursing (ACCS) the post-registration nurse had to be educated to an ordinary degree (Level 7), national diploma level or its equivalent. These courses were at level 7 according to the National Qualifications Authority of Ireland’s (NQAI) Framework of Qualifications. The BSc (Hons) in Nursing (ACCS) was a level 8 programme by (NQAI) standards and on par with the upcoming pre-registration degree for the undergraduates (NQAI, 2003).

However, for nurses who had attained a nursing education to Certificate level the BSc (Hons) in Nursing (ACCS) was developed in conjunction with a Foundation
Studies programme which facilitated these nurses to gain credits to be eligible to apply for the degree. This ensured that they were well prepared to gain maximum benefit from the degree (Dundalk Institute of Technology, 1998).

The BSc (Hons) in Nursing (ACCS) provided post-registration nurses with the opportunity to apply to study at both postgraduate diploma and masters level both at level 9 according to the Framework of Qualifications (NQAI, 2003). Career opportunities following this degree were varied ranging from positions in Management, e.g. Clinical Nurse Manager, to Education, e.g. Health Promotion Officer, to Research, e.g. Research Officer and Practice Development, e.g. Clinical Placement Co-ordinator (Dundalk Institute of Technology, 1998).

Part of the stated philosophy behind the BSc (Hons) in Nursing (ACCS) was the idea that nurses had a responsibility to continually develop their knowledge base so that they could function effectively as an integral multidisciplinary team member sharing their knowledge base with the view to improving practice for the benefit of the patient:

“Professionals have a responsibility to continually develop the theoretical and scientific basis of practice through research and inquiry. They collaborate with each other, both inter and intra-professionally, to provide high quality care for individuals, families and communities. Nurses have a duty to maintain and continually update their knowledge and competence through professional development. They have a responsibility for generating a culture in which new ideas can be fostered and shared and for facilitating the learning of students and colleagues. Nurses have responsibilities to disseminate new ideas, research findings and to utilize research-based practice. The nurse is presumed to have responsibility and potential for learning and has the right to time for development and support. The presented programme is designed to provide nurses with the opportunity to reflect, enhance and develop their professional role” (Dundalk Institute of Technology, 1998, p.17).

The BSc (Hons) in Nursing (ACCS) programme met the learning outcomes of a level 8. These were reflected in the overall aim of the programme which emphasised the skills of systematic reflection on practice and the development of knowledge and skills with which to function effectively as health care providers within their area of practice. What was different in the learning experience for post-registration nurses, both at diploma and the degree level, was the emphasis on human and biological
sciences and research which was lacking in the certificate apprenticeship model. This gave the graduates a firm scientific base (Dundalk Institute of Technology, 1998). This was not a specialist programme of study. It covered general topics related to the practice of nursing. However, it was anticipated that participants would exit the degree with a more in-depth knowledge of concepts related to their practice. The programme was expected to provide post-registration nurses with the ability to critically evaluate their practice and communicate this and discuss this with colleagues with the view to improving practice. They would gain the skills necessary to become a lifelong learner able to teach others including patients and staff (Dundalk Institute of Technology, 1998). Appendix R presents the learning outcomes of the BSc (Hons) in Nursing (ACCS) programme.

The BSc (Hons) in Nursing (ACCS) received an average of 33 applicants per year comprising of post-registration nurses across the nursing disciplines (General, Psychiatry, and Intellectual Disability). The level of time commitment required of the participating students was attendance at classes one day per week over two semesters on a full-time basis. Students could also take the programme on a part-time basis over 5 years. There was no memorandum of understanding between the health service providers and the Institutes of Technology that the students would be released to go to classes. However there was a guarantee that the fees would be paid by the health service providers and this was a national agreement which was one of the recommendations of the Commission on Nursing in 1998 (Government of Ireland, 1998; Department of Health and Children, 2000).

The BSc (Hons) in Nursing (ACCS) was a theoretical programme of study. The teaching strategies employed were intended to reflect an education model rather than a training model of education. Participants were encouraged to take an active role in learning. The programme philosophy emphasized the need for a balance between the need to enhance the students' knowledge base and the recognition that these students were professional adults with much to contribute to their own learning and that of their peers. Moreover, the wide range of experiences and backgrounds of these students both personal and professional were considered to be a valuable teaching and learning resource. Hence, throughout the programme students were encouraged to share and reflect upon their experiences to enhance the
understanding and application of theoretical issues to the practice of nursing. A wide range of teaching strategies were employed to reflect this student-centred approach, for example lectures, self-directed learning, class discussions, guided reading, project work, guest speakers, demonstrations, seminars and simulation exercises (Dundalk Institute of Technology, 1998).

The modules that were on offer took cognisance of the fact that nurses from all parts of the register would apply for the programme (Psychiatry, General, and Intellectual Disability). Participants had to complete 8 modules, four mandatory and four elective with no clinical component associated with this degree. The mandatory modules were designed to develop understanding of nursing, research, physiology and social studies and to provide core knowledge and skills which were further developed in the elective modules (Dundalk Institute of Technology, 1998).

The four elective modules were grouped into three strands namely management, clinical and generic. There was a wide variety of elective modules to choose from which reflected the wide range of health care topics relevant to the role of the nurse for example: finance, change management, health promotion, communication, teaching and learning, mental health and learning disability topics, primary health care, acute and chronic disease management and care of the elderly. Other themes that pervaded throughout the modules included nursing theory, evidence-based practice, policy development, law and ethics, quality health and information technology. Not all of the elective modules were on offer every year. However students, at the time of application, were invited to indicate their elective modules’ preferences so that this could be taken into consideration when offering the modules each year (Dundalk Institute of Technology, 1998).

The ACCS Degree provided an opportunity for post-registration nurses to catch up with the nurse education developments at the time. In turn it facilitated the growth of a body of experienced nurses who were then educationally prepared to mentor the new degree graduates.

Thus the BSc (Hons) in Nursing (ACCS) was up and running for post-registration nurses in the North East Institute of Technology, the North West and Midlands
Institutes of Technology from 1998. Also running from 1998 was the one year full time pre-registration Diploma in Nursing (nationally) and the one year Foundations Studies programme (National Diploma) for the post-registration nurses. Then, in 2002, the full time pre-registration Bachelor of Science (Hons) in Nursing (General, Psychiatry and Intellectual Disability) came on stream replacing the Diploma in nursing for the undergraduates. In the next year at the North Eastern Institute of Technology, in collaboration with the Midlands, North Western and Western Institutes of Technology, a suite of Higher Diploma speciality nursing programmes for post-registration nurses were on offer.

The Characteristics of the Higher Diploma in Nursing (Specialist Programme)

The Higher Diploma in Nursing started in the North East Institute of Technology in October 2003. This programme was developed in collaboration with the Midlands Institute of Technology, the North Western Institute of Technology and the Western Institute of Technology and their health care partners and was subsequently run in these colleges except for the Western Institute of Technology (Dundalk Institute of Technology, 2003). An Bord Altranais and the National Council for the Professional Development of Nursing and Midwifery (the funding agency) briefed the development team on the project to ensure that all programmes would meet their requirements for professional practice. Since the Report of the Commission on Nursing (Government of Ireland, 1998) referred to the proliferation of post-registration courses of varying length, content and academic awards, the Higher Diploma was meant to address this by employing the national curriculum development team to ensure a cohesive and strategic approach to the development of Higher Diploma programmes in nursing. (Dundalk Institute of Technology, 2003). Because of this unique national and collaborative approach to programme development this facilitated the development of a memorandum of understanding between the colleges and health service providers, related to issues like the release of staff to attend the programme and the availability of funding to cover the fees for the participants. It also facilitated student transfer and allowed sharing of teaching expertise (Dundalk Institute of Technology, 2003).
Higher expectations on the part of the public of a quality health care system in addition to advances in science, in terms of a greater understanding of disease and advances in health care technology, meant that the health care settings were becoming more complex and diverse. Thus, in line with the international experience, there were more opportunities for nurses to expand their roles in specialised areas which meant more autonomy and accountability in their role and status as integral inter-disciplinary team members in the provision and management of health care. (Dundalk Institute of Technology, 2003). At national level, the Commission on Nursing (Government of Ireland, 1998) was pivotal in moving forward the development of clinical career pathways for nurses, namely Clinical Nurse Specialist and Advanced Nurse Practitioner, through the development of specialist programmes such as the Higher Diploma. This notion was also supported by other policy documents which highlighted the growing need for nurses, who were working in speciality areas, to have the required knowledge and competence to function effectively within a health care network as part of a specialist health care team. These documents included: the Primary Care Strategy (DoHC, 2001) and the Interim Report of the Nursing Resource (DoHC, 2001). Specialisation in nursing and midwifery in Ireland had evolved in the absence of a national framework to guide the development of a coherent approach to the progression of specialisation and the development of a career pathway. In line with the recommendations of The Commission on Nursing (Government of Ireland, 1998) this function was given to The National Council for the Professional Development of Nursing and Midwifery. Thus this body (NCPDNM) was responsible for advising and monitoring the theoretical and clinical requirements for appointments to the two newly developed specialist roles, namely the Clinical Nurse Specialist and the Advance Nurse Practitioner. The Higher Diploma in Nursing, in a range of specialities, was the programme that would satisfy the educational background to the Clinical Nurse Specialist role (Dundalk Institute of Technology, 2003).

The admission criteria to the Higher Diploma Programme was that the nurse should be registered with An Bord Altranais (the Irish Nursing Governing Body) with two years post-registration experience, six months of that in the intended specialisation. They had to be employed in the relevant speciality for the duration of their course. This was to accommodate the clinical component of the programme. Academically
they had to have at least a Diploma in Nursing. Those nurses who were educated to Certificate level were required to successfully complete the Foundation Studies modules laid on by the programme unless accredited for prior certified learning (APCL) (Dundalk Institute of Technology, 2003).

It was anticipated that the majority of nurses enquiring about this programme would be staff nurses. Educational pathways open to nurses who undertook the Higher Diploma (Level 8) included an MSc (Level 9) and subsequently a PHD (level 10) (NQAI, 2003). Furthermore, nurses with a Higher Diploma had the necessary educational qualifications to assume a career as a Clinical Nurse Specialist. On completion of an MSc this facilitated their progression towards meeting the educational requirements of the Advanced Nurse Practitioner function (NCPDNM, 2002). However, nurses who did not wish to take up these career pathways exited the programme with a high level of knowledge, skills and abilities in a specialty area which allowed them to function as generalist nurses working in a specialty area. (Dundalk Institute of Technology, 2003).

Some nurses were already working as specialist in their field but not being recognised for this in terms of promotion. Thus, if it could be confirmed (up to April 2001) by The National Council for the Professional Development of Nursing and Midwifery that they were actually functioning in a specialist role, they automatically were given the position of Clinical Nurse Specialists/Clinical Midwifery Specialists (CNS, CMS). Otherwise a nurse who wished to become a CNS/CMS was required to have a minimum of five years post-registration experience, two years’ experience in the area of specialist practice, a basic competence level and a Higher Diploma in clinical practice. Since there were no programmes of study available to support this requirement, the Higher Diploma in nursing was developed to support nurses in this endeavour (NCPDNM, 2001 and Dundalk Institute of Technology, 2003).

For post-registration nurses who had attained a Certificate in Nursing level education, there were two foundations studies modules which the students could avail of to facilitate a smooth transition into higher education academic study. The first module was Foundations in Study Skills and Research. This module exposed
students to concepts in research and the fundamentals of basic academic writing including academic referencing. The second foundations module was: Foundations in Nursing. This module exposed students to core concepts in nursing especially those related to areas of study in the Higher Diploma (Dundalk Institute of Technology, 2003).

It was anticipated that the outcomes of undertaking the programme would have a tangible impact on the quality of care and quality of services provided by graduates. Certain domains of nursing knowledge and competence were desirable with an emphasis placed on research and communication skills. It was desirable that graduates would gain the necessary specialist knowledge and skills to poise themselves to function in the role of Clinical Nurse Specialist. There was a huge emphasis placed on clinical competence thus the need for close collaboration, in the learning phase, with nurse managers and clinical staff in the health service specialist's sites (Dundalk Institute of Technology, 2003). Appendix S presents the learning outcomes for the Higher Diploma in Nursing Programme.

Participants in the Higher Diploma entered one of three strands relevant to their respective discipline (Intellectual Disability, Mental Health and General Nursing). Each strand was further subdivided into sub-strands: Intellectual Disability Nursing (Older Person pathway or Challenging Behaviour pathway), Mental Health Nursing (Older Person pathway or Adult pathway) or General Nursing (Older Person pathway, Orthopaedic pathway or Renal pathway). Seven modules had to be completed; three core modules and three specialist modules and one of which was a clinical placement module (Dundalk Institute of Technology, 2003).

Regarding the clinical component of this programme, participants were assigned a clinical assessor who was required to undertake a two-day teaching and assessing course. This course was designed to prepare assessors to act as preceptors or mentors for the participants of the Higher Diploma programme. The Clinical Assessors were required to be academically and professionally advanced to the level of Higher Diploma.
As recommended by The National Council for the Development of Nursing and Midwifery (2002) the Higher Diploma programme was offered on a full-time basis consisting of 222 hours of theory input (this worked out to involve one day per week each semester over one academic year) and 975 hours practice (24 weeks =6 months), 250 hours (6 weeks) of the practice component had to be supervised by the clinical assessor. The remaining 725 hours (18 weeks) of placement were required to enhance clinical decision-making and critical analysis skills and practice. This meant that participants were required to have access to work placements or be employed in health care settings relevant to the desired work experience which was likely to be the case. Crucial to the learning experience was the requirement that students rotated outside of their usual practice areas in order to be exposed to a range of clinical learning opportunities and to gain maximum benefit from the programme (Dundalk Institute of Technology, 2003).

Students in this programme had access to full library services including audio visual material, books, journals, relevant databases to access library resources from remote locations. Students had access to lecturers on email and phone and were encouraged to make appointments to see them. Notes from class were available online via a programme called Moodle. Students could access notes and library resources online from home or work. The course did not have an e-learning mode. The core modules were delivered by the college lecturers and the specialist modules were delivered by the clinical staff or experts working in the specialist areas (Dundalk Institute of Technology, 2003).

From the development stage of this programme, the health service providers were fully on board in terms of collaboration between the Institutes of Technology and the Health Service collaboratively working on the development of it, buying into a commitment to provide one day off a week for participants to attend the programme. Furthermore, the Health Service paid the course fees of any participant who wanted to attend. Nurse Managers from all nursing disciplines were heavily involved in the consultation process and the curriculum development stages. The Health Service was also willing to facilitate the clinical component of the programme. The North Eastern Health Board Regional Library and Information Service offered a
comprehensive library service to all NEHB staff with the aim to support staff in their learning, development and research activities. Through a networked library service, resources could be easily accessed using the Library Information Management System at any NEHB library. This meant that any student in any site within the Health Board would have access to a wide, varied and comprehensive up-to-date collection and the benefit of assistance from the experienced library staff (Dundalk Institute of Technology, 2003).

So the expectations of the competencies that these graduates would have were quite high. They were expected to become specialists in nursing with the ability to function at an advanced level but also able to collaboratively work with others on the multidisciplinary team sharing expert knowledge with staff, patients and families. Furthermore, a lot of effort went into developing a comprehensive and responsive programme of study for nurses who wanted to either become specialists in their field or function as more knowledgeable general nurses in specialty areas. It was a rigorous programme of study but the colleges and the health service providers offering this programme, endeavoured to facilitate students in this professional development endeavour.

Due to a dearth of Irish research on post-registration nurses’ experiences of higher education nursing programmes like the ACCS and Higher Diploma programmes this study explores this phenomenon through the community of practice lens.

**Theoretical framework**

This research draws on a number of concepts from the community of practice theory described by Lave and Wenger (1991) and Wenger (1998). This study explores Irish post-registration nurses’ experiences of higher education nursing programmes in terms of influences on their motives to engage and their participation in such programmes. My focus on knowing what influenced their experiences suggests environmental factors or contexts that can positively or negatively influence the nurses’ experiences of undertaking a higher education programme. The community of practice theory is a social learning theory developed by Lave and Wenger (1991) and Wenger (1998) that describes how a practice evolves and how a learner
develops an identity within that practice. Lave and Wenger (1991) defined a community of practice as a group of people who share an interest, a craft, or a profession. The group evolves over time due to members’ common interest in a particular enterprise. The community of practice is created to gain knowledge related to the enterprise. Members achieve this by sharing knowledge and experiences thus they develop personally and professionally. This definition resonates with the environments the post-registration nurses were immersed in during their time in higher education. It can be said that these nurses were practicing in the nursing community of practice and now engaging in the academic community of practice. Wenger (1998) suggests that there is an interplay between the identity of a community member and the identity of the community of practice that leads to the community of practice shaping the identity of the member and vice versa. These post-registration nurses were further developing their identities to that of graduate nurses. Thus it seemed fitting, as a conceptual framework, to explore how the communities of practice they were immersed in might have influenced their experiences as they further developed their identities while undertaking a higher education programme.

**Approach to the study**

The research question in this study was:

“What are Irish post-registration nurses’ experiences of higher education nursing programmes in terms of influences on their motives to engage and their participation in such programmes?”

An inductive qualitative paradigm using a descriptive phenomenological design was used to address the research question. Subjective information was gathered from seventeen staff nurses in one-to-one interviews who were undertaking a higher education programme of study in an Institute of Technology in the North East of Ireland. A further two focus group interviews comprising of nine participants were conducted in two other Institutes of Technologies by way of triangulation the data gathers. Through the process of reflexivity and bracketing, the preconceived ideas of the researcher about the answer to the research question were addressed. The participants in this study were selected using purposive sampling.
Ethical considerations in this study were guided by the ethical principles of autonomy, beneficence/non-maleficence and confidentiality. By way of achieving trustworthiness of the findings, the credibility, confirmability and transferability of the findings were addressed. Data analysis was achieved using Giorgi’s (1985) framework of analysis.

**Significance of the study**

This study contributes to the body of knowledge related to nurse education, particularly post-registration nurse education. It builds on international research and a small body of Irish research related to post-registration nurses’ experiences of higher education nursing programmes in terms of influences on their motives to engage and their participation in such programmes. While previous studies have looked at these aspects of the experience, they fail to explore in detail contextual influences on the experience. Thus this study draws more attention to context as Irish nurses encountered higher education. The study highlights barriers and facilitators to achieving their goals of learning in higher education.

Furthermore, the nurses’ experiences are viewed through the lens of concepts from the community of practice theory described by Lave and Wenger (1991) and Wenger (1998) which provided a fresh perspective on this topic.

**Thesis outline**

**Chapter one**

This chapter introduces the aim of the study, the context to the study, the theoretical framework, the approach to the study, the significance of the study, followed by the thesis outline.

**Chapter two**

The literature review chapter reviews the relevant nursing and education literature related to post-registration nurses’ experiences of higher education nursing
programmes in terms of influences on their motives to engage and their participation in such programmes.

Chapter three
Chapter three gives an account of relevant concepts related to the social learning theory described by Lave and Wenger (1991) and Wenger (1998) which were considered useful to discuss and explain the findings in this study.

Chapter four
Chapter four is the methodology chapter. Here the rationale for using a descriptive phenomenological design to address the research question is discussed. A purposive sampling design for selecting the participants who were interviewed is justified. An in-depth discussion on how the interviews were conducted is included. Giorgi’s (1985) method of analysis of the data is discussed and justified. Ethical considerations are included in light of ethical principles. The trustworthiness of the findings is also considered in this chapter.

Chapter five
Chapter five presents the first instalment of findings which highlight the influences on post-registration nurses’ motives to engage in higher education.

Chapter six
Chapter six presents the second instalment of findings which highlights the challenges faced and coping strategies used by post-registration nurses while undertaking a higher education programme. Contextual influences on the participants’ challenges are also presented.

Chapter seven
In chapter seven the findings in this study are discussed in light of the literature and the concepts outlined in the conceptual framework.
Chapter eight
Chapter eight presents conclusions based on the findings. This is followed by the implications of the findings for nursing higher education, nursing practice, policy makers, and research. The strengths and limitations of the study are also addressed in chapter eight.

Databases consulted
The databases consulted included: Academic Search Premier, Cinahl, EBSCO Host DkIT’s Online Journals, Emerald, ProQuest Nursing and Allied Health Source, ScienceDirect, Library Book Catalogues at DkIT, Library e Resources at Sheffield University http://portal.shef.ac.uk and Google searches for online resources i.e. government websites and journals on line. The literature review concentrated mainly on available studies from 1990 to 2015. However, previous relevant work was also considered where appropriate.

Summary of chapter
This study explores Irish post-registration nurses’ experiences of higher education nursing programmes in terms of influences on their motives to engage and their participation in such programmes. The study is set during major reforms in the entry level education for nurses in Ireland from the 1980s to 2002 from the apprenticeship model to a degree in nursing. The Commission in Nursing (1998) made recommendations regarding the provision of higher education nursing programmes for post-registration nurses so that they could upskill to the same level as pre-registration nurses. Two programme types were developed for these nurses a General ACCS degree and a specialist Higher Diploma in nursing. While similar educational developments internationally sparked research exploring the experience of post-registration nurses of these new educational reforms there was a dearth of research conducted in Ireland. With the view to ensuring that Irish post-registration nurses were adequately supported in their endeavour to gain a higher education qualification, further research was warranted.

The study draws on a number of concepts from the community of practice theory described by Lave and Wenger (1991) and Wenger (1998) to explore Irish post-
registration nurses’ experiences of higher education nursing programmes in terms of influences on their motives to engage and their participation in such programmes.

An inductive qualitative approach using a descriptive phenomenological design was used to address the research question. Interviews were conducted to gain rich descriptions of the nurses’ experiences.

The study contributes to the body of knowledge related to nurse education, particularly post-registration nurse education. While previous studies have explored aspects of these nurses’ experiences, they fail to explore in detail contextual influences on these experiences. Furthermore, the use of the community of practice theory described by Lave and Wenger (1991) and Wenger (1998) provides a new perspective on this topic.

The next chapter presents a review of the literature focusing on post-registration nurses’ experiences of higher education nursing programmes in terms of influences on their motives to engage and their participation in such programmes.
Chapter Two: Literature Review

Introduction

In this chapter, literature related to post-registration nurses’ experiences of higher education nursing programmes in terms of influences on their motives to engage and their participation in such programmes is explored. Professional and personal motives and the factors influencing their decision to undertake programmes of higher education are noted. The nature of their engagement with higher education is considered, including the combination of student, work and family roles, the demands of academic study and the extent to which learning was supported within and beyond these programmes. A second set of literature is concerned with the unequal position of women in society and their status and frequent subordination in occupations such as nursing. Drawing on feminist theory and the writing of Freire, there is a discussion of how gender inequality is perpetuated in the working lives of women nurses and how this might be challenged by critical pedagogy.

Post-registration nurses’ motives for engaging in higher education

A review of the nursing literature revealed that post-registration nurses report professional and personal motives for engaging in higher education programmes of study.

Professional motives for engaging in higher education

Knowledge acquisition

In general, mature women engage in education for professional and personal motives. Professionally, women want to gain knowledge and improve their position in the labour market (Webb and Kevern, 2003). Nurses, working in a predominantly female profession, have also reported similar motives. In 1989, Lethbridge surveyed 253 Registered Nurses in the University of Washington, Seattle on registered nurses’ motives to undertake a baccalaureate degree in rural New England. The results
showed that the nurses had professional and personal motives for studying in higher education. One professional motive cited was the desire to gain new knowledge for their practice and thus they were keen to keep up to date (Lethbridge 1989). In these nurses’ experience they recognised that they had knowledge gaps related to their practice and looked to the higher education experience to update themselves.

The acquisition of knowledge has also been reported as a motive to engage in higher education by Gould et al. (1999) who conducted a qualitative study in the United Kingdom. The sample included 62 post-registration general staff nurses with at least 6 months’ experience in acute hospitals in central London who were studying English National Board general specialist courses. The results of this study showed that the nurses’ expectations from a higher education programme included increased theoretical knowledge, primarily technical knowledge, as opposed to gaining reflective practice skills, as the former would be of direct benefit to patients and would offer enhanced expertise in their area of work. The nurses anticipated that they would be better able to apply theory to practice on return to work with the view to improving the care they provided. Other evidence concurs with these findings as in Bahn (2007a) indicating that post-registration nurses recognise that knowledge they received in their original training did not have the level of depth needed for today’s climate. These studies are limited in that they may not reflect the Irish experience and they do not consider a community of practice perspective as is the case in the current study.

Irish post-registration nurses have also reported knowledge acquisition as a motive to engage in higher education. Two Irish studies were found in the literature that focused on post-registration nurses’ motives to and experiences of participating in higher education. Murphy et al. (2006) surveyed 61 Irish nurses working in various areas in the health service in Limerick who were studying management courses. The majority of the participants were women. The survey investigated the reasons the nurses participated in continuing professional education in Ireland and the benefits and drawbacks for the individual and their organization. The findings indicated primarily professional reasons for participating in higher education, the highest
ranking reasons included a commitment to a process of learning and continuous updating of knowledge and skills to use in practice.

A second Irish qualitative study was conducted by Cooley in 2008 in Galway with 18 primarily female staff nurses who were undertaking Diploma or Higher Diploma courses. Cooley (2008) investigated the post-registration nurses’ reasons to engage in higher education and the positive and negative influences of studying on their home and work lives. The post-registration nurses reported professional reasons for undertaking a higher education programme. One reason was ‘to keep up and keep in there’. The nurses wanted to aid their professional development by updating their knowledge base related to interdisciplinary team work, research and computers. Similar professional reasons for undertaking a high education course were reported in Dowswell et al.’s (2000) United Kingdom (UK) qualitative study on child care responsibilities and reasons for participation in continuing education and training. Interviews were conducted with 89 registered nurses, midwives and allied staff who described their experiences of participating in a range of formal professional development courses including degree level courses. The findings suggested that participants wanted to use their increased knowledge to improve their work standards. From an Irish perspective then, Irish post-registration nurses are keen to gain updated knowledge for their practice and they look to higher education to satisfy this need. On the other hand, although Murphy et al.’s (2006) findings were limited by a small sample size and numerical data, those undertaking management programmes had similar aspirations to update knowledge and improve their practice. Cooley’s (2008) and Dowswell et al.’s (2000) qualitative studies were similar to this current study as they investigated participants who were at a Higher Diploma or Degree level.

More recently, studies have shown that post-registration nurses, who have already availed of an update to degree level, are more likely to want to study at Masters level (Watkin, 2011). At Masters level, post-registration nurses have also reported knowledge acquisition as a motive to engage in further education. In a UK study by Watkin (2011) participants cited the acquisition of new knowledge with a particular
emphasis on research skills and evidence-based practice as motives to engage in a Masters. These findings concur with Zahran (2013) who investigated Masters level Jordanian nurses’ motives for undertaking a Masters programme. This ethnographic study with 37 participants revealed that the nurses perceived that undertaking a Masters would have an impact on their practice through the acquisition of such skills as critical thinking, innovation, and application of research to practice. This concurs with Watkin’s (2011) study, who found that Masters post-registration nurses wanted to acquire reflective skills that would sustain them as lifelong learners and the ability to provide innovate, effective care to patients underpinned by current evidence.

Front line post-registration nurses want to engage in higher education programmes because they want to gain new knowledge for use in their practice. However, the literature suggests that it may only be at Masters level that post-registration nurses come to appreciate the need to acquire skills for lifelong learning rather than entering a programme of study to acquire knowledge alone. This emphasises one of the flaws of the traditional education that post-registration nurses received which focused on imparting knowledge rather than the development of lifelong learning skills. Thus post-registration nurses entering higher education at the first degree level may still be expecting traditional pedagogical teaching methods that serve to impart knowledge only. Traditional pedagogical teaching methods have been criticised for maintaining nurses in a subordinate role which will be discussed later.

**Strengthen nurses’ role and status**

Some post-registration nurses, even though they have gained a degree, want to engage in higher education at Masters level because they feel it will strengthen their role and status within the multidisciplinary team. Zahran (2013) found that some participants were dissatisfied with their status as staff nurses and they sought to free themselves from their perceived subordinate role. Having attained degree status the nurses perceived that they had the potential for further education. However, they still perceived themselves to be in a subordinate role within the multidisciplinary team. Their crucial contribution as front line nurses was not respected or
acknowledged. These nurses were aware that gaining a Masters degree would not guarantee that they would be promoted beyond the level of a bedside staff nurse as these promotions were limited. Therefore the nurses aspired to undertake a Masters to satisfy the desire to become an academic, teaching undergraduate degree nurses in the colleges in Jordan, a move that would draw expertise away from the bedside. These findings suggest that some bedside staff nurses, at degree level, perceive a lack of appreciation and respect for the contribution they make to the multidisciplinary team. The result is that they feel devalued in their present role and aspire to enhance their status by moving to more academic educational roles in search of enhanced status at work. The only avenue to achieve this is to move up or out of the practice environment which creates a drain on the expertise available at the bedside.

Post-registration nurses, applying for a higher education course, may not perceive that moving up the career ladder into management, for example, will achieve the level of respect they anticipate from the multidisciplinary team. An interesting finding in Murphy et al.’s (2006) Irish study was that knowledge acquisition and career advancement were top priority for these nurses, which was not surprising as they were studying management courses. However, it was interesting to see that gaining professional respect from colleagues and the likelihood of influencing changes in the organization ranked low on their reasons to engage in higher education. It was not clear from the findings if the participants ranked these latter aspects low because they already felt respected or because they did not experience respect at work and they did not think that the higher education programme could alter this situation. Further qualitative exploration of these issues would have clarified these findings. However, the findings in this study highlight the possibility that upgrading to degree level may not be perceived as gaining any ground on relieving nurses’ struggle to achieve improved status among the multidisciplinary team.

The nursing literature thus far suggests that the current environments where post-registration staff nurses’ work do not always value their contribution to the multidisciplinary team and that the nurses’ educational backgrounds may have
contributed to this. Nurses may seek to enrol in higher education as a perceived attractive avenue to escape working at the bedside. This is in stark contrast to the reasons new nurses apply to higher education to enter the profession. The literature suggests that undergraduate nurses, entering the profession for the first time, view nursing as a highly respected profession. This was evident in Wilkes et al.’s (2014) survey of 743 student nurses in one Australian university. These findings point to a disconnection between the public’s perception of the nursing profession and the reality of post-registration nurses’ experiences in practice and education. None of the studies thus far have explored post-registration nurses’ reasons for engaging in higher education from a community of practice perspective. Since context appears to be influential, the community of practice theory which will be discussed later could shed light on these nurses’ experiences.

Competent mentors

Post-registration nurses consider that part of their role is to pass on their knowledge and expertise to new nurses entering the profession. In addition to theory input, student nurses entering the profession at degree level are required to engage in clinical practice in order to learn how to be nurses. ‘Bedside’ nurses are required to mentor these students into the practice of nursing. With the move to an all graduate nursing profession some post-registration nurses, who have not obtained a degree, feel that they need to upskill to that level so they can adequately address the learning needs of undergraduate nursing students. In an Australian qualitative study by Halcomb et al. (2012) 12 practice nurses’ experiences of mentoring undergraduate nursing students were explored. One theme that emerged in this study was the need for the practice nurses to mentor future workers through patience and reassurance. While they acknowledged that mentoring required additional time and posed multiple challenges, they were committed to providing the students with quality learning experiences. Thus they wanted to be competent in their role as mentors.

In an effort to provide quality learning experiences for nursing students, post-registration nurses look to higher education to achieve this. Participants in Gould et al.’s (1999) UK study, for example, reported that they engaged in a higher education
programme in order to enhance their ability to teach nursing students, patients and junior colleagues. Likewise, in the study by Dowswell et al. (2000) UK participants also reported, what they termed as, negative motives to engage in higher education. Negative professional motives included: feeling that they were not doing their job well, for example, not teaching students well. These nurses were feeling inadequate in their role as mentors for the undergraduate student nurses because they had not achieved that level of education themselves, albeit that they would have had a wealth of experience to impart. They anticipated that higher education would enhance their competency as mentors. These studies are limited to a UK and Australian perspective which may not resemble Irish post-registration nurses’ experiences.

Maintaining status

Evidence in the nursing literature suggests that post-registration nurses want to undertake a higher education programme because they feel educationally ‘left behind’ new graduates. The consequences of this manifests in feelings of intimidation and loss of status. A qualitative study conducted by Bahn (2007a) with 20 nurses at the University of Hull in the UK, found that nurses were motivated to participate in higher education because they did not want to be left behind by the changes in pre-registration nursing education. The young graduates coming out of college, with better qualifications, made them feel uncomfortable and intimidated. They perceived a loss of status as the new graduates were more knowledgeable.

Not having a degree can mean lack of career development losing out to new graduates who are more highly qualified. In Dowswell et al.’s (2000) study, half of the participants reported that they felt ‘stuck’ at work indicating that the wider profession of nursing placed pressure on them to undertake higher education because those who wanted to secure a promotion could not move in their jobs until they undertook a higher education programme. New graduates could potentially be more academically qualified to secure these promotional opportunities. Cooley’s (2008) Irish study also suggested that post-registration nurses wanted to gain access to higher education to increase their employability because they would have to compete with future higher educated nurses who were more qualified. Post-
registration nurses in the USA also report wanting to undertake a degree level programme to enhance their status and keep up with competitors. It is clear from these studies that post-registration nurses feel out of step educationally, with undergraduate student nurses and newly-qualified nurses. This sense of being left behind is a common motive to engage in higher education in order to achieve at least the same level of education as students and new graduate colleagues.

For some post-registration nurses, achieving the same level of education as student nurses and new graduates is not enough. Evidence suggests that post-registration nurses feel that they have to be more than one step ahead of nursing students in terms of catching up with them educationally. That is, they need to graduate at Masters level. A qualitative study conducted by Watkins (2011) in the UK with 19 nurses explored the reasons for applying for a Masters in nursing studies through distance learning. The finding suggested that the nurses were either personal or professional challenge seekers and the professional challenge seekers wanted to address issues of credibility or catching up. By this they meant catching up with new nurse graduates who were soon to come out of the colleges with a first degree in nursing. In the UK in 2010, The Nursing and Midwifery Council for England, Wales, Scotland and Northern Ireland announced that all undergraduate nurses would be educated to degree level from the year 2013/2014 to address the changing landscape of the National Health Service (NMC, 2010). The post-registration nurses in Watkin’s study did not feel adequately prepared to mentor these degree student nurses. They felt that a Masters was needed in order to be competent, credible mentors for the students.

Post-registration nurses want to do higher education courses for professional motives including to acquire knowledge and skills for lifelong learning, to escape from a perceived subordinate position on the multidisciplinary team and to avoid being left behind in the wake of new graduates with degrees in nursing. Some feel it is necessary to reach Masters level to keep pace thus avoiding credibility and limited career choice issues. Few Irish studies have been done on this topic but the literature suggests that pressures from the community of nursing impacts on post-
registration nurses’ motives to engage in higher education and a community of practice perspective may help to explain this.

**Personal motives for engaging in higher education**

In addition to professional motives, post-registration nurses report fewer personal motives for engaging in higher education. Nurses engage in higher education because they feel they have arrived at a personal milestone in their lives that affords them the opportunity to enhance themselves personally. In Cooley’s (2008) Irish study, for example, post-registration nurses were personally driven to undertake a higher education course because they perceived it was the right time in their lives for them and their family to do it. Another cited motive is that they are genuinely interested in improving their knowledge by undertaking a particular course which interests them (Dowswell et al. 2000).

Studies have shown that post-registration nurses want to undertake higher education programmes because they were ‘underachievers’ or they missed out on education in the past. They now want to prove to themselves that they can succeed academically. It also gives them the opportunity to catch up with other family members who had already attained a degree level education (Watkins, 2011, Dowswell et al., 2000). In Zuzelo’s (2001) UK qualitative study with 35 nurses examining how a Bachelor of Science in Nursing influenced their practice, the findings suggested that the post-registration nurses recognised the value of studying in higher education. They also viewed their attainment as a personal accomplishment that was beneficial in terms of showing example to their children and acting as a role model.

Some post-registration nurses report that they engage in higher education programmes to address issues of low self-esteem and to build confidence levels (Gould et al., 1999, Murphy et al., 2006). Mature women, in general, also cite improving their self-esteem as a personal motive to engage in education (Webb and Kevern, 2003). The literature suggests that enhancing social relationships such as
taking part in group activities and making new friends are motives for post-registration nurses to engage in higher education (Lethbridge, 1989). Such activities work toward building personal confidence and self-esteem. Other post-registration nurses report that they have a desire to continue learning to avert becoming ‘stale’ by maintaining their knowledge and expertise (Dowswell et al., 2000).

These latter personal motives for engaging in higher education such as a lack of confidence and low self-esteem reflect processes in the profession of nursing that can demotivate nurses, causing them to become jaded in their work. It is fair to say that these may not have been the personal motives the nurses had when they went into the profession in the first place. A recent study by Wilkes and Johnson (2014) cited personal motives for choosing to undertake an undergraduate nursing degree. The students stated that they wanted to help others and that they enjoyed interacting with colleagues whilst taking care of people. The concept of ‘love and like’ or an affinity for interaction with people was reported. These personal motives appear to diminish as time goes by in the career of some nurses. Wilkes and Johnson (2014) concluded that nurse educators need to continue to encourage student nurses to express their personal aspirations rather than always favouring professional attributes. Few Irish studies have explored the personal motives for post-registration nurses who engage in higher education. There are no studies that have explored this from a community of practice perspective.

**Contextual influences on post-registration nurses’ decision to undertake a higher education programme**

**Deterrents to engaging in higher education**

**Career prospects**

While post-registration nurses offer professional and personal motives for engaging in higher education, there is evidence to suggest that these nurses can be deterred from wanting to undertake further education. Some nurses cannot see the point in undertaking a degree as they believe that it will do nothing to change their
circumstances at work. Undertaking a higher education programme can raise expectations that career prospects may improve, salaries may increase, career opportunities will open up and there will be good support from the employer to engage in learning. This may not necessary be the case. Davy and Robinson (2002) undertook a UK quantitative survey with traditionally trained nurses about the constraints and effects of undertaking a degree. This was a large study with 620 nurses (94% women). The reasons cited in this study as deterrents to participation in higher education were the knowledge that it would not necessarily lead to an increase in pay in their current job as staff nurses and that it may not enhance their clinical skills. Likewise, Murphy et al. (2006) asked Irish participants what would discourage them from partaking in another course in the future and the most influential inhibitors were those which the organisation could exercise some control over such as a lack of career progression possibilities. In 2001, Zuzelo also found similar findings stating that while some UK nurses felt elated about undertaking a degree this was overshadowed by the realization that even though they were now graduating to degree level they were still at the bottom of the credentials ladder despite many years of service. If nurses perceive that their career prospects are unlikely to change after undertaking a degree this can be a strong deterrent from considering this option.

**Lack of resources at work**

The environment in which nurses are employed can pose as a deterrent to engaging in higher education programmes. Post-registration nurses often cannot partake in higher education programmes because they simply are not released from work to do so. There are various reasons cited in the literature for this. Staff shortages cause access issues for post-registration nurses who want to study in higher education. Participants in Gould et al.’s (2007) UK study reported that the lack of staff to fill in for their absence resulted in not being able to undertake Continuing Professional Development programmes (CPD). In fact these researchers found that nurses felt that they were lured into employment by the management of their respective UK Trusts with promises of the availability of opportunities for CPD. However, once
employed by the Trusts this policy was only given ‘lip service’ by managers. This, in turn, resulted in resentment on the part of the staff.

More recently in the UK, Watkin (2011) predicted that the numbers of UK nurses applying for Masters degrees would diminish due to cutbacks in the National Health Service, staff shortages, increased workloads and lack of protected time to study. It was thought that these issues would deter post-registration nurses from considering further study. Likewise, Schweitzer and Krassa (2010) undertook an integrative literature review on deterrents for nurses participating in continuing professional development. The authors concluded that availability of resources was an issue in terms of funding for programmes, not being able to get time off from work to attend, home and child care issues. As these studies were conducted in the UK the findings may not represent an Irish perspective.

**Power and control of managers**

Managers have the power and control to deny post-registration nurses from engaging in higher education programmes. Gould et al. (2007), for example, found that managers had the power to deny access to programmes of study for junior nurses. One reason cited for this was that managers felt threatened by the possibility that their subordinates would end up more knowledgeable than them. It was suggested in this study that management, through manipulation of access to Continuing Professional Development, had the power to influence opportunities for career progression positively and negatively thus keeping staff in line. Managers in his study suggested that they themselves could not pursue a degree because their role as managers was so pivotal to the running of the ward they could not possibly leave the ward to attend courses themselves. This admission demonstrates the level of the power and control managers exert in hospital wards to the extent that they felt that no one else could possibly relieve them of their duties in order for them to also upskill. Furthermore, ward managers have the power to deny access to higher education to front line nurses. These findings point to oppression and control of nurses which will be explored in more detail later.
Health service practices

Hospital practices can in themselves pose as deterrents to post-registration nurses engaging in higher education programmes. For example, some of Bahn’s (2007a) UK participants did not have staff appraisal systems in place where managers and the post-registration nurses could work out what educational inputs were required that satisfied the nurse’s educational interests and the needs of the unit. This resulted in less commitment from managers to support post-registration nurses’ decisions to undertake a higher education programme of study and this could pose as a deterrent. In the United States there are two levels of nurses, Associate Degree and Bachelor Degree nurses. The Associate Degree nurse studies for a shorter period of time than the Bachelor Degree nurse. The United States are working towards the goal of 80% of the Registered Nurses having a Bachelor’s Degree in nursing by the year 2020 (IOM, 2011). The American Association of Colleges of Nursing (AACN) have reported that they are making good progress towards this goal (AACN, 2012). However, one study showed how health service practices only posed as disincentives for nurses to achieve this goal. Orsolini-Hain (2012) conducted a phenomenological study with 22 experienced Californian Associate Degree nurses investigating hospital practices that served as disincentives for them to return to school to get a baccalaureate degree. Most of the nurses worked in direct patient care. This researcher found that the context and culture in the health care organisation was responsible for the nurses’ lack of interest in returning to education. Three issues contributed to this: a lack of distinction in role skill and status in direct patient care, Just-In-Time learning practices (in-service training) and the possibility for advancement without formal education. Comparing the Associate Degree and Degree nurses, both nurses did the same direct patient care job and were paid the same. The health service employer was more supportive of in-service training over returning to formal higher education. More often than not if a non-managerial direct patient care job was advertised, stating the need for a Bachelor’s Degree, this was overlooked for years of experience. This sent out a clear message that the Bachelor Degree was not so important. Thus these findings suggest that institutional practices can reinforce nurses’ beliefs that they do not need to return to school.
In the United Kingdom, since the Nursing and Midwifery Council for England, Wales, Scotland and Northern Ireland announced that all undergraduate nurses will be educated to degree level from the year 2013/2014 (NMC, 2010) discourses in the nursing literature reflect fears that post-registration nurses in the United Kingdom could be left behind on the career ladder if they do not get a degree. To keep pace with the new graduates, registered nurses may want to convert from the old diploma to degree. The Department of Health was considering ways to have a Registered Nurse’s experience recognised without having to do further study (Nursing Standard Analysis, 2009). This view was criticised saying that Registered Nurses, who accepted this option because they fear the rigors of academia, may then feel devalued and marginalised, condemning them to lower grade positions. Thus there was a call for financial and other support for the Registered Nurses to upgrade to the degree (Nursing Standard Analysis, 2009). Again this reflects a resistance in the work environment to supporting post-registration nurses in their endeavour to upskill and keep pace with educational advances in the profession of nursing. This can pose as a deterrent for engaging in high education.

Structures within the health service organisation can discriminate against nurses on the basis of social class and this can deter post-registration nurses from engaging in higher education. Adeniran et al. (2013) United States study highlights this. These researchers investigated differences in the level of mentorship function and self-efficacy, and the difference in participation in professional development and career advancement between United States educated registered nurses and internationally educated nurses working in a hospital setting within Philadelphia County. There were 200 nurses and 200 of their mentors in the study who received a descriptive web-based survey. The study found that the United States educated nurses were more likely to be white and in leadership position, whereas the internationally educated nurses were more likely to be Asian with dependants and in bedside staff nurse positions. The mentors for the internationally educated nurses were more likely to be ethnically diverse and most were in staff nurse positions. On the other
hand, the United States educated nurses’ mentors were mostly white and were in leadership positons.

Because of the way the mentorship was structured, Adeniran et al. (2013) found that the internationally educated nurses were less likely to look up to their mentors as a result of this disparity. They concluded that in order for a mentee to see a mentor as a role model the mentor should have attributes that the mentee can aspire to. Regarding professional development activities, Adeniran et al. (2013) found that the internationally educated nurses were half as likely to undertake a degree as the United States educated nurses and half as likely again to undertake another more advanced degree after that. This study underscored how organisational structures and processes can limit educational opportunities for working nurses with families who are ethnically diverse. Bearing in mind that the USA is working towards the goal of 80% of the US RNs having a BSc degree in nursing by the year 2020 (IOM, 2011) these discriminatory structures only serve to deter rather than encourage post-registration nurses from engaging in higher education. An Irish perspective on health service practices that deter nurses from engaging in higher education is warranted.

Factors that positively influence post-registration nurses to engage in higher education programmes

Learner Characteristics

While there are factors that can deter post-registration nurses from engaging in higher education, there are also factors that positively influence them to engage. One survey conducted by Kovner et al. (2012) in the States explored the characteristics of nurses who choose to go back to higher education to enrol on an additional degree (Bachelors or Masters) among those with an associate degree (n=917) or a Bachelor’s degree (n=643). Nurses who worked in an intensive care unit where there was more variety in the job and working day shifts were predictors of enrolment on an additional degree. These findings suggested that perhaps the complexity of the work environment constantly stimulates nurses to learn and thus
they are more ready to undertake further studies. Although the day shift work pattern lead the researcher to conclude that flexible work patterns predicted future enrolment this conclusion seemed unwarranted as a day shift work pattern resembled a fixed work pattern thus this would be harder to work around. Although this was a large study the findings refer to the American experience and this may not reflect the Irish experience.

**Encouragement from management**

Managerial support plays a vital role in influencing post-registration nurses to engage in higher education programmes. Bahn (2007a) found that getting approval from managers to attend higher education courses was easy for some nurses but problematic for others. These researchers found that staff appraisal systems played a role here. Some participants experienced staff appraisals and collaborative planning for courses but others did not. Through staff appraisal systems, staff and managers were able to discuss what higher education activities would benefit both the practice area and the staff members. Courses collaboratively negotiated like this were more likely to be approved by managers. Other details that could be worked out during staff appraisals were study time allocation and funding issues.

Other evidence concurs with these findings indicating that the role of nurse managers is vital with regards to the uptake and use of Continuing Professional Development. Gould et al. (2007) did a survey with 451 registered nurses in the United Kingdom looking at opportunities for continuing professional development and factors encouraging or discouraging uptake. One open-ended question on the survey revealed that managers were considered ‘good managers’ when they encouraged staff to undertake study days and courses that were appropriate for staff learning needs and where there was equitable access to the courses. These findings highlight the need for a collaborative approach, between management and post-registration nurses, at the outset when considering engagement in higher education courses to ensure the full support of management for the nurses involved. Further research could be conducted to explore Irish post–registration nurses’ experience of this theme.
Educational Institutional support

The nursing literature highlights that it is not only the health care organisation that should support post-registration nurses in their decision to engage with higher education. Educational institutions also need to play their part. Based on Kovner et al. (2012) findings they suggested that to make it easier for the Associate degree nurses to return to higher education, educational institutions should give credits for prior learning, thus reducing the cost due to repetition of credits and courses. In addition to this they suggested that, in recognition that the registered nurses would be working and learning, Bachelor Degrees and Graduate courses should be scheduled at times and in places that suited the nurses. In relation to this the researchers suggested that internet courses be employed. However, they found that the nurses themselves were cautious about internet courses as they questioned the quality of them. Finally, Kovner et al. (2012) argued that employers should be more flexible with scheduling so that registered nurses could have consistent days off to attend classes. These suggestions point to a need for stronger academic–clinical partnerships so that both sides are supporting the post-registration nurses in their decision to engage in higher education.

With the international trend for an all-graduate profession in nursing, educational and health service organisations need to consider the deterrents and factors that positively influence post-registration nurses’ decisions to engage in higher education. Evidence suggests that nurses’ experiences in the community in which they work appears to influence their decision to engage with higher education prior to enrolment. No studies cited have explored this phenomenon in terms of the community of practice theory which is the intention in this current study.
Post-registration nurses’ experiences during a higher education programme

Thus far the review of the literature has focused on post-registration nurses’ experiences of higher education programmes in terms of factors that influence their motives for engaging in a higher education programme of study. Now the review focuses on post-registration nurses’ experiences during such programmes and the influences on these. The literature suggests that the main aspects of these experiences relate to juggling multiple roles and the challenge of academic work. The literature also highlights the level of support post-registration nurses receive, while attempting to cope with these issues.

Juggling multiple roles

Juggling multiple roles is part of the experience of undertaking a Higher Education programme for post-registration nurses, particularly female nurses. The roles that must be juggled include home, work and college life. This can be a challenge for working nurses. An Irish survey conducted by McCarthy and Evans (2003) reported on the impact of continuing education on post-registration nurses and midwives in Higher Diploma and general degree programmes. Two hundred and seven questionnaires were distributed to a convenience sample in the west of Ireland with an impressive return rate of 71%. The finding suggested that managing the competing roles of work life, family life and study was a challenge for the majority of participants. Findings from Davy and Robinson’s (2002) English study concurred with these results showing that nearly half of their graduates did not plan to take a degree after qualifying and the main constraint to this was the difficulty of combining work with studying, especially for those women who had childcare responsibilities.

Stress related to multiple roles

Managing multiple roles can lead to stress for post-registration nurses particularly for females. When Australian nursing education transferred from schools of nursing into
higher education Glass (1997) conducted a phenomenological study to explore the impact this had on post-registration nurses’ personal and professional lives. The findings identified a “shared woman’s voice”. This voice allowed the nurses to express their experiences of adapting to multiple roles as nursing students, wives and mothers. This voice spoke about the support nurses got at home from partners, which in this study amounted to very little, leaving the women to shoulder their usual responsibilities at home as well as work and study. The balancing of all the roles caused stress and strain for the nurses. Stress was also noted in Stanley’s (2003) conceptualisation of the experience of undertaking a degree for post-registration nurses. Stanley’s (2003) UK phenomenological study with nine post-registration nurses, midwives and health visitors explored the impact of a part-time degree on the personal and professional lives of the participants. Stanley (2003) conceptualized the experience of undertaking a degree as a journey with four main aspects to it namely: the traveller, the guide, the journey and the journey’s end. In this study, the traveller (post-registration nurses) found the journey stressful because of the pressure of combining work, study, running a home and looking after relatives.

Similar Irish evidence exists indicating that juggling multiple roles can be a stressor for post-registration nurses when they enrol on a higher education programme. Evans et al. (2006), for instance, did a study with 132 registered nurses attending a part-time degree in nursing in two third-level institutions in Ireland. The study surveyed programme-related stressors affecting the nurses. The data was collected by an existing questionnaire deemed to be reliable to assess programme-related stressors for undergraduate nursing students. The findings suggested that balancing work and academic study ranked in the top five stressors for the post-registration nursing students. However, the validity of this questionnaire is questionable as it may not assess programme-related stressors for post-registration nurses who may have different characteristics to undergraduate student nurses.

Similar findings were noted in a later study by Tame (2013) who reported on the perceived status of being a university student from her Doctor of Philosophy thesis (2009) with 23 perioperative nurses. The findings suggested that the courses
caused perioperative nurses a degree of stress. This stress was related to the fact that the demands of the academic work was always at the back of their minds, essentially hanging over them. They also experienced further multiple demands from their roles as mothers and home makers that raised their levels of stress even further leaving them with no time to relax or socialise.

Even without the added challenge of studying, nurses in general are stressed due to work commitments and this has been linked to the intention to leave nursing. Jourdain et al. (2010) did a Canadian survey with 1636 staff nurses working in Canadian hospitals exploring the relationship between stress related to nurses’ work and the social environment, and their intention to leave nursing. 92% of the nurses were female and 74% were married or living with a common-law partner and 56% were working full-time. The findings suggested that the demands of work were the most important determinants of emotional exhaustion (burnout) and that this was indirectly related to the depersonalization of the nurses. Also resources available to the nurses mainly predicted depersonalization. Furthermore emotional exhaustion and depersonalization were linked to psychosomatic complaints and professional commitment. These, in turn, were linked to an intention to leave the profession. The authors concluded that there was a need to put strategies in place to prevent nurses from leaving nursing and these included decreasing job demands and providing more resources for them to do their job properly. They recommenced that nurses’ work should be restructured to reduce work overload and to increase the meaning of their work.

A similar study conducted by Garcia-Izquierdo et al. (2012) emphasised how nurses could become burnt out at work. These researchers surveyed 191 emergency department nurses employed in three university hospitals in Spain. 69% of this sample were women, 47% were married, 31 % were on full-time work. These authors explored predictors of emotional exhaustion, cynicism and professional efficacy. The findings indicated that excessive workloads and lack of emotional support predicted emotional exhaustion and cynicism. Lack of social support and the type of shift worked predicted professional efficacy. These authors concluded
that nurse leaders and organisational interventions needed to be put in place to address burnout in nurses thereby implementing preventive measures to ensure quality patient care and the well-being of nurses. Thus evidence suggests that the work environment of nurses is already stressful and this needs to be borne in mind when they enter higher education programmes where they will have the added pressure of academic work to cope with.

There is no doubt that nurses are very stressed at work. This stress can be compounded when added to juggling multiple roles if a post-registration nurse decides to undertake a higher education programme.

**Juggling multiple roles and family life**

The experience of undertaking a higher education programme can impact on the family life of post-registration nurses. Dowswell et al. (2000) noted in their study that participation affected home and work and there were changes in their participants’ role as parents or spouses. Participation in higher education led to a lack of time to spend on family and leisure activities and this, in turn, put a strain and tension on relationships. The course also affected their leisure activity. In Tame’s (2013) research, academic work impacted on post-registration nurses’ lives in terms of the need for them to make sacrifices, although temporarily, and they had to shift their priorities. The sacrifices they had to make were related to the competing demands of juggling multiple roles of mother, carer, partner, nurse and student. These findings concur with Stanley’s (2003) UK study where it was found that, due to the stress of not having enough time for family and partners, tensions ensued in relationships and the participants felt guilty about this. The parent role was a major source of conflict while studying. In another study conducted by Bahn (2007b) post-registration nurses reported reasons for not completing a course of study and these generally related to family pressures and commitments.

Other studies concur with these findings indicating the impact studying can have on the family life of a post-registration nurse. In Cooley’s (2008) study post-registration nurses had to organise their personal lives in order to attend school, for example
they had to arrange baby-sitting. Similar experiences have been reported in America. In one South Carolina State University, faculty observed that there was a higher attrition rate from distance RN to BSN nursing programmes. As a result, Dacanay et al. (2015) did a survey with 47 registered nurses who were undertaking distance RN to BSN programmes to identify factors that contributed to students’ success in distance education. The findings suggested that the nurses were juggling many roles. One of the themes that emerged was role stress related to multiple roles including being a student, breadwinner and primary family caregiver. This was helped by family support, encouragement and carpooling with a friend. Thus the literature suggests that post-registration nurses have to juggle many roles and this can impact on their family lives.

Support for nurses who juggle multiple roles

As post-registration nurses need to juggle many roles it is important to consider how they might be facilitated to cope with this. Speaking about the experience of perioperative nurses, who work long hours as do other nurses, Letvak (2001) advocated that solutions could be found to facilitate working women who need more flexibility in order to juggle roles of work, caring for children and older family members. These solutions include flexitime, job sharing, part-time work with pension benefits, compressed work weeks, and working around children’s school times (Letvak, 2001). These suggestions, although not made in the context of nurses also studying, would allow nurses to continue studying, working and attending to family responsibilities while creating financial savings as the need for paid child or older parent care would be reduced.

Few of the studies reviewed address how nurses try to cope with the challenge of juggling multiple roles themselves. Some nurses appear to be able to strike a work-life balance through a process of time management and planning ahead (Stanley, 2003; Tame, 2013). Others ask for deferrals in their course in order to cope with issues that life throws up like bereavements or other personal problems while they attend higher education courses (Stanley, 2003). On the other hand, Bahn (2007b)
noted that some nurses report that juggling roles is unlikely to force them to discontinue their programme indicating nurses’ commitment to learning.

Therefore, evidence in the nursing literature suggests that balancing home, study and work is a major issue for post-registration nurses who decide to do higher education courses. Writing about mature women’s experiences of higher education, one author suggested that mature women, in general, bear a double life load when they enter higher education because they have to take responsibility for the home and their study. Mature women nurses in higher education are hijacked by greedy institutions, that of home, the university and the healthcare system (Webb and Kevern, 2003). The challenge of juggling these roles has to be considered by health service providers and educational institutions.

While juggling multiple roles pose a challenge for post-registration nurses in higher education another challenge presents itself, that is the academic work required to earn the qualification.

**The challenge of academic work**

One of the most frequently cited challenges, that higher education institutions require post-registration nurses to master, is academic writing. In Stanley’s (2003) study some of the participants found writing into portfolios stressful. On the other hand, it also helped them to track their journey through the programme. The research project at the end posed the most challenging for participants and they likened that to reaching a summit. Likewise, in Evans et al.’s (2006) Irish study the top ranking stressor for their participants was ‘preparing assignments for submission’. The other stressors ranking in the top five were ‘doing the course assignments’, ‘the demands of writing an assignment to the necessary level’ and ‘the prospect of the final examination’. These researchers found that the younger participants were more likely to experience higher degrees of stress due to process stressors which were described as academic workload and time management difficulties. Participants in
Dacanay et al.’s (2015) South Carolina study also commented that assignments were very time consuming and that more flexible deadlines for assignment submission would help. Thus for the participants in these studies the course work was a major issue.

Other evidence suggests that the assessment of the academic writing skills of post-registration nurses in higher education programmes is inappropriate and can potentially pose as a barrier to future engagement in lifelong learning. Johanson and Harding (2013) undertook a qualitative Norwegian study with 30 post-registration nurses in higher education, exploring their experience of academic writing. The findings suggested that the post-registration nurses had limited previous experience of academic writing which contributed to the challenge. The participants associated academic writing with personal issues like lack of confidence. The authors suggested that post-registration nurses, who are expert clinicians and critical thinkers, may be assessed as less competent from an academic perspective purely as a result of a lack of academic writing skills. Participants in this study also reported that the structure of their essays were increasingly emphasised rather than the actual content. This led the participants to conclude that academic writing was unrelated to their own workplace. Johanson and Harding (2013) asserted that while clear written communication skills are needed in the workplace for nurses, the structural framework of nurses’ notes or clinical protocols are not related to the structure required in an academic essay. Nurses therefore perceive the two elements of writing skills as being unrelated.

This evidence suggests that higher education institutions may lose sight of the rationale for post-registration nurses’ entry to higher education. Johanson and Harding (2013) caution that when post-registration nurses are time pressured with juggling multiple roles, they may spend their time sacrificing content for style of writing which is contrary to their motive for entering the course. These authors contend that academic institutions need to rethink the need for post-registration nurses to ‘crack the code’ of academic writing in favour of more relevant and engaging assessment strategies that capture critical thinking skills and deep
learning. They suggest such strategies as journaling, concept mapping, questioning, debate, role play and team based teaching and assessing strategies as a means of facilitating critical thinking and promoting a culture of lifelong learning (Johanson and Harding, 2013).

Assessment, therefore, should not be a series of hurdles over which post-registration nurses need to jump in order to reach a specific grade. Assessment should be part of the process of learning and clarifying meaning (Santy et al., 2000) and some of these aforementioned strategies may better satisfy this goal.

By all accounts nurses, particularly women, find themselves having to juggle work, study and home life while undertaking higher education programmes. They also experience multiple stressors in terms of meeting the academic requirements of the programme of study. The need for support for nurses undertaking higher education programmes in order to cope with challenges they face while undertaking higher education programmes is evident in the literature. A diversity of assessment strategies can enhance the engagement and learning of students. The types of support cited in the literature that post-registration nurses experience include clinical and college supports.

Support for post-registration nurses undertaking higher education programmes

Support from the college

Modes of programme delivery

Classroom versus work based learning

Post-registration nurses’ experiences of higher education programme delivery features as an area for discussion in the nursing literature. One distinction that is
made is between classroom-based versus work-based learning. Gould et al. (2007) in their study highlight that eclectic modes of programme delivery are warranted and indeed preferred by post-registration nurses depending on the learning needs of the learners. Nurses in this study perceived that work-based learning programmes were not getting the emphasis they deserved and that they were just as important for effective learning as classroom-based programmes. Indeed the nurses perceived that learning on the job had the greatest impact on patient care. Work-based learning programmes, for these nurses, emphasised clinical experiences and skills. Clinical experience is and has traditionally been highly valued in nursing and for these nurses, courses that overemphasize assignments and accrediting for academic work, was causing nursing to lose its way in the direction of deskilling nurses. A community of practice perspective on this data may enhance the findings.

Distance learning

As a group of students who have work and home life commitments, the mode of delivery of programmes becomes very important in terms of students’ ability to participate on programmes of study. E-learning is one mode of delivery that has been considered to be a way to bring higher education to busy post-registration nurses. McCarthy and Evans (2003), for example, found that their Irish participants took issue with the fact that programmes of study were delivered in urban centres. This meant that nurses working in rural hospitals found access to programmes difficult. These study participants indicated that e-learning should be explored by colleges as a means of providing better access to higher education programmes for this group of nurses. Likewise in support of this view, in Davy and Robinson’s (2002) UK study, the growing availability of distance education for post-registration nurses in the UK was apparent. In their study, of those who had completed their degree, 95% physically attended part or all of the degree. However, of those who were currently taking a degree only 79% were physically attending. This was explained by the increase in the number students taking distance-learning degrees. This indicates that post-registration nurses are a group who are interested in higher education and may welcome eclectic modes of delivery that solve the access problem.
On the other hand, as a mode of delivery of post-registration programmes, some nurses have reported dissatisfaction with the idea of distance learning programmes. Seven et al. (2014) surveyed 238 Turkish post-registration nurses about their reasons for engaging in a post-registration programme and their opinions of distance learning education. The findings indicated that half of the nurses were in favour of distance education stating that it provides an opportunity to engage in education. On the other hand, about half of the nurses said they did not know about distance education and had concerns about the quality of that type of education. Furthermore, 40.8% of the nurses thought that distance education would be a more expensive way of learning and that it would yield insufficient practical training. They believed that there would be a lack of role modelling and instant feedback which could impair their education leading to malpractice. This points to nurses’ unfamiliarity with and fears about the value of distance learning which higher education institutions would need to consider if employing it as a mode of delivery.

A student’s perceptions about e-learning can also be associated with the student’s academic ability. A Canadian study by Owston et al. (2013) surveyed 577 undergraduate students, from various faculties including health. They explored their perceptions of blended learning and their achievement in the courses. The findings suggested that higher achievers were the most satisfied with blended learning, would take a blended learning course again and preferred the blended learning format to the face-to-face format. The higher achievers found that their e-learning course was more convenient and engaging and they felt that they learnt key course material better than the face-to-face format. The authors concluded that low achievers may not be able to cope with blended learning modes of delivery. Thus they recommended that students should be given choice regarding the mode of delivery in order to accommodate students who prefer and can achieve better results with face-to-face modes of delivery. These results are not specific to post-registration nurses but they point to issues that need to be considered when thinking about e-learning modes of delivery of programmes for post-registration nurses.
The literature suggests that the lecturer’s pedagogical beliefs can impact on e-learning adoption in nurse education. In a United Kingdom qualitative study with 38 nurse lecturers and staff responsible for e-learning adoption, Petit et al. (2012) explored soft factors, primarily pedagogical beliefs of lecturers that influenced e-learning adoption in nurse education in general. Four lecturer types were identified: the E-advocate, the humanist, the sceptic, and the pragmatic. E-advocates see the potential in e-learning to encourage learner autonomy and self-directed learning, which is a desired outcome of higher education for nurses, although they also believe that there should be some direction given regarding what information to access. On the other hand, the humanist emphasises human contact and does not believe in e-learning. The humanist believes that the essence of nursing can only be transferred by having direct contact with students. The sceptic has had previous negative experiences with using e-learning thus they are cautious about using it again. They find them frustrating and a waste of time. The pragmatist sees e-learning as a means to supplement what they have already covered in class. They believe that it is the lecturer’s responsibility to cover all the content to ensure the development of safe and competent practitioner. They do not think that e-learning methods can enhance communication and collaboration skills which are required to work as a team in nursing.

These authors concluded that it was the pedagogical beliefs of the lecturers that dictated e-learning use by lecturers. They noted that regardless of the lecturer type and even if learner-autonomy was valued, nurse lecturers still felt the need to maintain a certain amount of control over knowledge. That explained why nurse lecturers primarily use e-learning in an ‘on-line dumping’ fashion (Petit et al., 2012). Soft factors influencing e-learning adoption and the student’s comfort level with distance learning need to be taken into consideration in post-registration nurse educational programmes in addressing the access issue. Studies reporting on modes of delivery of higher education programmes for post-registration nurses have not previously explored this through the communities of practice lens which is the intention in this current study.
Academic supports

Academic support in the college

Registered nurses show resilience in terms of finding support to encourage them to continue with their quest for further study. Zuzelo (2001) showed that students garnished support in the college system. They found that they developed good relationships with fellow students in nursing programmes and these relationships were fun, supportive and informative in that their eyes were opened to the variety of nursing areas people worked in. They also found faculty support at the college in that they valued the personal attention they got from them and they found that faculty were empathetic and supportive if students were experiencing personal difficulties in their lives. Staff helped them work through problems so that they could continue with their studies.

On the other hand, the literature suggests that support of post-registration nurses within academic institutions is perceived as varied by some participants. Bahn (2007b) noted that tutors were perceived as both very supportive and available, or they were perceived as uninterested and boring which was not conducive to learning. Cooley (2008) had conflicting Irish evidence about support from academic institutions. One Diploma group said they were well supported, but the Higher Diploma group (specialist course) said they were not. Cooley (2008) attributed this finding to participants’ lack of experience in education and perhaps the level of difficulty of the more specialised Higher Diploma programme. Yet, in Stanley’s study (2003) each traveller (post-registration nurse) had various guides that helped them along their journey. The university tutor, termed as the “tour guide”, was pivotal to the success of the traveller’s journey through academia. The tutor was seen as someone who helped learners to reduce anxiety and motivated them through difficult times. However, participants in this study perceived that the tutor could have challenged them more in assignments and encouraged them more to argue their point thus helping them to develop better critical thinking skills which were needed back in their place of work. Other types of learning supports or guides cited in Stanley’s (2003) study were module leaders and fellow students. These guides helped the participants on a practical level, for example with their assignments and
presentations. A community of practice perspective would help to further explain these findings.

**Academic support in the clinical area**

For some post-registration nurses academic support continues on into the clinical area. One respondent in Gould et al.’s (2007) study stated that clinical tutors played an important role in relating theory to practice in the clinical area. Likewise, in Stanley’s (2003) study participants were assigned preceptors (mentors) in the clinical learning environment. The preceptors were assigned because they had knowledge of the clinical area and their role was to facilitate implementation of theory to practice. The quality of the support the participants received was, however, varied and few preceptors were actually educated to the same level as the learners (Diploma or Degree level) themselves. The consequences of this situation can play out as they did in Adeniran et al.’s (2013) study where the learner may not look up to the preceptor due to the perceived credibility of the preceptor. At the very least, when managers are allocating preceptors to post-registration nurse learners in the clinical area only nurses educated to the same level as the learners should be assigned. Stanley (2003) suggested that there was more emphasis placed on support for pre-registration nurses than post-registration nurses and that the preceptorship needs of post-registration students may be different to the needs of pre-registration students.

Evidence suggests that educational support that pre-registration nurses is generally quite intense. Jeffries et al. (2013) highlighted the development of a Clinical Academic Practice Partnership (CAPP) model adopted by the John Hopkins University School of Nursing in Maryland, USA, for their undergraduate nursing students. Within the CAPP initiative there are a number of roles involved. The student works closely with a preceptor who is a nurse working in the clinical area with expertise in orienting newly hired nursing staff to the wards, adjusting the style of preceptorship to suit working with a novice nurse. The role of the university faculty member is emphasised and includes more visibility in the clinical area. The
university faculty is a mentor and consultant to the preceptor. The hospital coordinator and the unit manager also play an active role in facilitating the learning environment for students and preceptors (Jeffries 2013). The CAPP model emphasises the intensity of support that student nurses receive while they are engaging in clinical practice. Such intensive, structured clinical supervision systems are not emphasised for post-registration nurses in higher education programmes of study especially if the programme does not have a clinical component.

In Ireland, in terms of preceptorship support for post-registration nurses in the clinical environment, one study highlighted a clinical educator role that purports to maximise learning in the clinical environment if the programme of study has a clinical component. Lambert and Glacken (2006) undertook an Irish study, with facilitators of post-registration paediatric nursing students and the students themselves, exploring the role of the Clinical Education Facilitator (CEF). The findings revealed that the role of the CEF was diverse, complex and multifaceted and vital to facilitating post-registration paediatric students to learn in the clinical areas. The role did not entail assessment of students thus this afforded the CEF role an element of neutrality that enabled the CEF to, educationally and emotionally, support students. As a form of support for post-registration nurses undertaking a continuing education programme this role appears to make sense and works well to ensure that students make the most of the placement element of their educational programmes, if placements feature in the programme of study and if the CEF is educated to the same level or beyond that of the post-registration nurse learner. The CEF role places the same emphases on support for post-registration nurses that is offered to pre-registration nurses.

The nursing literature suggests that higher education institutions make concerted efforts to support post-registration nurses in their pursuit of higher education as they juggle multiple roles and face academic challenges along the way. On the other hand, clinical supports are also required to ensure the post-registration nurses can engage with and complete their higher education programmes of study.
Clinical support

Study leave

In terms of their experience in higher education programmes of study, one issue post-registration nurses need to consider when embarking on a higher education programme is the time needed to engage in it. Nurses generally look to their employer to request free time to engage in study. The nursing literature demonstrates that getting study leave, to study or to attend classes, can be very difficult for some nurses. If adequate study leave is not available, then nurses have to do courses in their own time using days off and holidays. Davy and Robinson (2002) showed that, even prior to embarking on a programme of learning, 25% of the UK nurses in that study perceived that they would have difficulty securing adequate study leave in order to participate on the programme. Cooley (2008) also reported that Irish nurses in their study had to give advance notice to managers about study days, which is understandable, but then some had difficulty getting the required days off. The nurses in this study had mixed feelings about using home time to study. Some felt it was an escape from home life, others saw it as an intrusion on their time spent with family. In McCarthy and Evans’s (2003) Irish study, managers were described as unsupportive because they didn’t give adequate study leave and were perceived as not encouraging of nurses to study. Dowswell (2000) also found that nurses resented managers for this. McCarthy and Evans (2003) offered an explanation for this, stating that managers found it difficult to give study leave because of the numbers of post-registration nurses undertaking higher education in Ireland at that time. Thus to accommodate all the nurses this would have implications in terms of manning the wards in the health service.

Other evidence concurs with this lack of managerial support in terms of time off to study. Bahn (2007b) found that most of their UK participants were unhappy with the level of support they got in terms of time off from management to study, particularly in higher education courses. For some participants, if they could put forth a good argument for further education their request for time off was looked upon favourably.
On the other hand, some participants were not able to persuade their managers to give them the necessary time off. The nurses felt that this was because the managers were undertaking higher education themselves. Thus the managers were perceived as having more interest in their own educational advancement than the nurses’ education. Participants also found themselves at the mercy of individual management practices in terms of support. Bahn (2007b) makes an interesting observation here by suggesting that the nurses themselves appeared not to have the necessary assertiveness to demand the time off to attend classes, especially non-mandatory higher education programmes. Bahn (2007b) concluded from this that the nurses were reneging on their professional responsibility to assume accountability to their patients by ensuring their own competency. This observation points to issues of nurses as an oppressed group and their inability to speak up for themselves. This issue will be further explored later in terms of a critique of nursing education and the perpetuation of the oppression of nurses as a group.

A lack of clinical support, in terms of time off to attend college, forces post-registration nurses to find ways to get the support they need to continue with their studies. Dowswell et al. (2000) stated that the majority of their participants often had to do nights after attending class. They also had to make special arrangements at work to be freed up to attend. Some participants found that it was difficult to make these arrangements. They had to arrange, with senior staff, that their work was covered when they were away. Likewise, Murphy et al. (2006) showed that, for post-registration nurses, a major inhibitor to future participation on a nursing course was insufficient study leave provided by the employer.

Commenting on this issue, Dowswell et al. (2000), in their UK study, noted that the changes to nurse education were nursing driven and not employer driven. They suggested that while nurses attempted to get up to speed with these educational changes, the assumption that employers would accommodate this was faulty. Staff felt that promotional decisions were made by management based on qualifications, so this exerted some pressure on staff to upgrade. However, since Dowswell et al. (2000) found that management was not forthcoming with time off to support their
nurses in upgrading their qualifications they deduced that the employers were being unfair to their existing nurses giving an advantage to newly qualified nurses to get the promotions.

**Funding**

For post-registration nurses, funding for programmes of study is a major issue. Many nursing studies report on the lack of financial support from employers, for nurses seeking to resume study at higher education level. Bahn (2007b), for example, reported that staff in that study perceived that non-mandatory courses (like higher education degrees) were poorly financed but in-house classes (in-services in hospitals) were better financed as long as the staff could show they were relevant to their clinical practice. Bahn (2007b) commented that this limited the participants’ choice in terms of education. Dowswell et al. (2000) also found that as much as half of their participants were paying for their course fees themselves, only one participant stating that fees were fully funded and the rest of the participants' fees were only partly paid for by employers. Davy and Robinson’s (2002) English study reported that 25% of their participants thought that they would not be able to get funding for returning to study. McCarthy and Evans’s (2003) Irish study also highlighted that Higher Diploma participants perceived that they got more support from the Health Boards than did the General Degree nurses in terms of the level of financial support on offer. The funding issue reported here should not have been an issue at all for both groups as financial support was available from the Department of Health nationally for nurses returning to study at that time. In terms of financial challenges, participants in Dacanay et al.’s (2015) South Carolina State University study commented on the financial stressors of paying bills, tuition and family expenses. As these nurses had to pay for their fees themselves, the fact that they had to study prohibited them from doing extra shifts to cover the financial costs.

These issues of lack of funding and time off to attend higher education programmes could be perceived as an ‘anti-academic culture’ in the clinical environment. This hinders post-registration nurses’ endeavour to upskill in line with the international trends for an all graduate nursing profession. In response to this some post-registration nurses find it necessary to study in secret which is related to the level of
support post-registration nurses receive at work. Tame (2011) explored the topic of ‘secret study’ or the degree of openness post-registration nurses feel about studying in higher education. In her descriptive qualitative UK study with 23 perioperative nurses, who had recent experience of undertaking a post-registration university based education programme, Tame (2011) found that some participants had to be secretive with their work colleagues about their engagement in a university programme. The decision to tell or not to tell was related to the cultural discourse of the workplace, the participant’s academic confidence and the potential ramifications of failure. Secret studiers were often younger, newer members of staff and they studied secretly because they did not know what the culture in the ward was regarding studying. The participants anticipated negative reactions to the notion of studying because of jealously and the idea of bettering yourself. They studied in secret to uphold the anti-academic discourse while simultaneously pursuing their academic ambitions and avoiding negative reactions from colleagues. Tame (2011) concluded that where post-registration nurses worked in supportive cultures, regardless of the nurses’ level of self-confident or fear of repercussions, the nurses were more likely to study openly. However, a post-registration nurse working in an unsupportive culture was more likely to study in secret (Tame, 2011). These findings point to a resistance to the professionalization of nursing and an anti-academic cultural environment within which post-registration nurses work. They also suggest that the nurses themselves are aware of the existence, in their workplace, of negative attitudes towards the notion of nurses striving for further education to university level.

Post-registration nurses are also aware that the public may perceive that nurses do not require an academic background in order to nurse. The literature suggests that post-registration nurses seek to change this perception. Another theme from Tame’s study, published in 2013, reflects this. Tame (2013) found that perioperative nurses studying university courses, placed a lot of importance on having a student card. The student card to them symbolised their acceptance into “a perceived elite group” (Tame, 2013, p.135). In addition to the benefits of discounts in public life, like transport, the student card appeared to represent an “external confidence in their academic ability” (Tame, 2013, p.135). Although these nurses apparently could
receive the same discounts with their UK National Health Service Trust staff cards they elected to use their student card to get discounts off public services. Tame (2013) concluded from this that the student card raised their perceived public status from nurse to university student. The student’s role appeared to have more status than that of nurse or housewife. This was a source of excitement for the nurses as they were conditioned to believe that they were not academically able to participate in higher education but revealing their student status to others demonstrated their academic achievements and challenged these assumptions.

Nursing has been seen as a subordinate occupational role to medicine due to the emphasis on the curing aspect of medicine associated with academic and intellectual skills as opposed to the caring aspect of nursing associated with non-academic natural female attributes and roles in the home (Freshwater, 2000; Hahessy, 2007). While nursing is perceived as a highly respected occupation it is not seen as a highly educated one. For instance, pre-nursing students’ image of nursing has been reported as task oriented and that the nursing programme itself could be completed effortlessly. However, when student nurses enter the programme they report surprise at the level of education required (Emeghebo, 2012). In Tame’s (2013) study these assumptions and perceptions were challenged by the perceived status of being a university student. Tame (2013) suggested that the university student status allowed the nurses to move away from the public perception of the nurse as unintellectual in addition to verifying their intelligence to their colleagues, friends and family.

The literature suggests that support from the clinical area in terms of funding, time off and attitudes towards academia has an influence on post-registration nurses’ experiences of higher education. Support and encouragement from the clinical environment is crucial in order for post-registration nurses to be able to juggle multiple roles and openly celebrate the fact that they are gaining higher education credentials. Some nurses experience this support, others do not. No studies in the nursing literature have explored these findings in light of the theory of communities of practice.
A critique of nurse education

The literature review thus far regarding post-registration nurses in higher education points to experiences of struggle and a lack of support for the nurses to achieve their goal to upskill in response to an international call for an all-graduate profession in nursing. While post-registration nurses feel pressured to enter higher education in response to this initiative, anti-academic attitudes towards the notion of nurses entering higher education impact on the level of support nurses receive. As nursing is primarily a female profession, this situation is traditionally framed and explained drawing on literature about nurses as an oppressed group. Furthermore, nursing education has been the subject of critique for perpetuating the social inequalities that lead to this oppression. Here I present a discussion on the status of nurses in health care and a critique of the role nursing education plays in perpetuating nurses as an oppressed group.

Gender inequality in general

Women in society in general, traditionally and currently, fall victim to oppression and unequal treatment. Inequality between men and women has been associated with private and public patriarchy. According the Walby (1990) private patriarchy involves the exploitation of women by men in the home and public patriarchy is based principally in public sites such as employment and involves “segregation and subordination” (Walby, 1990 pp. 24). In terms of private patriarchy Ritzer (2015) highlights, for example, that there is inequality between men and women regarding the amount of time they devote to household tasks. Although the gap is shrinking, women still spend twice as much time (19 hours) on household tasks than men (10 hours). Mothers are more likely to engage in maintaining children while men are more likely to engage in recreational activities with children. When it comes to taking responsibility for caring for elderly relatives this is almost always the responsibility of women.
Gender inequality also exists in the public domain. Walby (2007), speaking about women in the UK, suggests that women are increasingly achieving higher levels of education and have more work experience thus they can access higher level jobs. On the other hand, amid occupational segregation, discriminatory practices and poor flexibility at work, these factors limit the reward women receive for their skills set. Overall women are less likely to be employed in the highest level occupations than men and it would take another 50 years to narrow the gap between women and men in this area. Traditionally women have been less likely to be able to secure a career due to interruptions in employment due to childcare commitments. But this trend is changing for some groups of women, especially women who have higher levels of education and are working in a professional occupation like nursing. This trend will only continue if there is flexible work practices and available affordable childcare (Walby, 2007). Thus women in general can be considered a group who have been subjected to gender inequalities in the home and at work and this can have implications for working women, like nurses, who are juggling work, home life and study if they are engaged in education.

**Women and productivity at work**

How women are treated at work has implications for the productivity of the economy. Walby (2007) writes that there is an increase in the level of education women receive relative to men which increases the likelihood of women being available to work in the knowledge economy which requires higher levels of education. This means that women can keep working while they have children. However, if women’s potential to contribute to employment is stunted then productivity suffers (Walby, 2007). In health care, where nurses are predominately female, the treatment of nurses at work can also have an effect on productivity or outcomes of a more serious kind, i.e. mortality rates. It has been shown that underfunding nursing education and low staffing levels can adversely affect patient outcomes. Aiken et al. (2014) undertook a retrospective study to examine if differences between patient to nurse ratios and nurses’ educational qualifications were associated with variations in hospital mortality rates after common surgical procedures. Discharge data was observed for 422,730 patients and 26,516 nurses practising in 300 hospitals in nine European
countries were surveyed to assess the effects of nursing factors on the likelihood of surgical patients dying within 30 days of admission.

The findings from Aiken et al.'s (2014) study indicated that an increase in a nurse’s workload by one patient would increase the likelihood of an inpatient dying within 30 days of admission by 7%. Every 10% increase in bachelor degree nurses was associated with a decrease in this likelihood by 7%. The researchers concluded that patients in hospitals in which 60% of nurses had bachelor degrees and nurses cared for an average of six patients would have almost 30% lower mortality than patients in hospitals in which only 30% of nurses had bachelor degrees and nurses cared for an average of eight patients. The findings suggest that the more nurses are educated to degree level and given fewer patients to care for, the more the mortality rates went down on hospital wards. In the predominantly female profession of nursing, the way nurses are treated in terms of support to upskill to degree level education and beyond and the level of workload they have can have an impact on productivity especially patient outcomes.

**Nurses and inequality at work**

**Doctors versus nurses**

Within the health service the two main groups where inequality exists is between nurses and doctors. Ritzer (2015), speaking about the American context, refers to the medical profession and the power it has and still exerts over nurses and any other member of the multidisciplinary team that might compete with it. The medical profession consists of predominantly males and one aspect of its power is evident in higher starting salaries than any other health care workers. The medical profession works closely with nurses (female dominated) in the health service and doctors rely on nurses for their contribution to do the caring and emotional work with patients. But nursing has struggled to achieve professional status in health care and has not achieved anything like the power, status, autonomy or income that the medical profession enjoys. While doctors hold on to the formal power in health care it has been suggested that nurses have a great deal of informal power regarding the day-to-day decision making and operation of a hospital health care service.
Pay differentials

Similar inequalities exist within the Irish health service, for instance, in terms of pay differentials among the Irish multidisciplinary health care team. Within this pay system the nurse is the lowest paid. The multidisciplinary team consists of doctors, nurses, physiotherapists, occupational therapists, dieticians, etc. and these provide health care collaboratively to patients all paid by the health service. These bring their own unique knowledge and skills to bear on patients’ health problems in a team effort. However, at a starting salary of €23,129 (INMO, 2014) nurses are paid the least of all the members on the team. After a four year degree a nurse can register with the regulatory body, An Bord Altranais. This entry level educational requirement is the same as a physiotherapist, for example, but this practitioner has a starting salary of €30,000. Medical doctors, on the other hand, complete a medical degree over 5-6 years in order to register with the Medical Council and then they complete a one year internship as a House Officer in a hospital setting. Thus, it takes longer to become a doctor but the starting salary of €65000 (Careers Portal, 2015) is significantly more than a nurse or any other member of the multidisciplinary team. The doctor is generally classed as the head of the multidisciplinary team thus this sets up a hierarchy within the team with the nurse at the lowest level. Whitehead (2010) argues that “the nature of hierarchy within social relationships inevitably leads to oppression” (Whitehead, 2010, pp.2). The hierarchal nature of the multidisciplinary team with the doctor leading the team sets up a socio-economic unequal relationship that leaves the nurse in an oppressed position.

The professional status of the nurse

In addition to inequalities on a financial level, historically, nursing has struggled to be recognised as a profession working with other professions within the multidisciplinary team. Whitehead (2010) suggests that the nurse is oppressed on multiple levels socially and economically. In terms of social class nursing has been classed as an associate professional and technical occupation, according to the United Kingdom
national statistics regarding the Standard Occupational Classification 2000 (Office for National Statistics, 2000). This classification system located registered nurses below medical practitioners and pharmacists in the classification system officially classifying the nurse as a semi-professional (Whitehead, 2010). One the other hand, in the revised Standard Occupational Classification 2010 (Office of National Statistics, 2010) nurses and midwives are described professionals:

“Nursing and midwifery professionals provide nursing care for the sick and injured and prenatal and post-natal care for mothers and babies, working with and providing high level support for other health professionals, within teams of other health care providers and/or working autonomously across defined areas of significant responsibility” (Office of National Statistics, 2010, pp.74).

Thus in the revised classification system nurses are considered professionals along with midwives. However interestingly, the description of their work role reflects that they are a support for the other professionals which still has connotations of a subordinate position.

**Oppressed group behaviour and nurses**

The nursing literature suggests that nurses exhibit oppressed group behaviour. The notion that nurses were an oppressed group, exhibiting oppressed group behaviour, was first suggested by Roberts (1983) who asserted that hospital administrators and physicians were the oppressors in health care and that nurses were the oppressed group. Oppressed group behaviour has been defined by Freire (1970) as identification with the oppressor, gregariousness and conformity, horizontal violence, emotional dependence and self-depreciation. Although Freire’s (1970) model of oppressed group behaviour has been cited as an explanation for destructive behaviour in nurses (Glass, 1998; Baltimore, 2006; Dunn, 2003; Fletcher, 2006), Matheson (2008) suggested that there was a lack of systematic studies to substantiate this claim. Thus Matheson (2008), using Freire’s (1970) framework of oppressed group behaviour, undertook a qualitative study with newly qualified nurses. They explored the question of oppressed group behaviours present in nurses' workplace stories (Matheson, 2008). The findings suggested that these nurses either witnessed oppressed group behaviour in their colleagues or managers or they exhibited it themselves in their workplace.
More recent evidence suggests that nurses experience oppressed group behaviour such as horizontal violence in the workplace. Purpora et al. (2012) undertook a quantitative study with 175 California Board of Registered Nurses measuring the relationship between horizontal violence, the oppressed self and the oppressed group. The Nurses Workplace Scale was used to measure the nurses’ attitudes consistent with the oppressed self and oppressed group. A revised Negative Acts questionnaire was used to measure horizontal violence. The results of this study indicated that an incidence of 21.1% of horizontal violence was reported by these nurses. There was a positive relationship between beliefs consistent with an oppressed self and horizontal violence and a positive relationship existed between beliefs consistent with those of an oppressed group and horizontal violence. Thus this recent evidence suggests that registered nurses may still experience oppressed group behaviour in their workplace. More importantly, the more nurses believe that the self is oppressed or they are part of an oppressed group the more likely they are to be subjected to horizontal violence although these findings only reflect the American experience. Purpora et al. (2012) asserted that more research was needed to expose horizontal violence in hierarchal hospital clinical environments where nurses’ work and the research should extend to identifying strategies that nurses can use to combat it. Furthermore, barriers within the social structures of work that prevent them from advocating for themselves and their practice needs to be researched. Thus evidence suggests that nurses experience inequalities within the health service and exhibit or experience oppressed group behaviours. It is within this context that post-registration nurses seek to do higher education programmes in order to break free from their perceived oppressed position in the health service. The next section explores the link between nurse education and the perpetuation of inequalities and oppression in nursing.
Critique of the traditional pedagogy in nursing

Traditional pedagogy in nursing

Traditional pedagogy in general has been criticised as a means of perpetuating existing societal power relationships and structures, resulting from the content delivered and the methods used (Freiré, 1970; 1981; Weiler, 1988). Freire’s (1970) observations, for example, led him to suggest that oppressive relationships are developed and maintained as a result of formal and informal educational systems and socialization. Feminist theory also recognises existing power relationships and societal structures as patriarchal, blaming traditional pedagogy for reproducing a society where gender determines the distribution of power and resources (Chinn, 1989; Scering, 1997). The educational base of post-registration nurses returning to higher education would have included traditional pedagogy. Traditional pedagogy in nursing came under fire in the 1980s with a call for curricular changes, in terms of content and teaching methods that might address power inequalities within the health care system (Stevens & Hall, 1992).

As outlined earlier nurses experience unequal treatment in the health service internationally. The traditional educational base and socialisation of nurses has emphasised practices such as respect for authority, and submissiveness which has perpetuated this unequal treatment (Rather, 1994). In terms of content nursing curricular changes were called for to shift the focus from medical diseases (the doctors domain) to emphasise the uniqueness of nursing care and the holistic human health and illness experience (the nurses’ domain) (Rather 1994). Further to this, the suggested pedagogical changes were to increase awareness of societal inequities, related to gender, class, or race, with the view to empowering student nurses to critique and take action to change oppressive social realities in their personal and professional lives (Falk-Rafael et al., 2004).

In terms of teaching methods, traditional pedagogy in nursing relied heavily on the lecture format which has been shown to no longer be effective in addressing these issues or indeed producing competent nurses (Ironside, 2003). Freire (1970)
attacked the so-called banking model of education, or the lecture, where the student is viewed as an empty vessel only to be filled by the teacher who is the authority on the subject matter. This then prevents the student's creativity and controls thinking and action in the learning situation. Thus the only thing the student learns from this dynamic is dependency on authority. The pedagogical changes that were advocated for nurse education placed an emphasis on this student-teacher relationship suggesting that teaching methods should be employed to reduce power inequities between teachers and students. The changes aimed to cultivate the student's critical thinking skills and raise the student's awareness of the social and political influences on health and on their personal and professional lives (Chinn, 1989).

It was envisaged that these pedagogical changes would be implemented as nurse education moved from the apprenticeship model to an all-graduate profession. However, even though traditional pedagogy has been shown to have limitations, nurse educators continue to teach using these methods (Diekelmann, 2001). A preferred pedagogical teaching strategy often cited in the nursing literature for nurses is critical pedagogy. This strategy has been linked with combating oppression through education.

**How oppression is perpetuated**

Nurses have been traditionally classed as an oppressed group in the workplace. The writings of Paulo Freire casts some light on how this situation is perpetuated. Freire’s (1970) theory suggests that an oppressed group views the oppressor’s values and beliefs as the correct ones. As the oppressed group internalises the dominant group’s belief system and conforms to its demands, oppressed group behaviours develop thus allowing the oppressor to gain control over the oppressed. Freire (1970) asserted that within an oppressed society a culture of silence ensues and this silence benefits the oppressor in order to maintain the status quo. A culture of silence leads to the development of a suppressed self-image in the oppressed. As mentioned earlier, Freire (1970) asserted that the banking model of education treats students as empty vessels to be filled and reliant on the authority of the all-knowing teacher. This sets up an unequal relationship where the teacher has all the power and the student is silenced. It is this dynamic that the student believes to be the
correct one in the classroom and beyond into their private and professional lives. In nursing, traditional pedagogy has perpetuated this dynamic leading nurses to exhibit and experience oppressed group behaviours.

In order for an oppressed group to recognise that a culture of silence exists and is designed to oppress, those who are being oppressed must develop a critical consciousness. This ‘conscientization’ or consciousness raising facilitates an awareness of social and political contradictions leading to informed action and thus freedom from oppression. Thus, nurses who experience oppression in the workplace, according to Freire (1970) as a starting point need to become aware that they are oppressed followed by action to change the status quo. Freire asserted that educational systems can facilitate this process. The main strategy that Freire (1970) advocated to address oppression was critical pedagogy.

**Critical pedagogy**

As a means of counteracting oppression, critical pedagogy places an emphasis on dialogue and democracy in the classroom. Freire’s (1970) critical pedagogical model sees the student and the teacher as active learners and the student also takes part in teaching. Teaching and learning from this perspective thus is based on dialogue. This sets up a democracy within the teaching and learning situation. The dialogue that takes place is a consciousness raising and questioning of the student’s status in society, where new levels of awareness are reached and the student gains confidence to act. Thus the student becomes a self-determining subject, a maker of culture and transformer of the world he/she lives in. At the same time the teacher must also relearn what he/she knows by also questioning their historical and social reality. This is achieved through dialogue, reflection and action. It is this critical pedagogical process that is advocated in nurse education as an alternative to the traditional pedagogy of the apprenticeship model of nursing education that post-registration nurses were subjected to.
Using Freire’s teaching model to raise consciousness in nursing

It has been suggested that nurse university lecturers are in a key position to facilitate nurses to change the oppressive nature of their personal and work lives. MacIntosh (2002) suggests that nurse educators can facilitate a community of nursing students to explore and raise awareness of gendered issues that influence their personal and professional lives. Freire (1970) proposed a critical pedagogical teaching model which was student centred and designed to lead to critical consciousness and liberation from the oppressed. This involved a practical strategy incorporating problem solving through dialogue thereby helping learners to become social actors (Marchbank and Letherby, 2007). Freire’s critical pedagogical teaching strategy involved an initial study of the students’ social reality followed by a codification session. Here students identify key factors in their lives and then they find a symbol that represents this. Students are then asked to look at the symbol not as reality but as a problem, first as an individual problem, then as a collective problem. Then through group discussion they explore what they know about the problem and what more they want to know. Finally, once their reality is viewed from a different prospective they then develop plans to enact change in their lives (Marchbank and Letherby, 2007). This teaching model provides a useful tool towards consciousness raising for nurses with the view to liberation from inequality in the workplace.

It has been demonstrated that Freire’s teaching model has the potential to facilitate consciousness raising in nursing with the view to action. This strategy has been used by Jacobs et al. (2005) to study nurses’ perceptions of circumstances within their work life and to describe processes by which these nurses could conceive of or make changes to these circumstances. The sample comprised of three groups of 8–15 female nurses working in New York and New England in the USA. An emancipatory design incorporated elements of Freire’s (1998) liberation theory, Habermas’ (1979) critical social theory and elements of feminist research outlined by Webb (1993). From Friere’s liberation theory the participants were considered co-researchers and reflection and actions were featured in the study design. From Habermas’ critical social theory, knowledge was considered emancipatory and critical reflections leads to knowledge. From Webb’s feminist research the
researchers saw power as equal between the researchers and participants, experience of the women was respected, women's lives were acknowledged and reflected as part of the process. The participants met once a week for 6–10 weeks to engage in a group process, each of the groups reflected on, discussed, and analysed their experience of practicing nursing. This research method emphasised the group process of ‘peace and power’, identification of codifications, identification of what is (problematisation), identification of what could be (untested feasibilities) and testing feasibilities (action emerges).

These researchers identified that this process produced knowledge leading to emancipation and liberation. While the researchers came up with findings describing the nurses' work lives, it was the research process itself that was the most important outcome of the study. This was because the process provided the nurses with a tool to reflect on their work lives beyond the study situation. The group interaction that took place in this study increased the nurse’s awareness, promoted reflection on the status quo, and energised the nurses to come up with possible solutions to changing that status quo. The researchers did admit though, that it was beyond the scope of the study to discover how many of the identified actions were actually implemented. However, during the meetings in the study there were references to actions or shifts in ways of being in their situation, for example valuing each other more, or change in attitude towards other nurses. Thus, this study emphasised how Freire’s critical pedagogical strategy could facilitate conscientization in nurses about oppressive circumstances in their lives with the view to enacting change as individuals and as a collective. In nurse education then an alternative to traditional pedagogy reflects a critical pedagogy that emphasises consciousness raising about social inequalities that affect everyone’s lives including nurses.

**Critical pedagogy and feminist pedagogy**

The central tenet of Freire’s theory is that education can maintain the dominance of those in power by controlling what is known (that is the curriculum), who and what can be taught and indoctrinating the norms of the dominant group. Feminist
pedagogy, used in nursing education, shares this focus on power but also emphasises gender inequalities. Feminist pedagogy sees power as being at work in how knowledge is constructed, what is accepted and valued as knowledge emphasising that it is masculine knowledge that is more valued (Weyenberg, 1998). Masculine knowledge is associated with medical curative knowledge as opposed to feminine knowledge associated with holistic caring of the illness experience.

Feminist pedagogy as a teaching approach focuses on liberation from oppression related to gender inequalities within social relations. A central theme in feminist pedagogy is the empowerment of women although oppression on any level including age and class are also addressed (Ironside, 2001; Weyenberg, 1998). General principles associated with feminist pedagogy include: education that engages with and enlarges the student's experience; there is an emphasis on thinking and reflection; the student interacts with the environment in the practice and construction of knowledge. Feminist pedagogy focuses on actual classroom practices or praxis and through reflection finds ways to integrate theory with practice. Feminist pedagogy shares Freire’s critique of the banking system in that it leads to powerlessness and passivity. Mainly used in women’s studies, feminist pedagogy is limited in its use due to large class sizes and mass education in higher education as this prohibits the required small group work, workshops, project work, team teaching and fewer lectures (Marchbank and Letherby, 2007). Thus the feminist pedagogical approach to teaching nursing students has been advocated in order to empower women, enhance awareness of and expose oppression within social environments including schools, home and work (Ironside, 2001; Weyenberg, 1998). Feminist pedagogy involves active participation, collaboration, connected and relational learning, and critical thinking (Weyenberg, 1998).

Recognising that there was little evidence to support the idea that feminist pedagogical approaches could increase empowerment in nursing students Falk-Rafael et al. (2004) conducted a study in Canada and the United States to find evidence that feminist pedagogy was effective in empowering a community of learners to make changes consistent with the ideals of empowerment in their
personal and professional lives. A total of 218 baccalaureate student nurses who had experienced courses using a feminist pedagogical approach were surveyed. 95% of the cohort were women. 40% were post-registration nurses. Using the Barrett’s Power as Knowing Participation in Change Tool (PKPCT) to measure student empowerment and despite a low response rate of 46%, these authors found that using a feminist pedagogical approach to teaching nursing students can increase empowerment over the course of a class and that classroom empowerment is likely to extend beyond the classroom to personal and work environments. Although it can be difficult to find opportunities to use feminist pedagogy in undergraduate nursing education due to large class sizes, it does provide a useful critical pedagogical teaching strategy to facilitate the empowerment of post-registration nurses in higher education and beyond in the workplace where numbers are likely to be smaller.

Critique of feminist pedagogy

While feminist pedagogy can enhance critical thinking skills and some evidence suggests it can empower nurses, discourse in the nursing literature question the idea of the educator as one who empowers. While the intention is that the nurse educator and student co-exist and undergo a transformation together in the classroom, the notion that the educator empowers sets up a hierarchical relationship (Weyenberg, 1998; Welch 2011) which is contrary to the goal of critical pedagogy. Also, there is still a question mark over whether empowerment of the student and personal change actually happens beyond the classroom as a result of feminist pedagogical approaches in nursing education (Weyenberg, 1998). According to Weyenberg (1998) this is one reason why some nurse educators are reluctant to use feminist pedagogy.

Furthermore, the literature suggests that only nurses who are undertaking upper level programmes like masters or PhDs would be exposed to feminist pedagogy and even at that, this would be the last time they would have exposure to them beyond the classroom situation (Weyenberg, 1998). This raises the question about the need
for a facilitator beyond the classroom to help nurses as a collective to not only reflect on nursing practice and social inequalities but also come up with solutions and act upon them with the view to making changes a reality.

From the previous discussion it is clear that reflection is part of the process in critical and feminist pedagogies and it is used in that context to raise consciousness with the view to empowering learners in practice settings. In nursing education, reflective practice has become a mandatory practice in the United Kingdom (Clegg, 1999) and in Ireland (Government of Ireland, 2000; Dundalk Institute of Technology. 1998). As such it has been used mainly as an assessment process within these accredited programmes. Clegg (1999) argues that the assumption is that the learners will change as a result of engaging in reflection but “the parameters of that change are discursively constructed prior to the novice’s engagement” (Clegg, 1999, pp.173). The reflective practice process in this context is more about surveillance and judging the competence of the learner’s competence with practices and innovations that the practitioner has no real power to change. While reflection in this context may produce powerful emotions and even may provide for small scale resistance, empowerment may be limited to the micro level (Clegg, 1999). The idea of reflective practice was introduced by Schon (1983) with the view to enhancing professional knowledge and status. However, for a profession like nursing that choose to implement it, the success of this agenda is limited. Clegg (1999) suggested that the reason for this is the in nursing, a largely female profession, which has had traditionally a low professional status, nurses knowledge is also traditionally granted low status compared to medical knowledge. Any reflective strategies that are designed to enhanced nurses knowledge claims and values like caring are more likely to create marginalisation because the “attributes most associated with femininity and, despite their real value, are unlikely to be accorded the status reserved for supposedly rational knowledge such as medicine” (Clegg, 1999, pp. 173). Clegg (1999) does not advocate a complete rejection of reflective practice as a form of coaching for a profession like nursing. However, Clegg does caution that there is a need to recognise the limits of its claims as a means to enhance the professional status of nursing.
Summary of chapter

Post-registration nurses have personal and professional motives for engaging in higher education programmes. These motives have been influenced by the community in which they work. In some cases the context is a deterrent and in others it is encouraging nurses to engage in higher education. While post-registration nurses engage in higher education programmes, women especially can struggle with juggling multiple roles in addition to coping with the rigours of academia. Again, the support to facilitate this group of nurses is varied especially in the clinical area. The level of support post-registration nurses receive in order to keep pace with the call for an all-graduate profession has been linked to enduring anti-academic attitudes and the oppression of nurses. Pedagogical practices in nurse education has been criticised for perpetuating this situation. Critical and pedagogical approaches have been suggested as an alternative pedagogy to address this.

This current study explored Irish post-registration nurses’ experiences of higher education nursing programmes in terms of influences on their motives to engage and their participation in such programmes. Much has been written about these themes in the nursing literature internationally, particularly in America and Australia as these countries introduced degree level education for nurses before the United Kingdom or Ireland. These studies are relevant to this current study because they were conducted in response to the introduction of higher education for nurses in the respective countries, yet they may not reflect the Irish context. Of the four Irish studies cited only two were similar to the current study. However, they were conducted in different areas in Ireland. There was a mix of methodological approaches used in the literature with only one Irish study using an in-depth qualitative approach to the topic. This restricts the scope of the other Irish studies to superficial information in contrast to the current study which uses a qualitative approach to obtain more in-depth information, particularly on Irish post-registration nurses’ experiences of higher education nursing programmes in terms of influences on their motives to engage and their participation in such programmes. None of the studies cited have used the community of practice theory as a lens to explain their findings. As post-registration nurses’ motives to engage and experiences in higher
education appear to be context dependent, the community of practice theory would appear to provide a useful perspective on these nurses’ experiences.

The next chapter presents relevant concepts from the social learning theory communities of practice by way of a conceptual framework for the study. The community of practice theory developed by Lave and Wenger (1991) and later Wenger (1998) emphasises the role practice plays in learning and identity formation. The nursing literature highlights that post-registration nurses’ experiences of higher education programmes are often influenced by the practice area where they work. Given this evidence the communities of practice theory was deemed useful in explaining Irish post-registration nurses’ experiences of higher education nursing programmes in terms of influences on their motives to engage and their participation in such programmes.
Chapter Three: Conceptual Framework

Introduction

From an examination of the literature, it is clear that the workplace and the academic community can have a positive or negative influence on post-registration nurses' experiences of learning in higher education. As a conceptual framework to explore and explain findings in this current study about Irish post-registration nurses' experiences of higher education nursing programmes in terms of influences on their motives to engage and their participation in such programmes, I wish to explore Lave and Wenger (1991) and Wenger's (1998) theory of communities of practice. This theory describes what a community of practice is and how it evolves and also how newcomers learn and form identities within a community of practice. The purpose of this chapter is therefore to present relevant concepts from the theory and to demonstrate the potential and limits of communities of practice as a theoretical basis for this study.

Community of practice

The idea of a community of practice originated from the work of two cognitive anthropologists, Lave and Wenger (1991) who were developing a social learning theory. Lave and Wenger (1991) moved away from the conceptualization of the learner as a receptacle of knowledge and learning as a discrete cognitive process divorced from its meaning in the context of the lived-in-world or practice. In other words, learning is situated within a community of practice. To understand how learning occurs outside the classroom, Lave and Wenger studied apprentices and how they became established members of a practice. They used the term community of practice to describe how people learn through practice and participating in practice and they called this ‘situated learning’ (Lave and Wenger 1991). They defined a community of practice as a group of people who share an interest, a craft, or a profession. The group evolves over time due to members’ common interest in a particular enterprise. The community of practice is created to gain knowledge related to the enterprise. Members achieve this by sharing
knowledge and experiences thus they develop personally and professionally (Lave and Wenger, 1991). Wenger (1998) emphasized that a community of practice is not always harmonious or collaborative nor is it an emancipatory force. Further to this, a community of practice is the place where a novice develops an identity. Learning is not just about gaining knowledge, it is about developing an identity and the construction of an identity happens as a result of the negotiation of meanings in our experience as members of a community of practice. It is interplay between the identity of the member and the identity of the community of practice that shapes the identity of the member.

The profession of nursing functions like a community of practice. Nurses engage in the enterprise of caring for patients and they work together for that common good. Knowledge is shared among the nurses in order to ensure that patients receive continuity of care. In this study the post-registration nurses were engaging in higher education in order to gain new knowledge to be implemented in practice. The theory of community of practice is about how people learn outside of the traditional classroom setting. Although the post-registration nurses in this study were learning primarily inside the classroom (another community of practice), from the nursing literature review, it appears that the community of nursing practice can have had an impact on their experiences of this. Thus I want to explore this theory further in terms of how it might help to explain how the community of practice influenced the nurses’ experiences of learning in higher education.

The dimensions of a community of practice

According to Wenger (1998) a community of practice has three dimensions: mutual engagement, a joint enterprise and a shared repertoire.

Mutual engagement

Mutual engagement refers to the constant interactions that occur between participants in a community and is fundamental to relationships that are required for
a community of practice to thrive. Participants in a community of practice need to be engaged in what matters to the community. The members of a community of practice are diverse with different ambitions and goals. Together, this diversity of people engage in a particular activity which makes up the community of practice (Wenger, 1998). The profession of nursing can be considered a community of practice. Nurses are in regular communication with each other on a daily basis about the practice of nursing. Staff nurses caring for patients must communicate with each other, for example, at change of shift, passing on vital information about the patients they cared for that day so that continuity of care can be achieved. The members of the community of nurses are also diverse. The staff nurse is the front line nurse providing direct care to patients. Then there are multiple levels of managers whose roles are to coordinate and manage the resources available that makes the care of patients possible. Their role also involves development of and coordination of the operationalisation of policies and procedures relevant to the practice of nursing. There is constant communication between managers and staff nurses to this end.

A Joint Enterprise

In a community of practice the members organise themselves around a particular joint enterprise. This enterprise is understood and renegotiated by all the members of the community. The joint enterprise is a particular activity or area of knowledge which gives the participants a shared identity. The enterprise is joint, not in the sense that everyone agrees with everything or believes in the same things but that the members of the community continually negotiate the enterprise. The practice is constructed by the members around what they recognise as their particular enterprise. Furthermore, the members of the community of practice are mutually accountable for the enterprise. That is the members have a sense of responsibility towards each other and the enterprise (Wenger, 1998). The nursing community is constantly renegotiating the joint enterprise of the practice of nursing. The way nursing is conducted today is very different to how it was conducted in the past. An example of this would be the technological advances available in health care as a whole and raised expectations of patients necessitate that nurses have a more advanced entry level education. In the past, the curriculum for nurses involved a
certificate in nursing or the apprenticeship model and this was deemed appropriate as the educational base for nurses at the time. Now, in Ireland An Bord Altranais, the regulatory body, has negotiated a new curriculum for nurses, the Degree in Nursing as the educational base. Furthermore, new advanced roles have been negotiated for nurses, the Advanced Nurse Practitioner and the Nurse Specialist and these new roles have necessitated the development of specialist educational programmes and Masters programmes for nurses, which were developed in the academic community of practice. These changes have resulted in a nursing enterprise today that has been negotiated between the members of the nursing community.

The enterprise of a community of practice is essentially indigenous or home grown. Although a community of practice develops within a larger context which imposes constraints and conditions on the community of practice, the participants will respond with certain inventiveness in order to pursue their enterprise within the constraints and conditions. External forces do not have power over a community’s production of its practice. The community negotiates the enterprise (Wenger, 1998). The move to an all-graduate profession in nursing had to be implemented within the constraints of available health service budgets and resources. In this study, I want to explore how post-registration nurses experienced this move and how the nursing community responded to it.

A shared repertoire

The third dimension of a community of practice is the shared repertoire. The repertoire of a community refers to all the activities, ways of doing things, tools, actions, and stories, routines that are part of the practice and have been modified over the course of the community’s existence. The repertoire is shared because the members of the community identify with it (Wenger, 1998). The community of nursing practice also has a unique shared repertoire. Nursing activities are unique and can be distinguished from the activities of other members of the multidisciplinary team. While dietitians, for example, focus on working out specific diet plans for
patients, nurses monitor patients to ensure that the diet has been consumed and tolerated.

It can be said, therefore, that the post-registration nurses in this current study are members of the nursing community of practice. The nursing literature suggests that this work environment can impact on their experience of undertaking a higher education programme. Thus I want to explore how the dimensions of a community of practice might help to explain the findings in this study.

**Community of practice and negotiation of meaning**

An important concept in Wenger’s (1998) theory is the idea of negotiation of meaning in practice. Wenger (1998) asserts practice is not just doing things but it is the meaning that is produced that defines a practice and this meaning has to be negotiated. He suggests that the best way to talk about practice is to discuss it in terms of “the social production of meaning” (Wenger, 1998, p.49). We engage in activities to pursue an enterprise but it’s the meanings we produce that matter most about that activity (Wenger, 1998). Nursing practice is not just about doing certain activities with patients, according to Wenger (1998) it is about the meaning related to those activities that is what matters. In the context of nursing then, nurses make a unique contribution to the practice of health care within a multidisciplinary team. The doctor’s domain is to diagnose and cure disease whereas the work of a nurse is about the holistic care and relief of discomfort of the patient even discomfort caused by treatments ordered by the doctor, e.g. after an operation. Thus the practice of nursing has a particular meaning different to the work of a doctor or any other member of the team. When post-registration nurses undertake a higher education programme, the assumption is that they will be moving towards a new sense of meaning in their practice as a result of that education. This meaning in nursing practice, according to Wenger (1998), has to be negotiated through a process of participation and reification.
Participation and negotiation of meaning

Participation according to Wenger (1998) is one aspect of negotiation of meaning and is part of the social learning process. Participation is how people learn especially in a practice. Participation is a process of taking part and sharing with others. It’s about relations with others, action and connecting with others. Wenger (1998) uses the term “participation to describe the social experience of living in the world in terms of membership in social communities and active involvement in social enterprises” (Wenger, 1998, p.55). Nurses participate in the activity of nursing, or the negotiation of the meaning of nursing, not as individuals, but as a social interactive interdependent community. The enterprise of nursing is a social activity among nurses and other communities they work with. The post-registration nurses in this study have already learned how to be nurses. They have negotiated meaning, through studying to certificate or diploma level education and they have practiced or participated gaining years of experience. However, they are now participating in higher education, while also participating in practice, so they could negotiate the meaning of what it is to be a nurse with a degree. As participation is a social interactive activity within a community of practice, in this study I wish to see how communities of practice might have influenced the post-registration nurses’ experiences of participation in negotiating that new meaning. I say communities of practice because these nurses may have been members of a number of communities as will be discussed later.

Participation is a social activity. It is about “our mutual ability to negotiate meaning” Wenger (1998, p.57). Participation and the negotiation of meaning is not always about equality or respect within that social relationship. Members of a community of practice can mutually recognise how to negotiate meaning even in relationships that are unequal through participation. Thus negotiating meaning is a social activity and we mutually recognise our ability to do this. Participation is not always about collaboration, it can be conflictual or competitive (Wenger, 1998). Here Wenger
(1998) is referring to our ability to know our place in the experience of participating in a practice. Post-registration nurses who are trying to participate in negotiating new meaning in their practice by engaging in a higher education programme are in an unequal relationship with, for example, a nursing manager who has the power to control the resources to allow the nurse to participate. In this study I wish to explore this aspect of participation.

Reification and negotiation of meaning

The second aspect related of the negotiation of meaning is reification (Wenger, 1998). Reification is “the process of giving form to our experience by producing objects that congeal this experience into ‘thingness’. In doing so, we create points of focus around which the negotiation of meaning becomes organized” (Wenger, 1998, p. 58). Wenger (1998) says that “any community of practice produces abstractions, tools, symbols, stories, terms and concepts that reify something of that practice in a congealed form” (Wenger, 1998, p. 59). In nursing, the concept of reification relates to things produced in nursing like the production of nursing policies and procedures related to nursing practice. These objects give form to the activities nurses do in practice. In the context of this study reification can relate to the Irish national policy to provide higher education opportunities for all Irish post-registration nurses. The resources that are made available to make that policy a reality are the reification of that policy.

Wenger explains that “reification as a constituent of meaning is always incomplete, ongoing, potentially enriching and potentially misleading” (Wenger, 1998, p. 62). To explain this in the context of this study, for example, nursing managers may reify the Health Service commitment to provide higher education for all Irish post-registration nurses by posting notices to inform them of available programmes of study. They may even provide them with the available funding. However, if managers are unable to release nurses to attend the programmes of study then the organisation’s commitment to higher education of post-registration nurses, reified in the notices or the provision of funding, is misleading. Wenger (1998) says that to negotiate
meaning there has to be the right balance between participation and reification. In this example, in order to convey meaning of the policy, the nursing managers would have to participate fully in facilitating the national policy by ensuring that the nurses are free to participate in the programmes of study. In this way the right balance between participation and reification is achieved. This aspect of the community of practice theory will be explored in this current study.

Community of practice an emergent structure

A community of practice is an emergent structure because it involves learning, which is the driver of practice, and the practice is then the history of that learning. It is produced by the members through negotiation of meaning and the introduction of new elements. Wenger (1998) suggests that a community of practice is also “a recovery process, with the constant potential for continuing, rediscovering, or reproducing the old in the new” (Wenger, 1998, p.96). As such a community of practice is therefore “highly perturbable (shaken up) and highly resilient (resistant and durable)” (Wenger, 1998, p.96). Nursing, if viewed as a community of practice, is indeed or should be open to new and novel elements, for example post-registration nurses offering new ideas when they come back from undertaking a higher education programme. This can then cause a ripple effect in the practice which should be able to absorb it and stabilize itself while incorporating the new ideas. Together the nurses should renegotiate the meaning of this ripple for the practice. This idea of a community of practice as an emergent structure will be explored in this study and related to the nurses’ experiences of undertaking a higher education programme.

Stability

Within a community of practice there can be aspects related to stability that can affect the evolution of a community of practice. For example, policies and procedures can maintain consistency in a community of practice. Powerful people in an organisation can create stability that discourages the negotiation of meaning (Wenger, 1998). In other words this person can stop progress and thus the evolution
of a practice. Nursing practice has many policies and procedures that guide practice which maintains a stability or consistency in the level of nursing care provided. These ensure that there is consistency in how nurses do things and they are created based on the current research and knowledge at the time. As Wenger says there is always a person in power or in control of ensuring that these polices are adhered to or implemented. In nursing this is the nurse managers. They have the disproportionate power to enforce policies which ensures the continuity of nursing practice. In this study, I want to explore the relationship between post-registration nurses’ engagement in higher education and the concept of stability of the community of nursing practice.

**Destabilising event**

In contrast to stability a community of practice can experience a destabilizing event. This can cause a disruption to the stability of the practice. Wenger (1998) argues that “destabilizing events do take place, but communities of practice reorganize their histories around them, developing specific responses to them that honour the continuity of their learning” (Wenger, 1998, p.98). In nursing, a good example of a destabilising event is the introduction of the degree as a basic education for nurses. This event did not just affect new nurses. It had implications for the practice and the old timers who did not have a degree. I would like to explore the concept of ‘destabilizing events’ in relation to the community of nursing practice and the introduction of an all-graduate profession in nursing and how this impacted on the post-registration nurses’ experience of undertaking a degree.

**Generational encounters**

When new members meet old–timers in a community of practice this is referred to as a generational encounter. It is essential that a practice allows sustained generational encounters where the newcomers are integrated and allowed to engage in the practice in order to perpetuate the practice. It is during these generational encounters when shared learning takes place (Wenger, 1998). In nursing practice nursing students who are undertaking a degree in nursing arrive on the wards and
they are exposed to generational encounters with staff nurses (post-registration nurses), nurse managers and other members of the multidisciplinary team. The presence of student nurses has been negotiated through a memorandum of understanding between the Higher Education Institution and the Health Service provider so that they can have exposure to the practice of nursing which forms part of their learning experience.

The transition from classroom to practice, for novices, is not an easy one. It requires that the novice gets enough attention and is involved in enough relationships with old-timers in order to truly gain access to the community of practice and thus become full participants in it. While under pressure to get their own work done, old-timers have to put in a lot of effort to introduce newcomers to the practice (Wenger, 1998). Likewise, student nurses can find it difficult to enter the community of nursing practice where they have to learn the practical aspect of nursing and where they are expected to put theory into practice. But, as Wenger says, they have to infiltrate the community, develop relationships and get enough attention from the busy old-timers to facilitate their learning. Student nurses are assigned designated preceptors who are selected to mentor students in clinical practice. In relation to this study, I want to explore how generational encounters occur between the post-registration nurses and undergraduate nursing students who are undertaking a degree.

Generational encounters between newcomers and old-timers are not always free of conflict. As Wenger (1998) suggests, communities of practice are not places of peace. Generational differences bring unique perspectives to the history of a practice. These perspectives have to be worked out which involves continuity and discontinuity propelling the practice forward (Wenger, 1998). The process of newcomers learning in a community of practice is not a smooth one. It can be fraught with conflict. The new replaces the old and that process is turbulent. But this is necessary in order for the practice to move forward. When post-registration nurses come in contact with student nurses who are working towards a degree in nursing, according to Wenger this can set up a conflict. I want to explore the concept of generational encounters and its usefulness to explain this conflict, if one exists in the
context of nursing. Furthermore, the post-registration nurses who were undertaking the Higher Diploma programme had a clinical component where they encountered old-timers in specialty areas. Thus I want to explore how generational encounters relate to two aspects of the nurses’ experiences: post-registration nurses’ encounters with student nurses and post-registration nurses, as students themselves, encounters with clinical staff in specialty areas.

**Practice as boundaries**

Each community of practice has its own distinct enterprise which creates boundaries between communities of practice (Wenger, 1998). Within a health care organisation many communities of practice exist. These can range from the communities of practice in the multidisciplinary team like medicine, nursing, physiotherapy, to others like human resources and finance. Within the nursing and medical communities of practice there are distinct specialties like cardiology, orthopaedic or gynaecology all with their distinct boundaries of practice. Being a member of a community of practice involves engagement in that practice but also relations with other communities of practice (Wenger, 1998). This is true for the nursing community of practice. Nurses are not only concerned with their own practice or enterprise but they also have to enter into relations with a host of other communities of practices. Nurses need to understand their roles in relation to these. They work closely with these and communicate regularly with them. As the nurses were undertaking a higher education programme they had to cross boundaries into the academic community of practice. Thus it is important to consider these boundaries and their relationship to post-registration nurses’ practice and learning.

Wenger (1998) suggests that communities of practice do not exist in isolation. Their enterprises are interconnected in some way. They can be connected through shared artefacts and members (Wenger, 1998). A typical example of this in health care would be the common artefact of patients’ notes which is shared by all members of the multidisciplinary team. All members of the team write their own unique progress notes about the patient into this common file. A finance officer in a health care facility
would be classified as a shared member of multiple communities of practice within the health care organisation. With regards to post-registration nurses’ experiences of undertaking a higher education programme, I want to explore the relevance of communities of practice relating to other communities of practice.

Crossing boundaries

Crossing boundaries into a different community of practice exposes a person to different enterprises and repertoire, different ways of engaging in practice and a different community of practice history. This creates a tension between experience and competence whereby learning is possible or indeed hindered (Wenger, 1998). The concept of crossing boundaries can be relevant to this study in relation to post-registration nurses who are entering academia (also a community of practice) or those who are undertaking specialist programmes of study. They are essentially crossing boundaries into a different community of practice in these cases. Thus I want to explore the concept of crossing boundaries in relation to these nurses’ experiences.

Boundaries as discontinuities

Wenger (1998) discusses the boundaries of communities of practice in terms of discontinuities. The boundary of a community of practice can be reified with markers of membership, for example titles or dress code or academic qualifications. Whether these actually act as boundaries depends on how much they effect participation in the community of practice. These markers signify where one community of practice ends and another one starts. Even if there are no obvious boundary markers or reifications there can exist subtle barriers to participation. The use of jargon, for example, can signify who is an insider and who is an outsider in a community of practice creating a barrier to participation (Wenger, 1998). I want to explore the concept of boundaries as discontinuities in relation to communities of practice in explaining the tensions that may arise when post-registration nurses encounter academia and the reifications marking the boundaries of that community such as the academic assignment.
Connections across communities of practice

Connections are achievable across boundaries of communities of practice through boundary objects and brokering.

Boundary objects

Boundary objects are “artefacts, documents, terms, concepts, and other forms of reifications around which communities of practice can organize their interconnections” (Wenger, 1998, p.105). As in the example above a patient’s file can be construed as a boundary object connecting multiple communities of practice. It is a common artefact familiar to all members of the multidisciplinary team in healthcare. Boundary objects can connect and disconnect communities of practice. “They enable coordination, but they can do so without actually creating a bridge between the perspectives and the meanings of various constituencies” (Wenger, 1998, p.107). So in relation to a patient’s file, the file creates continuity between the multidisciplinary team (they are all entering their perspective into the file) but also discontinuity in that the members of the team do not have to enter fully into the meanings of the other communities of practice. In this study, the concept of the boundary objects can be useful with regards to objects that facilitate connections for Higher Diploma nurses into the specialist community of practice.

Brokering

Brokering, according to Wenger (1998), is “connections provided by people who can introduce elements of one practice into another” (Wenger, 1998, p.105). Thus a broker is a person who participates in more than one community of practice and spanning boundaries is part of their function or role (Wenger, 1998). Wenger (1998) suggests that for learning to happen boundary encounters must occur. Boundary encounters are facilitated by skilled brokers who span communities of practice and facilitate learning and change. A broker has a complex job of coordinating and aligning the different communities’ perspectives. This person needs to have enough legitimacy to be able to influence development of practice and address conflicting interests. This person must be able to facilitate learning by introducing elements of one community of practice into another. As a result of this “brokering provides a
participative connection – not because reification is not involved, but because what brokers press into service to connect practices is their experience of multi-membership and the possibilities for negotiation inherent in participation” (Wenger, 1998, p.109).

In relation to this study, an example of a broker would be a preceptor who has two functions, working in practice and educating students. I want to explore the concept of brokering in terms of how it might help to explain post-registration nurses’ experiences of encountering different communities of practice and the brokers who facilitate this.

**Continuities and discontinuities**

A community of practice involves continuities and discontinuities. On the one hand, it is always reinventing itself even though it remains the same practice (continuity). On the other hand, change is inevitable and the members of the community must renegotiate their mutual relationships and how they participate in order to accommodate the requirement for change (discontinuity) (Wenger, 1998). These concepts are relevant in this study as the post-registration nurses are responding to the changes taking place in nursing education. In nursing, change is always happening. Nurses have to invest energy into renegotiating their mutual relationships and forms of participation to reflect the required changes (discontinuity). Although change is inevitable in nursing this change happens in order to improve on the same essence of nursing which is caring for the sick and vulnerable (continuity).

**Participation creates continuities**

In communities of practice, people and their identities become so heavily invested (participation) in the history of the practice, in what they do and in each other that it is difficult to become a different person within the same community of practice (continuity). Also it is not easy to transform oneself without the support of the members of a community of practice (Wenger, 1998). With regards to this study, I
want to explore how post-registration nurses’ investment in a community of nursing practice might impact on their ability to transform their identities by undertaking a higher education programme. How much support did they get in order to make this transformation?

**Participation creates discontinuities**

Participation creates discontinuities in the evolution of a practice. Here Wenger (1998) refers to how members come and go, move on to new positions or become jaded in their work (Wenger, 1998). Likewise, nurses move on to different positions in nursing, they get promotions, or they even leave nursing to go to a different career. The concept of participation creating discontinuities is relevant in this study in relation to post-registration nurses’ motives for engaging in higher education and will be explored in that context.

**Generational discontinuities**

When newcomers become part of a community of practice, generational discontinuities occur at different levels. For example newcomers become old-timers or they adopt new roles as teachers of newcomers. As a result of this, their perspectives and identities evolve. Suddenly someone else is looking up to you and relying on your knowledge and experience to teach them about the practice. The member might view this as progress as they realise that they can now help someone else and they have a lot of knowledge and experience to pass on. On the other hand they might see this as a big challenge because they are expected to know more than they think they do. Either way, the past, present and future come together as a result of these generational discontinuities (Wenger, 1998). Likewise in nursing and in relation to this study, post-registration nurses, who were once newcomers to the profession, now are expected to pass on their knowledge and experience to the new generation. This process forges a new identity of being responsible to pass on the history of the practice but also to pass on the current new learning and skills to further develop the practice. I want to explore this idea in relation to post-registration nurses who have to teach student nurses who are at a higher level of education than them. How does that impact on their identity?
Community of practice and identity

Identity is constructed through the process of negotiating meaning within a community of practice. Identity is related to a person knowing who he/she is by what is familiar, usable and negotiable but also a person knows who they are not by what is strange and unknown. Through participation and reification identity is shaped through experience and the social understanding of the community. It is by participation and reification in life experiences, and in relation to this study, nursing and educational experiences, that identity is formed (Wenger, 1998).

Identity and competencies

The development of an identity involves becoming competent as a member of a community of practice. The member needs to become competent in all the dimensions of a community of practice. In order to achieve this three competencies must be achieved. These include: mutuality of engagement, accountably to a joint enterprise and negotiability of the shared repertoire.

Mutuality of Engagement

Mutuality of engagement is “the ability to engage with other members and respond in kind to their actions, and thus the ability to establish relationships in which this mutuality is the basis for an identity of participation” (Wenger, 1998, p.137). Thus mutuality of engagement highlights how a member learns how to interact and work with other members of the community of practice leading to that member complying with or coming to know that community of practice (Wenger, 1998). Mutuality of engagement involves diversity in that members of the community of practice are diverse and have diverse roles and goals within it (Wenger, 1998), for example there are different level of nurses with their own diverse roles in nursing. However, all members mutually engage in the practice in order to evolve the practice (Wenger, 1998). Thus, relating mutuality of engagement to nursing practice, nurses in the community of nursing practice, through participation, collaboratively relate to each
other and these relationships bind the members of the community together as a social entity. All levels of nurses need to be competent in mutuality of engagement in order for the enterprise of nursing to evolve and work effectively and efficiently. Being able to mutually engage then is a competency in nursing that shapes the identity of every nurse.

In the context of this study, the competency of mutuality of engagement is relevant in that the post-registration nurses embarking on a higher education programme is not a solitary venture. It impacts on them but also impacts on their colleagues. The community, due to the collaborative nature of mutual engagement, should cooperate with the post-registration nurses as they endeavour to participate in higher education. “A community’s regime of competence is not static. Even knowing something entirely knew, and therefore even discovering, can be acts of competent participation in a practice” (Wenger, 1998, p.137). The post-registration nurses in this study are attempting to enhance their competency as members of a community of practice by discovering new knowledge for the good of the practice demonstrating competent membership of the practice. As mutuality of engagement is a characteristic of a competent community of practice member, the other community members should be supportive of post-registration nurses so that they can succeed in higher education gaining competent membership of the practice as higher educated nurses. This, in turn, further develops the community of practice. I want to explore how the concept of mutuality of engagement relates to post-registration nurses’ experiences in higher education as they endeavor to enhance their competency as community of nursing practice members.

Accountability to a Joint Enterprise

The second competency a community of practice member must achieve is being accountable to a joint enterprise. This means “the ability to understand the enterprise of a community of practice deeply enough to take some responsibility for it and contribute to its pursuit and to its ongoing negotiation by the community” (Wenger, 1998, p.137). These attributes shape the member’s identity (Wenger,
From the nursing literature review post-registration nurses appear to demonstrate accountability to the enterprise of nursing by pursuing a higher education qualification rendering them even more competent in their practice and better teachers of newcomers to the practice. In the context of this study I want to explore the concept of accountability to the enterprise in relation to post-registration nurses undertaking a degree. For example I would like to explore how the community of practice might influence the post-registration nurses' ability to be accountable to the enterprise.

**Negotiability of the Shared Repertoire**

The third competency that a community of practice member achieves is being able to negotiate the repertoire. The repertoire is “words, artefacts, gestures and routines …recognizable in their relation to the history of mutual engagement” (Wenger, 1998, p.83). Wenger (1998) calls “a community’s set of shared resources a *repertoire* to emphasize both its rehearsed character and its availability for future engagement in practice” (Wenger, 1998, p.83). A community member is able to negotiate and use this repertoire. In terms of identity then the history of a community of practice becomes part of the member. Identity becomes a personal set of events, memories and experiences linked to the repertoire of the practice. Negotiating this repertoire happens over time (Wenger, 1998). The things we do in nursing have come about because they have been rehearsed. They are common things we do and use and thus they are available for reuse again and again and for further use.

In the context of nursing the repertoire is the nursing jargon, artefacts like instrument used (bedpans), gestures as in a caring touch and routines like bed bathing. Negotiability of the repertoire then is defined as: “the ability to make use of the repertoire of the practice to engage in it. This requires enough participation (personal and vicarious) in the history of the practice to recognize it in the elements of its repertoire” (Wenger, 1998, p.83). Registered nurses have a vast amount of participation in the practice of nursing to recognize the existing repertoire of nursing and they are highly capable of using the repertoire. But Wenger (1998) suggests that
negotiability of the repertoire “requires the ability – both the capability and the legitimacy - to make this history (of nursing practice) newly meaningful” (Wenger, 1998, p.137). As the repertoire of nursing changes over time, due to the practice evolving, nurses have to negotiate that new and improved repertoire. Thus post-registration nurses who engage in higher education are reinventing their histories and bringing it to a new meaning, thus acquiring the competency of negotiating the repertoire of nursing. I want to explore the usefulness of this aspect of the theory in explaining the experience of post-registration nurses’ experiences of undertaking a higher education programme.

Wenger (1998) suggests that competence may be the driver of experience. By this he means that when a certain level of competence is required in a practice the members then need to align their experience to match that level of competence. This is true for newcomers but also for old-timers as the practice evolves. As nursing practice evolves and, indeed, nursing education evolves in respect to patient needs, the existing nurses must recognize that they too have to catch up with the evolving practice. This is what the post-registration nurses sought to do. They have had to respond to new educational standards in order to maintain their competence.

Conversely Wenger (1998) argues that experience can drive competence. He suggests that if a community member has an experience (for example did a degree and acquired new knowledge or clinical experience) which falls outside of the regime of competence of a community, they may want to change the community’s regime of competence so that it includes their experience. To do this they would have to negotiate that experience’s meaning with the community of practice. They would have to engage with the members in new ways in order to be taken seriously or they would have to have enough legitimacy in order to introduce this new experience to the other members. The competency of negotiability of a shared repertoire will be useful in exploring post-registration nurses’ experiences in the speciality placements.

The concepts of mutual engagement, accountably to a shared enterprise and negotiability of a shared repertoire are three competencies that a community of
Practice member must achieve. In this study, I propose that these concepts are useful in terms of explaining some of the contextual influences on post-registration nurses’ experiences of undertaking a degree in nursing.

**Identity development**

In addition to describing how a person becomes a competent member of a community of practice Wenger (1998) discusses how a community member develops an identity within a community of practice. Wenger refers to three modes of belonging in identity development. These include: Imagination, Engagement, and Alignment.

**Imagination**

Imagination is the process of:

“constructing an image of ourselves, of our communities, and of the world, in order to orient ourselves, to reflect on our situation, and to explore possibilities... thinking of ourselves as a member of a community ….these images of the world are essential to our sense of self and to our interpretation of our participation in the social world” (Wenger, 2000, p.225).

Thus imagination refers to thinking about ourselves as a member of a community of practice like the community of nursing. Looking forward to what it would be like, Wenger (1998) also refers to the idea of identification through imagination. Identifying with something in a broader context takes the work of imagination. In terms of this study and post-registration nurses’ motives to engage in higher education, it would be appear that internationally, post-registration nurses engage in the process of imagination. They imagine having a new identity, that of functioning as a nurse with a higher education qualification. They identified with others qualifying at that level and they imagine their careers following the same path. They imagine what it would be like to do a degree and how their practice might change as result of doing so.
Wenger’s (1998) argues that negotiability through imagination refers to learning from storytelling and communicating with others. He says that imagination is not a solitary process. It is a social process which involves communal imagination because others are imagining the same things as ourselves. Through the process of imagination, with others imagining the same thing, post-registration nurses explore new possibilities that are achievable by undertaking a higher education programme. They learn by communicating with others in the learning situation of higher education. In doing this, they facilitate the process of enhancing their competence in the community of nursing practice. I want to explore the concept of imagination as it relates to post-registration nurses’ motives to engage in higher education.

Engagement

According to Wenger (1998), the second mode of belonging, engagement, also contributes to the process of identity development. Engagement is defined as:

“doing things together, talking and producing artefacts (e.g. helping a colleague with a problem or participating in a meeting). The ways in which we engage with each other and with the world profoundly shape our experience of who we are” (Wenger, 2000, p.225).

The concept of engagement will be useful in this study to explore the experience of Higher Diploma nurses as they engage in the speciality placements. On the other hand this concept relates to the ACCS nurses as well who did not have a clinical component to their programme but could be said to engage in practice vicariously in the college.

Wenger (1998) also talked about identification through engagement in relation to identity formation. We identify with an enterprise by engaging in it. Wenger (1998) says that “our enterprises and our definition of competence shape our identities through our very engagement in activities and social interactions” (Wenger, 1998, p.193). For post-registration nurses participating in higher education, it is through...
engaging with new practices that they can identify with it and thus evolve their identities and the enterprise of professional nursing.

Alignment

The last mode of belonging and mechanism for developing an identity is alignment. Wenger (1998) asserts that “the process of alignment bridges time and space to form broader enterprises so that participants become connected through the coordination of their energies, actions and practices” (Wenger, 1998, p.178). Thus alignment is being part of the bigger picture or the larger community relevant to ones community of practice. Wenger (1998) says that we might engage with our community of practice and imagine about the broader enterprise or community without alignment or wanting to align with that broader enterprise. Alignment is “making sure that our local activities are sufficiently aligned with other processes so that they can be effective beyond our own engagement” (Wenger, 2000, p.225). Effective alignment means putting what we learn into practice. Post-registration nurses engaging in higher education should return to their area of work and implement or align with the learning they received in the wider community; that is the academic community of practice. This current study explores the concept of alignment in relation to the Higher Diploma nurses, in particular in terms of aligning theory to practice in the specialty placements as they had an opportunity to do so in their programme.

Educational design and identity development

According to the community of practice theory an educational curriculum should be designed with the development of the learner’s identity in mind. This education should incorporate the three modes of belonging: engagement, imagination, and alignment. Thus in addition to traditional, educational experiences a curriculum design should provide the learner with opportunities for engagement in a community of practice where they can contribute to an enterprise and engage with others around that enterprise. The learner should be allowed to also take charge of their learning rather than the educator trying to cover a lot of material. “A curriculum would
then look more like an itinerary of transformative experiences of participation than a list of subject matter” (Wenger, 1998, p.272). In other words, educational institutions, like higher education in nursing, should consider providing practical or clinical experiences in addition to theoretical input for learners, so that they can engage actively in a community of practice thus providing opportunity for the learner to develop the identity of members of that community. In nursing this configuration is always the case principally for undergraduate nursing students but not always so for post-registration nurses.

It is not enough to provide opportunities of engagement thus building learners’ capabilities but they also need to have a sense of possible trajectories within the various communities. In order to achieve this the educational design must build in imagination so that the learner can explore who they are and who they could be. Strategies to achieve imagination include orientation, reflection and exploration. Learners should be oriented to a community of practice by providing a panoramic view of it and all the possible trajectories. There should be opportunity for reflection so that learners can distance themselves from what is obvious to look at it in a new way. Furthermore the learner should be able to explore and experiment by trying something different (Wenger, 1998). In nursing education this would mean that learners, like post-registration nurses undertaking a higher education programme, would engage in reflective practice and experience a variety of clinical placements so they could experience and explore possibilities within those placements.

Educational alignment requires that learners not only engage and get a panoramic imagination of a community of practice, but learners then must have first-hand experience of what it takes to contribute to an enterprise. They must figure out what the demands of participation are in a community of practice and how they can affect that practice (Wenger, 1998). Here it is suggested that the learner, while still on the periphery but approaching full participation in a community of practice, feels what it is like to be a full member of that practice understanding all the nuances and responsibilities and accountabilities of what it is to be a full member. In undergraduate nurse training, alignment would equate to the internship year at the end of the programme. In this study, the concept of educational design incorporating
engagement, imagination and alignment is relevant and can be explored in the context of the experiences of the higher diploma participants in the study.

Identity and trajectories

An aspect of identity formation is the concept of trajectories. Wenger’s (1998) definition of trajectory implies not a path with a fixed destination but a continuous movement linking the past, present and future. He suggests that within a community of practice and in relation to identity formation there are different types of trajectories possible: peripheral trajectories, inbound trajectories, insider trajectories, boundary trajectories, outbound trajectories and paradigmatic trajectories.

Peripheral trajectories do not lead to full participation in a community of practice but allow enough access to it to add to a person’s identity.

Inbound trajectories mean that newcomers join a community of practice with the intended expectation of becoming a full member in it. While their present participation might be peripheral their identities are devoted to their future full participation in the community of practice.

Insider trajectories means that the formation of identities does not end after full participation in a community of practice is achieved. Identities continue to evolve and are renegotiated as the practice evolves.

Boundary trajectories relate to trajectories that span across community boundaries, linking communities of practice. Wenger (1998) suggests that maintaining identities across boundaries is a challenge for individuals and involves brokering.

Outbound trajectories relates to moving out of a community of practice. This means that the identity formed in the community of practice will have to change and the identity evolves as the person develops new relationships and negotiates meaning in a new enterprise (Wenger, 1998).

Paradigmatic trajectories are a set of models provided by the community of practice for negotiating trajectories. Paradigmatic trajectories “embody the history of the community through the very participation and identities of practitioners” (Wenger,
From this perspective practitioners and their stories in a community of practice are a major source of learning for newcomers. Wenger (1998) suggests that coming in contact with paradigmatic trajectories or visible career pathways provided by a community of practice is the most influential aspect that is responsible for a newcomer’s learning. Through engaging in practice newcomers witness paradigmatic trajectories which “provide live material for negotiating and renegotiating identities” (Wenger, 1998, p.156). However, newcomers are also forming their own unique identities and essentially these are new trajectories or models for ways of participating in a community of practice (Wenger, 1998). This suggests that old-timers are also exposed to the newcomers’ new trajectories which can influence their trajectories. I want to explore the concept of trajectories especially paradigmatic trajectories in relation to post-registration nurses and their experience of undertaking a higher education programme. What paradigmatic trajectories were they exposed to and influenced by? In this study I want to explore how the concept of trajectories relates to post-registration nurses’ experiences of undertaking a higher education programme. In the context of the theory of communities of practice the concept of trajectory only relates to newcomers to an occupation. I want to examine its applicability to old-timers which is what post-registration nurses would be classed as.

**Trajectories and generational encounters**

Further to his discussion on trajectories Wenger (1998) suggests that newcomers are not necessarily invested in changing a practice. They are invested in continuity of the practice because it connects them to the history of the practice. They need to learn about the practice in order to fashion their own identities. On the other hand, old-timers, while they have great investment in the history of the practice, are not necessarily interested in continuity. That is, as they wish to evolve the practice, “they might thus welcome the new potentials afforded by new generations who are less hostage to the past” (Wenger, 1998, p.157). As a result of these generational encounters, identities are shaped through a complex meeting of the past and the future. In this study, I want to see how the notion of generational encounters relate to post-registration nurses’ trajectories as they meet newcomers on their own trajectories.
Identity and Nexus of Multi-membership in communities of practice

The different parts of a person's identity are constructed as a result of being a member of different communities of practice somewhat like a jigsaw. We participate in a number of different communities and develop different parts of our identity in those communities through engaging in different ways. The whole identity is a connectedness or nexus associated with the different parts of ourselves, which are constructed in the different communities of practice (Wenger, 1998). In the case of post-registration nurses their identities are constructed as a result of being a member of the nursing profession, a family unit and the college system. Juggling these roles can be a challenge as has been noted in the nursing literature. Being part of all these communities can influence a person's identity and can have an impact on everything the person does even though different identities are more prominent depending on the community of practice one is in at any one time (Wenger, 1998). That is post-registration nurses may conduct themselves differently at home, work or at the college. As membership of different communities can conflict as well as complement each other Wenger (1998) suggests that identity is neither a unitary nor a fragmented concept. Rather identity involves not just a single trajectory into a community but a nexus of multi-membership in different communities of practice.

With respect to nexus of multi-membership in different communities of practice Wenger (1998) suggests that it requires a process of reconciliation in order to restore the identity to a state of harmony. This involves:

“combining the different forms of participation in the different communities. When learners go into a new community of practice they have to deal with conflicting forms of individuality and competence as defined in different communities” (Wenger, 1998, p.160).

Thus the different forms of membership in multiple practices have to coexist. This reconciliation is an on-going process. This notion of an on-going reconciliation process is reflected in the constant juggling of roles that post-registration nurses have to do as suggested in the nursing literature. I want to explore the concept of
nexus of multi-membership in relationship to post-registration nurses juggling the roles of work, family life and study.

Learning and legitimate peripheral participation

For learning to happen Lave and Wenger (1991) suggest that this takes place in the workplace. Newcomers learn through a process of legitimate peripheral participation. Learning, therefore, is considered a social process rather than the cognitive acquisition of knowledge. The learner learns from a more experienced practitioner within a social context. The concept of legitimate peripheral participation relates to the gradual and increasing participation of a newcomer into a community of practice. Thus learning is a situated activity where the learner moves towards full participation in the sociocultural practices of a community (Lave and Wenger, 1991). The newcomer actively participates in the social community and constructs an identity in relation to that community (Wenger, 1998). In addition to this the community of practice itself is being reproduced and transformed as a result of this system of relationships (Lave and Wenger, 1991).

Legitimacy

To be on an inbound trajectory a newcomer has to be given sufficient legitimacy to be treated as a potential community member. Legitimacy, or being considered a rightful member, can take different forms such as “being useful, being sponsored, being feared, being the right kind of person, having the right birth” (Wenger, 1998, p.101). Thus, for example, nursing students who are sponsored by a college to do clinical placement as part of the nursing programme gives students enough legitimacy to be accepted as students:

“Granting the newcomer legitimacy is important because they are likely to come short of what the community regards as competent engagement. Only with enough legitimacy can all their inevitable stumblings and violations become opportunities for learning rather than cause for dismissal, neglect, or exclusion” (Wenger, 1998, p.101).
In the context of this study the High Diploma programme granted legitimacy to its participants because it had been negotiated with the clinical setting, through a memorandum of understanding that the students would engage in the clinical area to learn specialist nursing practice. This gave them access to specialist practice and preceptors that supervised them and allowed them to engage in the practice of specialised nursing practice.

Peripherality:

Peripherality refers to the opportunity for a newcomer to have exposure to a practice but not fully participating in it. This can be achieved in different ways such as being supervised or given lessoned responsibility. It involves explaining and storytelling not just about the practice outside of it but “stories are part of the practice and take place within it” (Wenger, 1998, p.100). Wenger (1998) suggests that learning through observation is helpful but only as a precursor to actual engagement in practice. Role models, like preceptors, can be important in facilitating learning but the role models must be members of the community in order to adequately play this role (Wenger, 1998). The newcomer does not stay on the periphery indefinitely however. There is progression to full participation by virtue of the newcomer taking on more and more responsibility and accountability for actions, the tasks becoming more difficult and complex. At the same time the newcomer is progressively adopting the identity of a master practitioner (Lave and Wenger, 1991). In this study I wish to explore the concept of peripherality in the context of post-registration nurses’ participation in the specialist clinical placements which was available to the Higher Diploma nurses.

The concept of legitimate peripheral participation refers to learning whereby newcomers participate and are accepted into a community of practice on the periphery where there is low cost for errors and they were supervised. The community of practice is the learning place. In this study I want to explore the usefulness of the concept of legitimate periphery participation in explaining the experience of the Higher Diploma nurses who had a clinical component to their
programme. They got the opportunity to engage in the community of practice relevant to the modules they were taking in the college and they were on the periphery. However this was not the case for the ACCS programme nurses.

Participation and non-participation

Identities can be formed through the process of participation and non-participation in practices (Wenger, 1998). Non-participation in a practice can occur, for example when nurses work alongside other members of the multidisciplinary team, doctors, physiotherapists, dieticians, but they are not members of these practices. Yet the nurse’s identity is made up of participation in the nursing communities of practice and non-participation in these other communities of practice. Wenger (1998) makes a distinction between the concepts of peripherally and marginality with regards to non-participation. For a learner to be on the periphery, and thus non-participation, this provides the learner with an opportunity to learn as a non-participant. The learner observes a community member performing a skill before having to undertake the skill. But in this case the learner is on an inbound trajectory towards full participation in a practice. On the other hand, where non-participation involves marginality the learner is kept in the margins of a community of practice preventing the learner from becoming a full member of the community of practice. Reasons for this marginalisation may be because of deep-seated practices within the community of practice that the new learner is not privy to preventing a trajectory to full participation. This concept of non-participation can be useful in context of this study in order to explore aspects of the nursing community of practice that may prevent or facilitate nurses from fully participating in activities that are designed to facilitate the further development of the nursing community of practice. How do the post-registration nurses experience non-participation?
Critique of communities of practice

Lave and Wenger (1991) and Wenger (1998) developed the social learning theory of communities of practice. They essentially describe how a practice evolves and how a newcomer to that practice learns to become a member. No studies were found in the nursing literature that took a community of practice perspective on post-registration nurses’ experiences of Higher Education. However, this theory is not without its critics. Here I present a discussion of discourses and empirical studies which highlight the strengths and limits of the theory.

Studies in the field of education concur with the community of practice theory suggesting that the environment within a community of practice can influence how well newcomers are integrated into a community of practice. One such study was conducted by Avis et al. (2002). These authors explored, through the lens of communities of practice, the constructions of learners in post-compulsory education and training in the United Kingdom. They drew on data from three empirical studies which looked at different aspects of post-compulsory education. One study included staff development officers who were in further education. The second included trainee further education teachers and their understanding of further education in a new university and the third was a study of teachers and learners who were involved in General National Vocational Qualifications (GNVQ) at one college. Findings from this study suggested that communities of practice are formed by “the material conditions and discursive contexts in which teachers and learners are placed” (Avis et al., 2002, p.45). This suggests that the environment is an important influence on learners in a community of practice. Further to this, in the GNVQ study, some of the teachers and learners worked in pedagogical orientations which allowed for dialogue and participation which also concurs with the community of practice theory. Communities of practice were also evident in this study where lecturers and learners collaboratively worked together to resolve problems leading to a negotiated curriculum.
The concept of learners being accepted into a community of practice as participants is not always supported in the education literature and this has repercussions for the community of practice itself. In the same study by Avis et al. (2002), these authors found that if learners are excluded from a community practice, as active participants, then the formation of a vibrant community of practice is undercut. This underscores the importance of newcomers’ presence in a community of practice for the perpetuation of the community of practice. Could the same conclusions be drawn about post-registration nurses as learners in a community of practice? What material conditions and discourses are they part of that might influence their learning?

The concept of legitimate peripheral participation was found be useful at raising issues regarding the formation of professional identity in yet another study by Bathmaker and Avis (2005). These authors examined professional identity, through the lens of communities of practice theory, among new lecturers preparing to teach in further education during a time of change and transformation in the further education college system in England. One finding of particular note was that the trainee lecturers were marginalised and alienated from the academic community rather than being allowed to fully participate in the community of practice. Furthermore, the culture of the community of practice did not match the trainees’ professional identities. Bathmaker and Avis (2005) concluded that Lave and Wenger’s (1991) conception of legitimate peripheral participation did not allow for a new work order in existing communities of practice in further education in England. Essentially change in the community of practice had the impact of marginalising newcomers. Poor work conditions, lack of resources and management support affected the communities of practice within further education leading to burnout, low morale and a loss of commitment to students. This underscores the relevance of the immediate and wider social context in which learners are immersed within a community of practice and the barriers to learning they can be faced with. The marginalisation that these trainee lecturers experienced appeared to be linked to resistance to change and the development of a new professionalism, on the part of the old-timers in the further education system. This study resonates with the current study which explores post-registration nurses’ experiences of higher education in the midst of major reforms in nurse education to an all graduate profession in Ireland.
this current study, I want to explore if the community of nursing practice influences the nurses’ experiences during these reforms.

The concept of legitimate peripheral participation has been useful in understanding processes entailed in learning and in newcomers becoming full members of organisations. Fuller et al. (2005), for example, explored the strengths and weaknesses of Lave and Wenger’s (1991) concept of legitimate peripheral participation. They drew on findings from two case studies done in the United Kingdom in the manufacturing industry and secondary schools. One study by Fuller and Unwin focused on the learning of apprentices in the steel industry and the relationship between the apprentices and older workers. The second by Hodkinson and Hodkinson focused on how secondary school teachers learned at work. One observation that was made was that the concept of peripheral legitimate participation helped to understand the experience of a full member who becomes a novice. This was seen using an example of a new Head of Department who has to fit into a new community of practice (Heads of Department) yet also into the wider community of the school. In this example there were no other Heads of Departments to which this person could emulate. This suggested that the extent of peripherality experienced by this person varied. This idea may be relevant in the current study as the nurses are already experienced and the extent of their peripherality may also be varied.

Another observation related to legitimate peripheral participation emphasises that the amount of participation a learner will be allowed depends on the learning situation the learner is in. Thrysoe et al. (2010), for example, did a phenomenological study describing the opportunities that ten final year nursing students had to participate in a community of practice as part of their programme in Denmark and how these opportunities were exploited. The findings indicated that the students did travel on a continuum from less participative to more participative but this depended on the learning situation they found themselves in, the seasoned practitioner they were working with and their own level of engagement. A prerequisite to participation was that the members of the community of practice and the newcomers saw participation as worthwhile and that both parties were willing to use all the required resources that
allow active participation. These authors also found that participation can be strengthened when the student is integrated not only professionally but also socially and when the seasoned practitioners show an interest in the knowledge and experience that the students also have to offer.

The concept of boundaries of communities of practice was also explored in Fuller et al.'s (2005) study. For instance, they found that while departments within the organisations concerned could easily be defined as communities of practice, the boundaries of these were not necessarily precise. They deduced that the organisational structures and power relations within the organisations determined the existence of communities of practice, their nature and their boundaries. This suggests that the boundary lines between communities of practice can be blurred.

Focusing on learning in a community of practice, Fuller et al. (2005) argued that it is not only newcomers who learn from old-timers but old-timers can also learn from newcomers, or the novice becomes the expert. This point is under-emphasised in the community of practice. On the other hand, Fuller et al. (2005) points out that Lave and Wenger's (1991) community of practice theory does not take into account the role of teaching in the learning process. Their study findings indicated that novices and experienced employees also learn from in-service type courses or sessions within the workplace and outside of it. In addition to this, apprentices and experienced employees engage in teaching as they have skills and knowledge which they are able to pass on. One weakness Fuller et al. (2005) found in Lave and Wenger’s (1991) theory was that they were too dismissive of formal education as a source of learning. Their research suggests that formal learning is also a form of participatory learning and can be an integral part of wider learning within a community of practice on the condition that it is seen as a legitimate activity, for the learners concerned both newcomers and old-timers, within the community of practice. This point resonates with the current study as while all of the post-registration nurses are participating in formal learning, only the Higher Diploma nurses have a practice component. It is of interest, therefore, to explore if the Higher Diploma nurses have an advantage over the ACCS nurses in terms of learning.
Another weakness in Lave and Wenger’s theory relates to identity formation of newcomer. Fuller et al. (2005) highlight that Lave and Wenger (1991) only focus on how a newcomer’s identity can be formed which presupposes that they come to the community of practice with a “tabula rasa” or blank slate (Fuller et al., 2005, p.66). However, evidence from their research suggested that newcomers come with well-formed identities with beliefs, understandings and attitudes. Thus prior learning, including education, helps to form the whole person and then this embodied person learns to belong to a new setting or community of practice. This finding is echoed in O Connor’s (2010) doctoral thesis of Irish student nurses and the influence of clinical experience on their professional identity. She found that student nurses come to the profession of nursing with individual biographies and social backgrounds that have already predisposed them to the identity of a nurse, for example they have family members who are nurses. Then as Fuller et al. (2005) suggest this whole person changes to the community of practice through the process of interrelationships between the person, the community and the wider context. This idea will be of relevance to explore in the current study as the post-registration nurses in the Higher Diploma programme come to the speciality placements with a wealth of experience already in the practice of nursing.

The last weakness highlighted by Fuller et al. (2005) which related to Lave and Wenger’s (1991) theory was that they did not fully investigate the importance of conflict and unequal power within an organisation and its impact on the community of practice and the wider context. From their case studies, Fuller et al. (2005) found that power was an importance factor in relation to opportunities or barriers to learning for study participants. Control and the organisation of work can affect learners’ opportunities to learn. “Those with control over such resources can exert their power to create or remove barriers and boundaries which facilitate or inhibit participation” (Fuller et al., 2005, p.66). The issue of power and inequality will be explored in the current study in relation to support for post-registration nurses undertaking higher education programmes.
Other writers pick up on the issue of power and control in a community of practice. Writing about the limitations of communities of practice theory Roberts (2006) expands on issues of power in communities of practice. Roberts (2006) argues that in negotiating meaning in a community of practice it is vital to consider the role of power in this process. She points out that while newcomers to a community of practice may move from the periphery to full membership, established practitioners, who have full participation, will have a greater role and thus will have more power in negotiating meaning. Case and Jawitz (2004) contend that this generational encounter can cause conflict and the voice of the newcomer can become muted due to this difference in power between the newcomer and the old-timer. Roberts (2006) also argues that within decentralised organisations power is distributed thus one could expect that more members can negotiate meaning. On the other hand, in hierarchical organisational structures power is centralised and is limited to only key individuals thus the voices of other members are silenced. Furthermore members of an organisation who have knowledge to share may be bypassed in favour of external experts thus diminishing their power to negotiate. I want to explore the issue of power and how it might impact on the experience of post-registration nurses in higher education.

Wenger’s (1998) concept of paradigmatic trajectories suggests that coming in contact with visible models of career pathways, provided by a community of practice, influences a newcomer in a positive way to learn how to become a full member of a community of practice. However, he does not allude to negative consequences of how paradigmatic trajectories might turn newcomers off such trajectories. An example of this is seen in Hill and Vaughan’s (2013) study. They identified that although 60% of medical students in the United Kingdom were female, only 33% applied for surgical training. They used the concept of paradigmatic trajectories to explain this disparity. Using thematic analysis they analysed in-depth interviews with 19 clinical medical students (male and female) exploring their experiences at medical school. The findings from the study revealed that the female students’ experiences of a surgery rotation was mostly represented by men and that they were considered as “other” in the surgery rotation. The findings suggested that the female students were marginalised in terms of experiences of participation and they could not
imagine a future for themselves as successful female surgeons. On the other hand
the men in the study obtained hands-on experiences of participation and did not feel
marginalised by paradigmatic trajectories. Based on the paradigmatic trajectories
constructed from their exposure to the surgical rotation the female medical students
opted out of careers in surgery. Thus the concept of paradigmatic trajectory could
be extended as a useful theoretical tool to explain not only positive learning
experiences of participation but also as a deterrent to career choices.

The critique of communities of practice outlined above draws on studies that explore
this theory in relation to mainly industry and teachers, undergraduate nursing
students and medical students. No studies have been found that explore the
experience of post-registration nurses undertaking a higher education programme
through the lens of communities of practice. In this study, I wish to explore how the
theory of community of practice can help to explain post-registration nurses’
experiences of undertaking a higher education programme.

Summary of chapter
The theory of communities of practice was developed by Lave and Wenger (1991)
and Wenger (1998). The theory emphasises how a practice evolves and how a
member develops an identity within that practice. A community of practice is an
emergent design with specific dimensions and boundaries. A member develops an
identity through imagination, engagement and alignment and by acquiring
competencies. According to Wenger (1998) this identity is primarily shaped within
the community of practice rather than in formal educational settings. Identity also
involves trajectories and multi-membership in different communities of practice. A
newcomer to a community of practice learns through the process of legitimate
peripheral participation. Furthermore, although this theory has been shown to be
useful in explaining workplace learning it is not without its limits. I will draw on the
concepts outlined in this chapter to explain and explore the findings in this study.

The next chapter presents a discussion on how the research question was
addressed methodologically.
Chapter Four: Methodology

Introduction

In this chapter the methods used to address the research question are discussed. The research question was “What are Irish post-registration nurses’ experiences of higher education nursing programmes in terms of influences on their motives to engage and their participation in such programmes”. The chapter argues that a phenomenological design was deemed appropriate to address this research question. The methods of data collection and analysis are discussed. Consideration is also given to the ethics of the study and transferability of the findings.

The research paradigm

An inductive process was employed in this study to explore the lived experience of post-registration nurses in higher education. Gray (2009) highlights that researchers take either an inductive or deductive approach to addressing research problems/questions. The inductive approach involves the collection of data or making many observations which are then analysed to identify patterns or relationships between variables. From this process, generalisations are constructed or even theories are developed about phenomena. The purpose of this approach is not to verify or refute theory, which reflects a deductive approach, but to “establish patterns, consistencies and meanings” (Gray, 2009, p.15). This is in keeping with the Community of Practice theory which emphasises that practitioners and their stories in a community of practice are a major source of learning for newcomers. It is through the sharing of these stories that meaning is constructed (Wenger, 1998). In this study an inductive approach was used to address the research question because the patterns of the subjective experiences and meanings of the participants were the main concern.

Constructivist epistemology

According to Gray (2009) epistemology is the philosophical standpoint of a researcher related to what kind of reality/knowledge is valid and acceptable. A constructivist epistemology stresses that there is no external truth or knowledge to
be discovered but instead reality is constructed in the minds of participants as a result of interacting with the world. This is an opposing epistemology to objectivism which asserts that there is a reality out there independent of human consciousness. This reality can be measured by objective means (Gray, 2009). In this study a constructivist epistemology was adopted because I was interested in the constructed reality of post-registration nurses’ experiences of undertaking a higher education programme. This was the most appropriate epistemology because these nurses were interacting with the world of post-registration higher education and their stories could inform me about what that experience was like.

Theoretical Perspective

Phenomenology

“Phenomenology is the study of lived, human phenomena within the everyday social contexts in which the phenomena occur, from the perspective of those who experience them” (Titchen and Hobson, 2005, p.121).

Phenomenology

The methodological theoretical perspective used in this study was phenomenology. Phenomenology is the study of human experiences that can be understood by asking humans about their experience in the world from their perspective. Assumptions underlying phenomenology include a focus on revealing meaning of experience, not developing theory. This knowledge is gained by sharing the meaning of experiences. When the researcher reads a text or hears the story of a participant the researcher intuitively grasps the meaning it. People interact with the world and they interpret their experiences and construct meanings as a result of this interaction. Thus the researcher’s job in phenomenology is to analyse people’s experiences so that he/she can understand how a phenomenon is given meaning by the participant and to get to the essence of the phenomenon. The researcher aims to understand fully the lived experience and the participants’ perceptions of that experience. Thus the researcher asks what the essence of this phenomenon is as it is experienced by the participants. What is the meaning of the phenomenon to these participants? Two different philosophical traditions inform the phenomenological method and these originated from Edmund Husserl (1857-1938) and Martin Heidegger (1889-1976) (quoted in Streubert and Carpenter, 2011, p.75). Husserl’s descriptive phenomenology was Eidetic which involves extraordinarily accurate and
vivid recall especially of visual images. On the other hand Heidegger’s interpretive phenomenology was Hermeneutic which emphasises the principles of interpretation or the art of interpreting the meaning of an object. The overall aim of phenomenology is to enter another world and discover the meaning or understanding of a phenomenon (Streubert and Carpenter, 2011). In this study I adapted Husserl’s descriptive phenomenology because the aim of the study was to describe post-registration nurses’ lived experiences of undertaking a higher education programme. I was interested in a vivid and accurate recall of their experience as it was lived.

**Research Design: Descriptive Phenomenology**

The main assumptions underlying Husserl’s (1970) (quoted in LoBiondo-Wood and Haber, 2005, p.140) descriptive phenomenological design are that: Subjective information is important to researchers because human actions are influenced by what they believe to be real. The scientific approach is required in order to illuminate the essential part of the lived experience specific to a group of people. The researcher must bracket all preconceived ideas about the phenomenon to ensure rigour. The researcher must suspend priori conceptualisations that might bias the researcher. There is only one interpretation of experience: that is the universal essence or eidetic structures common to people who have the same lived experience. The researcher focuses on people and phenomena and the description of these. The core concepts and essence of these are described. The researcher focuses on describing human experience. It’s a description of ordinary experience of everyday life, of people’s beliefs, feelings, actions, what they see and hear (LoBiondo-Wood and Haber, 2005). In this study, the descriptions of post-registration nurses’ experiences of undertaking a higher education programme were my primary concern.

In order to stay faithful to Husserl’s assumptions, the researcher undertaking a descriptive phenomenological design employs the following four steps: bracketing, intuiting, analysis and description. Bracketing means keeping at bay preconceived ideas about phenomena. A journal helps in this process (Streubert and Carpenter, 2011). In this study I kept notes about my biases and preconceived ideas about the experience of undertaking a higher education programme in order to bracket by
biases. Appendix C outlines an extract from a bracketing memo. *Intuiting* means remaining open to the meanings attributed to the phenomenon and is another step in the descriptive phenomenological design (Streubert and Carpenter, 2011). In this study, having bracketed my own biases, I made a conscious effort to remain open to the descriptions and stories of the participants. *Analysis* is about making sense of the essential meaning of the phenomenon (Streubert and Carpenter, 2011). To analyse the data I used Giorgi’s (1985) method of analysis to make sense of the descriptions of the participants. Finally, the descriptive phenomenologist *describes or defines* the phenomenon (Streubert and Carpenter, 2011). In this study, I provide a detailed description of the lived experience of post-registration nurses’ experiences of undertaking a higher education programmes in the findings section.

**Reflectivity: the voice of the researcher**

The process of phenomenological bracketing was considered and carried out in this study through the process of reflexivity. Lincoln and Guba (2011) define reflexivity as “a conscious experiencing of the self as both enquirer and respondent, as teacher and learner, as the one coming to know the self within the process of research itself” (Lincoln and Guba, 2011, p.183). They also suggest that the process of reflexivity makes the researcher ask why the research question and participants were chosen; it urges the researcher to examine the self in the research enquiry and the influence the researcher may have had on the findings” (Lincoln and Guba, 2011). Finlay (2002) suggests that it is generally accepted that the researcher, particularly in qualitative research, does have an influence on the entire research process from selection of the problem to interpretation of data. The meanings and conclusions arrived at by the researcher are jointly constructed between the researcher and participants within socially constructed contexts. In other words, another researcher would not arrive at identical, albeit similar conclusions since that researcher comes with a different social background also. They suggest that being reflexive is an intrinsic part of qualitative research. Finlay (2002) offers five different ways of being reflexive, one of which is “introspection” (Finlay, 2002, p.212). Introspection involves examining personal feelings and reactions and making explicit the researcher’s position in the research (Finlay, 2002). Thus as part of the research
process in this study I engaged in introspection in order to illuminate my own feelings and biases about undertaking a high education programme so that I could ensure they did not interfere with reporting only the participants’ experiences. Reflecting on my positionality in this study, I considered why I chose to study the lived experience of Irish post-registration nursing students in Higher Education nursing programmes. My background in nursing involved becoming a registered nurse in 1982 in Ireland under the apprenticeship model, graduating with a Certificate in Nursing. Later in 1984 I became a registered midwife in England, also at certificate level. After practising as a midwife in England and Saudi Arabia, and as a nurse in Toronto, Ontario I completed a post-registration BSc in Nursing degree in Toronto (1993) and a Masters in Education also in Toronto (1995). In 1998 I began lecturing on the Diploma in Nursing which replaced the Certificate in Nursing for undergraduates in Ireland and later in 2002 the new pre-registration four year full-time nursing degree for undergraduate nursing students. In 1999, I had the opportunity to teach on the recently developed BSc (Hons) in Nursing (ACCS) programme for post-registration nurses in my local North Eastern Institute Technology on a part-time basis. The programme was offered in the evening for the convenience of the registered nurses who worked in the North East of Ireland ahead of the imminent introduction of the new pre-registration nursing degree for all Irish undergraduates nursing students in 2002. Also in 2002 I was involved in the development of core modules and taught on the new Higher Diploma programme which was designed for post-registration nurses who wanted to take a specialist programme related to their area of work. Thus by 2003, I was teaching on the new pre-registration nursing degree, the post-registration ACCS degree and the Higher Diploma for post-registration nurses working in the North East of Ireland.

As a lecturer teaching on the two higher education programmes on offer for post-registration nurses in the North Eastern Institute of Technology, I became aware that the post-registration nurses, while very motivated to learn, often interrupted class time with discussions about the post-registration nurses’ frustrations about the challenges they faced in order to attend classes and ultimately succeed in their endeavour to gain a degree in nursing. Thus it was the struggles of these post-registration nurses that sparked my interest in the study to begin with. I was interested in their stories about their experiences of undertaking a higher education
programme with the view to understanding how their experiences could be better facilitated and supported.

The reason for choosing the participants in this study was because they were the most convenient people available who were experiencing the national initiative to provide post-registration nurses with Higher Education nursing programmes ahead of the introduction of the all new entry level degree for student nurses nationally. This provided me with an opportunity to explore how this initiative was being received and supported by educational and clinical institutions.

In reflecting on my own background and biases regarding the research question, my own experience of the Irish nursing education system as a student nurse, my experience of working in the health service and now my experience of teaching post-registration nurses could have had an influence on the findings in this study. I had to acknowledge that I had lived through a time when nurses functioned within a health service where the Certificate training was considered adequate for nurses and that this level of education was considered enough compared to others on the multidisciplinary team. I had experienced the resistance, referred to in the context chapter that ensued when nursing education moved into higher education. Coming to this study with these experiences and these biases in mind may have coloured my view of the participants’ experience negatively. That is, I may have expected that they were still experiencing resistance to the changes in nursing education and this resistance might have impacted on their efforts to pursue higher education. However, identifying these biases and bracketing them from the outset helped me to reduce the potential for researcher bias. As Finlay (2002) suggests “the researcher’s position can become unduly privileged, blocking out the participant's voice” (Finlay, 2002, p.212). My efforts to bracket my own biases regarding the answer to the research question helped me to avoid blocking the participants’ voices and allowed me to only listen to and report their experiences. The bracketing process was facilitated in this study by the use of memos. Appendix C outlines an extract from a bracketing memo.
**The Participants**

The term population refers to the total number of cases that have certain characteristics and the sample is a subset of this. The inclusion criteria are the characteristics a case must have in order to be eligible to be in a study (Polit and Beck, 2012). In phenomenological studies, diversity of the experience of the phenomenon is sought. So the researcher would look for people in different locations or other differences in the shared experience of the phenomenon (Streubert and Carpenter, 2011). In this study the inclusion criteria was any post registered staff nurse who worked in a Health Service Executive facility (hospital or community, the disciplines of Psychiatry, General or Intellectual Disability nursing) in the North East region of Ireland. The staff nurses had to be undertaking a higher education programme, either the ACCS or the Higher Diploma in nursing programmes in the North Eastern Institute of Technology (for the one-to-one interviews and the main cohort of participants) or in the North Western or Western Institutes of Technology in Ireland (for the focus group interviews to aid in verifying the findings). A small sample size is usual in phenomenological studies because the goal is to explore and describe the essence of a phenomenon. The sample size is determined when data saturation is achieved (Streubert and Carpenter, 2011). Thus, seventeen (n=17) staff nurses volunteered to be in the one-to-one interviews, the main cohort of the study, from the North Eastern Institute of Technology. Nine (n=9) staff nurses volunteered to be in the focus group interviews, five from the North Western Institute of Technology and four from the Western Institute of Technology.

**Sampling Design**

The phenomenological design typically uses purposive sampling to select participants for a study. This type of sampling involves selecting participants who are information rich about the phenomenon under study. Participants must have experience of the phenomenon and be able to articulate what it is like to experience it (Streubert and Carpenter, 2011). Purposive sampling was used in this study to select participants. Post-registration nurses, who were studying in two higher education nursing programmes in the North Eastern Institute of Technology were information rich about the experience of undertaking a higher education programme.
For the one-to-one interviews in this study, I had access to the classes participants attended thus the students were approached directly in class and invited to volunteer to participate in the study. For the focus group interviews the Heads of Departments in the two Institutes of Technology in the west of Ireland forwarded the information leaflet and the consent form to students in the ACCS or Higher Diploma programmes. From there the students emailed me to express an interest in participating in the study. There are a number of different types of purposive sampling. One of these is maximum variation sampling. This type of sampling involves selecting people or settings “with a wide range of variation on dimensions of interest” (Polit and Beck, 2012, p.517). In this study purposive sampling facilitated access to participants from diverse backgrounds (nurses from a variety of disciplines, nurses from different work settings, for example, hospital and community-based nurses and nurses from different geographical locations in Ireland). The advantage of using maximum variation sampling is that participants with diverse perspectives and backgrounds related to the phenomenon under study can help to develop and challenge concepts emerging from the data. Another advantage is that any common patterns in the data, regardless of the diversity of the participants, can help to validate the core experience or phenomenon being described (Polit and Beck, 2012). In this study I used maximum variation purposive sampling in order to validate core experiences described by the participants. Participants in the study were from a variety of disciplines in nursing and the participants in the focus groups were from the west of Ireland providing geographical variability.

Purposive sampling is a form of non-probability sampling which means that not everyone in the population has a chance to be in a study. This issue is mainly relevant to quantitative studies. In quantitative research the drawback of this is that the sample is unlikely to be representative of the population thus caution must be exercised when generalising results (Polit and Beck, 2012). On the other hand in qualitative research trustworthiness and transferability of findings are the main concern. There are strategies that can be employed to enhance trustworthiness of findings and these are considered later in this chapter.
Method of Data Collection

In phenomenological studies the interview is the main method of data collection (Streubert and Carpenter, 2011). The interview facilitates the illumination of participants’ descriptions of the phenomenon of interest (Kvale and Brinkmann, 2009). Furthermore, from a community of practice and critical pedagogical perspective the meanings post-registration nurses assign to their experiences in higher education could be accessed through dialogue which sets up a democracy between the researcher and the participant. Thus in this study, as I was interested in the descriptions of the post-registration nurses’ experiences of undertaking a higher education programme, the interview was the data collection method of choice. Two types of interviews were conducted, one-to-one interviews and focus group interviews. Seventeen one-to-one interviews were conducted with the main study participants and two focus group interviews were conducted with nine participants in order to enhance the trustworthiness of the data.

Semi-structured interview

The one-to-one interviews

Semi-structured interviews were utilised in this study. In semi-structured interviews the questions or general areas for discussion are specified, but the interviewer is free to probe participants, ask additional and follow-up questions when interesting information relevant to the research question is revealed. Qualitative research is generally employed to gain insights into the human experience. Phenomenology in particular seeks to describe the essence of human experience. Thus interviews are the data collection method of choice in order to yield rich narrative descriptions and insights into people’s experiences, opinions, values, aspirations, attitudes and feelings (Hennink, Hutter and Bailey, 2011). The semi-structured interview allowed me the opportunity to put some structure on the interviews. This type of interview provided the flexibility to seek clarifications and to probe the participants further about their experiences. The interviews were facilitated by the use of a topic guide which outlined the general areas for discussion. Appendix Q contains the semi-structured topic guide.
Before each interview

Before each interview took place I ensured that I had a copy of the topic guide and I prepared the digital tape recorder, with batteries, to audio tape the interview. Tape recorders allow for an accurate record of the conversations that take place in an interview and thus helps to prevent systematic bias. The recordings can be easily transcribed verbatim. The disadvantage of recording is that they can make participants uneasy. However this effect generally disappears after the first few minutes when participants are preoccupied in conversation (Hennink, Hutter and Bailey, 2011). After a minute or two into each interview it became apparent that the participants were relaxed and comfortable to engage in conversation.

Following their acceptance of an invitation to participate in the study, each interview participant was contacted to negotiate an agreed date, time and venue to conduct the interviews. Kvale and Brinkmann (2009) suggest that the venue should be appropriate for the length and kind of interview. Areas that are within earshot of others, liable to constant interruptions and noise should be avoided. The interviews in this study were mainly conducted in my office with some being conducted in small classrooms (focus groups).

The interviews began by thanking participants for attending and reiterating the purpose of the study. This was achieved by reviewing the information leaflet and getting the participants to sign the consent form. Hennink, Hutter and Bailey (2011) suggest that it is in the opening stages of an interview that trust is established in order to achieve the success of the interview. Thus, in addition to information about the study, I emphasised the confidential nature of the study in order to put each participant at ease. Participants were also given the opportunity to ask clarification questions before the interview began.

During the interview

During the interview process, as suggested by Kvale and Brinkmann (2009) I made every effort to keep the conversation spontaneous so that I was more likely to get lively and unexpected answers. My goal was to keep the conversation flowing and to motivate the participants to talk freely about their experiences. I achieved this goal by asking questions which were open-ended, asking participants to clarify and
elaborate on their stories and paraphrasing as suggested by Hennink, Hutter and Bailey (2011). Another strategy employed to help participants to describe their experiences was the use of probes. Probes, according to Kvale and Brinkmann (2009) are an interview tool used to delve deeper into pertinent issues highlighted by participants. The types of probes I used were detail orientated, as suggested by Hennink, Hutter and Bailey (2011), for example asking ‘who’ ‘what’ ‘where’ and when questions; elaboration probes which involved nodding, utterances and remaining silent to encourage participants to talk on. Clarification probes were also used when I was unsure of what respondents were talking about.

An important strategy I employed was critical listening as suggested by Hennink, Hutter and Bailey (2011). This skill involves actively paying attention to verbal and non-verbal communication of participants so that the researcher can understand the participants’ perspectives and experiences. Critical listening ensures that unexpected topics introduced by participants are further explored, contradictions, puzzles, discrepancies in the data are clarified and any incomplete replies, omissions or gaps are followed up (Hennink, Hutter and Bailey, 2011). Critical listening was essential during the interviews to ensure that I did not miss any important points made by the participants.

At the end of the interview
At the end of each interview, I thanked participants for attending and generously sharing their experience and asked if there was anything else they would like to add. Kvale and Brinkmann (2009) suggest that participants may have feelings of emptiness at the end of an interview because they have put in a lot of effort during the interview. Thus I spent a short time in general chit chat to complete the process.

The focus group interviews
In this study I conducted two focus group interviews for the purpose of verifying findings which were concluded from the main one-to-one interviews. This was done in order to enhance the rigour of the study and trustworthiness of the findings. The focus group interviews were conducted with five Higher Diploma and four ACCS post-registration nurses from two Institutes of Technology in the west of Ireland. These institutions were selected because the two programmes of study were
developed in collaboration with the same programmes in the North Eastern Institute of Technology. Thus the post-registration nurses in those colleges were effectively doing the same programmes of study as the main study group but in a different location. This facilitated an attempt to use triangulation in order to enhance the credibility of the findings. Kvale and Brinkmann (2009) suggest that the focus group interview, while it can be difficult to control, is suited to exploratory studies where a collective discussion is encouraged by a moderator in order to generate different viewpoints on a topic of interest (Kvale and Brinkmann, 2009). The focus group interviews in this study were indeed more difficult to control than the one-to-one interviews, however I found them useful in challenging the findings from the one-to-one interviews. While some of the findings were verified by these interviews, it was noted that not all the findings were verified. This was expected as it would be impossible to replicate the context of the main study group. Appendix F highlights focus group support for themes and sub-themes found in this study.

**Pilot testing the topic guide**

The topic guide used for interviews should be pilot tested for a number of reasons. The pilot test should be conducted with participants who have the same characteristics as the main study participants. It provides information on whether the structure of the interview guide will help to answer the research question. It informs the practical aspects of the interviews, for example, pacing, timing, using equipment and length of the interview. It allows the researcher to practise the skills of interviewing, minimising such aspects as the use of leading questions. After a pilot test the interview guide can be revised (Hennink, Hutter and Bailey, 2011). In this study I conducted a pilot test of the topic guide with two post-registration nurses, one from the ACCS programme and one from the Higher Diploma programme in the North Eastern Institute of Technology. From this exercise I discovered that the initial topic guide was too broad. Thus the questions were reviewed to be more focused on the participants’ experiences of higher education nursing programmes in terms of influences on their motives to engage and their participation in such programmes.
Strengths and limitations of interviews

Interviews can be used in order to gain in-depth insights and information about people’s experiences and stories. They can also help to get contextual information about the participants in a study. On the other hand, interviews have limitations in so far as the researcher needs to have good interviewing skills to obtain rich information from the participants. Interviewers need to be flexible in changing the topic guide to follow interviewees’ story lines (Hennink, Hutter and Bailey, 2011). In this study, I found that pilot testing the topic guide helped to sharpen my interview skills in order to encourage participants to talk freely about their experiences of undertaking a higher education programme.

Data Analysis

Before analysis of the data began each interview in this study was recorded with a digital recorder to ensure an accurate record of what took place in the interview. After each interview, verbatim transcription was carried out, by myself, as close to the time of the interview as possible. I found this exercise useful as I was able to decipher and transcribe any part of an interview that was unclear since I was able to remember what took place in the interview.

In phenomenological studies it is suggested that a data analysis framework is used in order to facilitate the analysis of the mass of qualitative data generated from the interview process. Using a data analysis framework can help to illuminate the phenomenon under study (Streubert and Carpenter, 2011). One such framework is Giorgi’s (1985) method of data analysis. Giorgi’s method of analysis has four stages as follows:

- Read through the text to get a sense of the whole
- Suspend belief of the outer world to avoid having preconceived ideas (bracketing)
- Determine natural meaning units that make up the whole as told by the participants. Do this by re-reading transcripts to identify participants’ experiences related to the phenomenon under study. (Intuiting/analysis)
• Interrogate the natural meaning units and central themes in them. Do this by asking questions of the data related to the research question in an ordered and systematic way. The final themes are developed from this questioning process (Intuiting/analysis)

• Then the themes that are developed are described in relation to the research question (Describe) (Giorgi, 1985).

In this study the first step in the analysis process was to get a sense of the whole of the phenomenon, which is the experience of undertaking a higher education programme for post-registration nurses. I achieved this by undertaking all the interviews myself which allowed me an initial immersion in the data to begin to get an indication of the main themes coming up in the data in answer to the research question. After undertaking the interviews, I transcribed each interview verbatim. This process also allowed me to immerse myself in the data for a second time where I was further able to determine what themes were evident in the data. Then, as advised by Giorgi (1985), I read through the data with the research question in mind to get a sense of the whole phenomenon, making memos as I went along.

Giorgi (1985) suggests suspending preconceived ideas about the phenomenon throughout the analysis process which equates to bracketing in phenomenology. As discussed earlier I did this by identifying my biases through a process of reflexivity and memo writing.

The next step in the analysis process was to read through the interviews to determine what Giorgi (1985) describes as natural meaning units. This is done by re-reading transcripts to identify participants' experiences related to the phenomenon under study. During this process I had to bear in mind the process of phenomenological intuiting whereby I had to remain open to the experiences of the participants. I looked for natural meaning units with the help of the process of open coding the data. The open coding process is described by Glaser and Strauss (1967), Strauss and Corbin (1990) and Charmaz (2006) in their discussions about
the process of analysis in grounded theory. Corbin (2005) suggests that open coding is about breaking up the data and identifying concepts that describe incidents in the data. “Concepts are identified from distinct events/incidents in the data which may be actions and interactions, or meanings given to events or emotions that are expressed about certain events” (Corbin, 2005, p.50). To open code the data I read through every line of the transcripts and, bearing the research question in mind, I expressed the data in the form of concepts or natural meaning units which I wrote at the side of the transcripts. Appendix A presents an extract of open coding from Lora’s interview.

Having completed the open coding process for each transcript, I then began the next step in Giorgi’s (1985) data analysis process which entailed interrogation of the natural meaning units. Here I asked questions of the formulated concepts or natural meaning units in order to develop themes and subthemes from the data relevant to the research question. Here I found the analytic procedure of the constant comparative method used in grounded theory useful to interrogate the natural meaning units or concepts. The constant comparative method is conducted by the

“asking of questions about the data; and the making of comparisons for similarities and differences between each incident, event and other instances of phenomena. Similar events and incidents are labeled and grouped to form categories” (Strauss and Corbin, 1990, p.74).

Thus in this study, natural meaning units developed in all the transcripts were interrogated by comparing them to other natural meaning units for similarities and differences. If they were similar then meaning units were collapsed into one unit. If they were different they were left as discreet units. An example of this procedure would be, as in Lora’s interview in Appendix A, where the natural meaning unit of “Some colleagues don’t feel a degree is necessary in order to be a nurse” was developed. In other interviews I looked for any reference to staff nurse colleagues not feeling that a degree was a necessary prerequisite to be a nurse. Then these references were compared with the natural meaning unit developed in Lora’s interview for similarities and differences. This procedure, although painstaking, was conducted for all the natural meaning units which were developed. Eventually these natural meaning units were drawn together from subthemes which were in turn
drawn together to form themes and overall themes. As Giorgi (1985) suggests, the final themes are developed through the interrogation process. In this study, the constant comparative method was continued to ensure that all subthemes and themes had earned their right to be there and that they were discrete. Table 1 presents an example of how the natural meaning unit “Some colleagues don’t feel a degree is necessary in order to be a nurse” was renamed “higher education is too academic” and how this became the subtheme of “negative attitudes towards higher educated nurses”.

<table>
<thead>
<tr>
<th>Meaning Units from Open Coding Process</th>
<th>Final Subthemes after Interrogation of Natural Meaning Units</th>
<th>Final Themes after Interrogation of Natural Meaning Units</th>
<th>Overall Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Higher education is too academic</td>
<td>Negative attitudes towards higher education for nurses</td>
<td>Attitudes towards higher education</td>
<td>Contextual issues influencing motives</td>
</tr>
<tr>
<td>Steers nurses away from patient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Higher education is common place</td>
<td>Positive attitude towards higher education for nurses</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 1 Example of a natural meaning unit developed into a subtheme

The final step in Giorgi’s (1985) data analysis process is to describe the themes that were developed in relation to the research question (Giorgi, 1985). In this study this step is carried out in the findings section. There, each theme and subtheme is introduced, described and supported with raw data from the participants’ transcripts. Appendix E presents the data analysis summary.

**Ethical Considerations**

The British Educational Research Association (BERA, 2011) sets out ethical guidelines for the conduct of educational research. These guidelines indicate researchers’ responsibilities to participants. The main ethical issues this study took
into consideration were guided by the principles of Autonomy, Beneficence/ non-maleficence and confidentiality. Ethical approval was also sought.

**Autonomy**

BERA (2011) advise that participants’ autonomy must be protected in educational research. Autonomy is about ensuring that participants are able to make a free choice to participate or not in a study. Autonomous participants are able to control their own actions. The concept of self-determination is related to autonomy. It means that participants can voluntarily decide to participate or not in a study and to withdraw from a study without the risk of repercussions. Therefore participants should not be coerced into participating in a study (Polit and Beck, 2012). This principle includes the concept of informed consent. Participants, in order to have free choice, must be able to make an informed choice to participate (Polit and Beck, 2012). In this study the principle of autonomy was upheld by informing the participants about the study through the use of an information leaflet. Appendix G contains the information leaflet for the one-to-one interviews and Appendix H contains the information leaflet for the focus group interviews. In this leaflet I described what the study was about, how participants’ anonymity would be maintained, what the benefits were of participating and I gave them contact details if they wanted to ask questions about the study. In addition to this leaflet participants were provided with a consent form which they signed to indicate that they were willing to be in the study (Appendix I). The information leaflet was given to the participants in advance of the interviews and any questions they had were addressed before interviewing began. Also the signed consent forms were collected before commencement of interviews. While participants can give consent at the start of a study, in qualitative research it is important to ensure that the participants are still comfortable with being in the study, thus a rolling informed consent is employed. This means that during the research process the researcher should be open to checking in with participants that they still want to continue in the research especially if they experience any kind of distress during the study (Piper and Simmons, 2011). For example, during one of the one-to-one interviews one participant asked if this was all confidential and at that point informed consent was reviewed with this participant who was reassured that her identity would be protected.
Beneficence/ non-maleficence

The ethical principle of beneficence is related to maximizing benefits of a study to participants or to society. It’s about doing good (Polit and Beck, 2012). In this study, the participants were informed, in the information leaflet, about the reasons for the study and the benefits to other post-registration nurses undertaking higher education programmes and to the nursing community as a whole. The benefits highlighted to them included strengthening the collaborative approach to delivering educational programmes to post-registration nurses. In addition, they were informed that the outcomes of this study would help to support post-registration nurses in their quest to enhance their professional identity and thus strengthen their ability to pass on that identity to students and contribute to quality care for patients.

The ethical principle of non-maleficence refers to minimising harm. Participants should not be exposed to unnecessary discomfort (Polit and Beck, 2012). This principle was considered in this study. According to BERA (2011) the rights of vulnerable subjects must be attended to in educational research. If participants experience distress during a study, it is the responsibility of the researcher to discontinue any actions that causes that distress. Distress can take any form, for example overburdening participants on top of their busy work schedules (BERA, 2011). The participants in this study were post-registration nurses who were parents and partners as well as having to work full-time in the clinical setting. In order to uphold the principle of non-maleficence I honoured my promise to participants that interviews would not run any longer than one hour. This ensured that I was not taking up any more of their time than was necessary. Also I negotiated with the participants the time and place for the interviews so that they were not going out of their way to participate in the study.

Confidentiality

According to BERA (2011) confidentiality must be protected in educational research. The ethical principle of confidentiality holds that participants need to be reassured that their identity and participation in a study will not be revealed to anyone outside of the study situation. In this study the participants’ identities were protected through the use of pseudonyms. Additionally, access to data was restricted to myself, my
supervisor and one other independent researcher who was asked to verify the findings. All of the transcripts, consent forms and personal information of the participants were either stored in a locked cupboard or if in electric form, password protected on my computer. After this study has been evaluated by the University of Sheffield all of the data will be destroyed.

**Ethical Approval**

Research ethics committees have been set up in many disciplines in order to ensure that researchers have thought about all the relevant ethical issues related to a proposed study (Piper and Simmons, 2011). In order to protect the rights of the participants, ethical approval was sought and granted for this study from the ethics committee at the University Of Sheffield, School Of Education. Appendix J contains the ethical approval email from the University of Sheffield. In addition to this, permission was sought from the Head of Department at the North Eastern Institute of Technology (see Appendix O and P), the Director of Nursing Studies at the North Western Institute of Technology (see Appendix M and N), and the Head of Nursing and Health Science at the Western Institute of Technology (see Appendix K and L).

**Timescale of the Research Project**

It was anticipated that this research project would take approximately two years to complete, spanning the timeframe from September 2005 to October 2007. However, due to personal issues and difficulties the study took longer from September 2005 to December 2013. The timescale for the research project is outlined in Table 2.

<table>
<thead>
<tr>
<th>Months</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>September-December 2005</td>
<td>Introduction, start literature review, find participants</td>
</tr>
<tr>
<td>February &amp; March 2006 March, April, May 2007</td>
<td>Pilot interviews, one-to-one interviews</td>
</tr>
<tr>
<td>April and May 2007</td>
<td>Focus Group interviews</td>
</tr>
<tr>
<td>June 2007- September - 2008</td>
<td>Analysis</td>
</tr>
<tr>
<td>2009</td>
<td>Write up results</td>
</tr>
<tr>
<td>2010</td>
<td>Further review of literature based on findings</td>
</tr>
<tr>
<td>2011</td>
<td>Methods section/Discussion</td>
</tr>
<tr>
<td>2012-September 2013</td>
<td>Discussion/Conclusion</td>
</tr>
<tr>
<td>December 2013</td>
<td>Formal submission of thesis</td>
</tr>
</tbody>
</table>

*Table 2 Study Timetable*
Trustworthiness of the findings

Trustworthiness of findings in qualitative research relates to the rigor of a study and equates to the concepts of validity and reliability in quantitative research. Trustworthiness can be established by addressing the credibility, confirmability and transferability of study findings.

Credibility

Credibility relates to confidence in the findings or asking if the findings represent a credible representation of the participants’ stories or experiences. Credibility can be established through prolonged engagement, triangulation and external checks. Prolonged engagement means that the longer the researcher is with the data the more in-depth understanding he/she has of it (Polit and Beck, 2012). In this study I spent a considerable time with the data. Firstly I interviewed the participants myself, over a two year period 2006-2007, during which time I transcribed the interviews. This process alone offered me two opportunities to engage with the data. Then the analysis required an initial reading of the transcripts followed by a detailed read through in order to code the data. After coding the data, time was spent reviewing codes to establish themes and subthemes. Then a painstaking process took place of reviewing the themes to collapse themes and finalise sub-themes.

Another strategy used in qualitative research to establish trustworthiness of data is triangulation. This entails using different data sources to validate conclusions. Triangulation can be in terms of time (different time), space (different places) or person (different people) (Polit and Beck, 2012). In this study I used triangulation by conducting two focus group interviews with post-registration nurses who were undertaking ACCS degree and Higher Diploma programmes in two colleges in the west of Ireland. These interviews were conducted after the main one-to-one interviews were conducted. The objective of this exercise was to confirm the stories of the participants in the main study group thus adding to the credibility of the findings. It was not anticipated that the focus group interviews would confirm all the themes and subthemes that emerged from the one-to-one interviews. However, it
was observed that there was some agreement with most of the major themes albeit not all of the subthemes. Appendix F presents Focus Group Support for Themes and Subthemes). External checks are another strategy used by qualitative researchers to establish credibility of findings. This refers to peer debriefing or sessions with peers who are expert in research and the topic area in order to challenge the researcher’s conclusions (Polit and Beck, 2012). In this study my findings were reviewed by my academic supervisor and I also asked a lecturer/researcher colleague at work to review conclusions having read a number of transcripts. This process was conducted with credibly of findings in mind.

**Confirmability**
Confirmability refers to the objectivity or neutrality of the data and the control of researcher bias. According to Polit and Beck (2012) confirmability can be established by developing an audit trail which is a record of how the researcher conducted the study. Thus an independent researcher conducting the same study could follow the same steps and theoretically come up with similar findings. In this study detailed notes, or procedural memos, were kept on the analysis process recording all initial codes, how codes were drawn together to form themes and how the themes were collapsed and saturated with subthemes. Appendix B contains an extract of a procedural memo. In addition, notes were made along the way to record and bracket my own biases and beliefs about the phenomenon under study in order to ensure that the participants’ voices were heard. Appendix C presents an extract from a bracketing memo.

**Transferability**
Transferability refers to how well the findings can be transferred across groups and settings. The term is similar to the concept of generalisability in quantitative research. To enhance the transferability of findings in qualitative research thick description of the setting or context helps potential readers of the study findings to decide if they can identify with the results of a qualitative study (Polit and Beck, 2012). Every effort was made in this study to describe the context and the setting of the study in the context chapter and by providing a description of the profile of the participants. Each theme and subtheme in the findings was described and supported with raw data extracts from the participants’ transcripts. Thus a reader of
these findings may be able to identify with the themes that were identified in this study.

**Summary of chapter**

The research question in this study was “What are Irish post-registration nurses’ experiences of higher education nursing programmes in terms of influences on their motives to engage and their participation in such programmes”. This question was addressed by using a qualitative descriptive phenomenological research design. As this design requires bracketing of preconceived ideas about the research topic, I outlined my positionality through the process of reflexivity. A purposive sample of 17 post-registration nurses were selected, who were studying in higher education programmes in an Institute of Technology in the North East of Ireland. The data collection method was one-to-one interviews. However, two focus group interviews were conducted with nine other nurses in the North West and West of Ireland for the purpose of triangulation of data. Giorgi’s (1985) method of data analysis was employed as a framework for analysing the data. Ethical considerations in this study were discussed in light of the ethical principles of autonomy, beneficence/non-maleficence and confidentiality. Finally, this chapter presents how I addressed the issue of trustworthiness of the findings in terms of credibility, confirmability and transferability. In chapters five and six the findings in the study are presented in themes and subthemes supported by extracts from participants’ transcripts.
Chapter Five: Findings: Influences on motives

Introduction
The purpose of this study was to explore Irish post-registration nurses’ experiences of higher education nursing programmes in terms of influences on their motives to engage and their participation in such programmes. General, psychiatric and intellectual disability post-registration staff nurses took part in this study. Some nurses worked in the hospital setting whilst others worked in the community. The nurses were studying on one of two higher education nursing programmes; ACCS Degree or Higher Diploma at the North Eastern Institute of Technology. The structure of this chapter, and all subsequent findings chapters, is such that themes and sub themes are presented with supporting quotes from this main study group of participants. Focus group interviews were conducted for the purpose of triangulation. Focus group support for themes is indicated in Appendix F. Where appropriate, quotes from focus group members are also included. All the findings chapters include diagrams where appropriate to facilitate an illustration of findings presented. This chapter begins with the demographic profile of the participants followed by their motives for participating in a higher education programme. Then the contextual influences on their motives to engage in higher education are presented.

Demographic profile of the participants
In the one-to-one interviews, in the main study group, seven staff nurses were enrolled in the Specialist Higher Diploma (H Dip) programme. Four of these were community psychiatric staff nurses and of these three were functioning as Clinical Nurse Specialists but had not yet achieved the official promotional recognition for this role. The participants enrolled in this programme were studying in a strand commensurate to their discipline, for example the psychiatric nurses were undertaking the adult mental health strand and the intellectual disability nurse was undertaking the challenging behaviour strand. Two nurses from medical wards and who worked primarily with older people were undertaking the older person strand. Three nurses had achieved certificate level education and three diploma level. Only one nurse had already achieved a degree level education. The nurses in this group
were highly experienced, ranging from 3 to 19 years of experience in the practice of nursing.

In the focus group interviews, five staff nurses were enrolled in the Specialist Higher Diploma (H Dip) programme. All of these nurses worked in the hospital setting. These participants were studying in a strand commensurate to their discipline. Three nurses had achieved certificate level education and one diploma level. Again one nurse had already achieved a degree level education. The number of years of experience ranged from 8 to 24 years which also demonstrated that these nurses were very experienced in their discipline. Table 3 outlines the profile of the Higher Diploma participants.

<table>
<thead>
<tr>
<th>Participant</th>
<th>Programme</th>
<th>Job Title</th>
<th>Discipline</th>
<th>Community or Hospital Based</th>
<th>Qualification</th>
<th>Number of years qualified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Molly</td>
<td>H Dip (AMH)</td>
<td>Staff Nurse/CNS</td>
<td>Psychiatry</td>
<td>Community</td>
<td>Certificate</td>
<td>18</td>
</tr>
<tr>
<td>Ed</td>
<td>H Dip (AMH)</td>
<td>Staff Nurse/CNS</td>
<td>Psychiatry</td>
<td>Community</td>
<td>Diploma</td>
<td>6</td>
</tr>
<tr>
<td>Susan</td>
<td>H Dip (AMH)</td>
<td>Staff Nurse/CNS</td>
<td>Psychiatry</td>
<td>Community</td>
<td>Diploma</td>
<td>13</td>
</tr>
<tr>
<td>Marie</td>
<td>H Dip (AMH)</td>
<td>Staff Nurse</td>
<td>Psychiatry</td>
<td>Community</td>
<td>Certificate</td>
<td>19</td>
</tr>
<tr>
<td>Elaine</td>
<td>H Dip (OP)</td>
<td>Staff Nurse</td>
<td>Older Person</td>
<td>Hospital</td>
<td>Diploma</td>
<td>3</td>
</tr>
<tr>
<td>Lizzy</td>
<td>H Dip (OP)</td>
<td>Staff Nurse</td>
<td>Medical</td>
<td>Hospital</td>
<td>Certificate</td>
<td>8</td>
</tr>
<tr>
<td>David</td>
<td>H Dip (CB)</td>
<td>Staff Nurse</td>
<td>Intellectual Disability</td>
<td>Hospital</td>
<td>Cert, Degree</td>
<td>16</td>
</tr>
<tr>
<td>Helen</td>
<td>H Dip (OP)</td>
<td>Staff Nurse</td>
<td>Older Person</td>
<td>Hospital</td>
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<tr>
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<td>Older Person (Rehab)</td>
<td>Hospital</td>
<td>Certificate</td>
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<tr>
<td>Nettia</td>
<td>H Dip (OP)</td>
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<td>Older Person (Rehab)</td>
<td>Hospital</td>
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<tr>
<td>Alex</td>
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<td>Psychiatry</td>
<td>Hospital</td>
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<tr>
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<td>Psychiatry</td>
<td>Hospital</td>
<td>Diploma</td>
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Table 3 Characteristics of Higher Diploma (H Dip) Participants

(AMH=Adult Mental Health, OP=Older Person, CB=Challenging Behaviour, CNM=Clinical Nurse Manager, CNS=Clinical Nurse Specialist, Cert=Certificate, H Dip=Higher Diploma)

In the one-to-one interviews, in the main study group, ten staff nurses were enrolled in the ACCS programme. All of these nurses worked in the hospital setting, two of these were psychiatric nurses and the rest were general nurses. The majority (9) of
these nurses had achieved diploma level education. Only one nurse had already achieved a certificate level education. The nurses in this group were slightly less experienced than the Higher Diploma nurses ranging from 6 months to 7 years of experience (one nurse) in the practice of nursing. One nurse had 30 years of experience.

In the focus group interviews, four staff nurses were enrolled in the ACCS programme. Three nurses worked in the hospital setting and one in the community setting. The majority of this group were psychiatric nurses (3). All four nurses had achieved certificate level education. The nurses in this group were slightly more experienced than the nurses in any of the other groups ranging from 14 to 32 years of experience in the practice of nursing. Table 4 outlines the profile of the Higher Diploma participants.

<table>
<thead>
<tr>
<th>Participant</th>
<th>Programme</th>
<th>Job Title</th>
<th>Discipline</th>
<th>Community or Hospital Based</th>
<th>Qualification</th>
<th>Number of years qualified</th>
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<td>Lora</td>
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<td>Breda</td>
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<td>General/Older Person</td>
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<td>Ann</td>
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<td>General</td>
<td>Hospital</td>
<td>Diploma</td>
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<tr>
<td>Dianne</td>
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<td>General</td>
<td>Hospital</td>
<td>Diploma</td>
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</tr>
<tr>
<td>Kate</td>
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<td>General</td>
<td>Hospital</td>
<td>Diploma</td>
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</tr>
<tr>
<td>Benny</td>
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<td>General</td>
<td>Hospital</td>
<td>Diploma</td>
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Focus Group Interview 2
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<th>Qualification</th>
<th>Number of years qualified</th>
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<td>Uma</td>
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<td>Nichole</td>
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<td>General (Outpatients)</td>
<td>Hospital</td>
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Table 4 Characteristics of ACCS Degree Participants

(Psych = Psychiatric Nursing, Gen = General Nursing)

Overall, there were 17 post-registration nurses in the main study group one-to-one interviews and 9 nurses in the focus group interviews.
Post-registration nurses’ motives for undertaking a higher education programme

Post-registration nurses experienced contextual influences on their motives to engage in higher education programmes. The participants’ motives to undertake a higher education programme fell into four major themes: Educational equality, knowledge acquisition, career advancement and morale enhancement. The contextual influences on these motives fell into three themes. These included: Attitudes towards higher education, resources and supports. These contextual influences help to explain the participants’ motives to undertake a higher education programme.

Educational equality

In this study, educational inequality was an issue for participants which generated the first major motive for post-registration nurses to undertake a higher education programme namely educational equality. Post-registration nurses were aware that their own entry level education to nursing was not on par with other members of the team that they worked with. This theme had two subthemes which included student educational equality and team educational equality.

In this study post-registration nurses wanted to study in a higher education in order to resolve a perceived educational inequality between them and higher educated nursing students and newly qualified nurses. Participants reported that they wanted to take a higher education programme because they perceived the need to become educationally on par with current student nurses and newly-qualified degree educated nurses. They felt the need to update themselves so that they could become better mentors to current student nurses who were taking the entry level degree. They also stated that they felt intimidated by newly-qualified nurses.

In this study, some of the participants perceived that they should be educationally equal to the new nursing degree students. This would facilitate them in mentoring the students at the required educational level. They felt that undertaking a higher education programme would update them to a level where they could communicate
with the students, understand and facilitate their learning requirements. Marie, a community-based Psychiatric Staff Nurse illustrates this point:

“Well the way I looked at it was, with the students coming up now they were all going to college and doing the degree and I felt that with them coming out, that you know, they were talking in a different language, not in a different language, but you know the way they’d be using different buzz words... Like I wouldn’t have been really up to date.....I felt that I was in a position that I needed to update myself because we had students coming out with us and I felt to be able to, I suppose communicate with them, I needed to be up to date with what’s happening and I felt that that was the best option, doing it. Yea it was really for myself and to help me with the students” (Marie, H Dip, Psychiatric Staff Nurse, Community).

It is within the remit of registered nurses, and indeed their professional responsibility, to mentor novice nurses. However, the post-registration nurses in this study were working in health care institutions where novice nurses were also undertaking degrees in nursing as the entry level education into the profession. Thus they felt the need to be on par with nursing students educationally in order to teach them effectively.

In addition to a desire to be able to effectively mentor student nurses, some of the ACCS degree nurses reported that not having a degree themselves made them feel intimidated by the newly-qualified degree level nurses coming out of college. Bridget, a hospital-based General Staff Nurse with seven years of experience, showed how years of experience were no match for education level:

“But I suppose from what I felt when the other girls all had their degrees and I didn’t, I was quite intimidated.....But I know that certainly I was because I just felt that, you know, that they had done a lot more, umm, study than I had ever done” (Bridget ACCS, General Staff Nurse, Hospital).

Post-registration nurses in this study were also aware of the unequal educational status between themselves and the rest of the multidisciplinary team. Some of the Higher Diploma programme nurses perceived that post-registration nurses should be educationally equal to other professions with whom they worked. As other professionals on the multidisciplinary team would enter their profession at the degree level, for example doctors, physiotherapists and occupational therapists, participants
perceived that they should also have a similar basic level of education. Marie, a psychiatric community staff nurse explains:

“Mm well I suppose as I said earlier, I suppose the fact that the course went from certificate based to degree level that it, you know, it puts the nurses up there in line with other careers….whereas beforehand like nurses weren’t in the same league really” (Marie, H Dip, Psychiatric Staff Nurse, Community).

The nurses in this study were highly motivated to bridge the gap between their entry level education and that of the current student nurses and the multidisciplinary team with whom they worked.

While educational equality was a motivating factor for participants, some perceived that they had knowledge deficits that motivated them to study in higher education in order to acquire new knowledge to underpin their practice as a nurse.

Knowledge acquisition
In this study another major motive for post-registration nurses to undertake a higher education programme was the acquisition of knowledge. The knowledge acquisition theme had two subthemes which included evidence-based practice and specialist focus. These subthemes essentially constituted the types of knowledge that the participants anticipated they would acquire from their chosen educational programme.

Some of the nurses brought up the topic of evidence-based practice. For these nurses, there was an awareness of the new focus on evidence-based practice and the fact that it was no longer good enough to practice “the way it’s always been done” (Elaine, H Dip, General Staff Nurse, Hospital). They knew that they needed to update their knowledge base because they were out of touch with current practice in nursing. They understood that to get up to speed with evidence to underpin their practice they would have to do a higher education programme where they would be exposed to the latest evidence related to their practice and how to access it. Elaine explains:
“And mm I think there’s so much changing in nursing now. It’s not just based on what you’ve learned from say…..that you have done in the cert…. That’s the way it’s always been done. Whereas everything now, you know, you have to put it down to evidence base and research” (Elaine, H Dip, General Staff Nurse, Hospital).

Other Higher Diploma nurses were aware that they would have to take a higher education programme because of a new focus on specialism in nursing. The nurses were either working in a specialist area with no specialist qualification or they wanted to move to a specialist area which required a specific educational background. Therefore nurses who took the Higher Diploma decided to do this programme to enhance their knowledge in their specialty area of interest. Ed was a Psychiatric Community Staff Nurse who was functioning as a Clinical Nurse Specialist in his field but required a Higher Diploma in his speciality in order to update his knowledge in his speciality area and to secure the Clinical Nurse Specialist position. Ed illustrates this point:

“I knew, I had been a few years qualified and I had done nothing, well not done nothing… Mm but I knew I wanted to go and do something and I didn't want to do a generic degree. Because it just wasn’t going to get me anywhere. Mm and I wanted to do something more specific, so that would mean like something like the course that I did or an addiction counselling course or something a little bit more specific that would move me on….. I was crying out for something, for some form of more formalised education and to focus” (Ed, H Dip, Psychiatric Staff Nurse/CNS, Community).

For most of the participants, gaining new knowledge was an important motive. Nurses wanted to learn more about evidence-based practice because they were out of touch with new knowledge. Nurses who undertook the Higher Diploma felt that they were out of touch with current practice and that they wanted to study more specialist knowledge.

The acquisition of new knowledge was a motive for most post-registration nurses to undertake a higher education programme, but nurses also perceived the need for career advancement which became another motive.
Career advancement

In this study, post-registration nurses wanted to undertake a higher education programme in order to advance in their careers. Career advancement had two subthemes namely altruistic and pragmatic career advancement. Altruistic career advancement primarily focused the participants outwards towards advancing themselves ultimately for the benefit of the patients. Whether this meant moving up the career ladder or not, the primary focus was that they could give more individualized effective care to patients in their care. Pragmatic career advancement focused the participants inwards towards benefiting themselves and this generally was associated with moving up the career ladder or horizontal movement to a different area or securing recognition for functioning at an advanced level.

A number of nurses stated that they took a higher education programme for altruistic motives in that they wanted to engage in patient-focused care. Undertaking a higher education programme would help them to learn about how they could practice this better. Patient-focused care emphasises care based on individual patients’ needs rather than the needs of the institution. Ed, for example, who undertook the Higher Diploma, was interested in a promotion, not necessarily a management role, but a role that would help him to focus on individualised patient care.

“Ok when I came to this job, which was about three and a half years ago now…, I had begun to get back some of that autonomy as a nurse and back some of that client focus. And the course just came at the right time for building on things that I had learnt before. And sort of my way of thinking about things before. And looking at patient advocacy and client focus and tailored packages of care and all that sort of stuff” (Ed, H Dip, Psychiatric Staff Nurse/CNS, Community).

Susan, a community-based psychiatric nurse, wanted to advance in her career but to her this was perceived as going into management and thus moving further away from the patient. A career move to a Clinical Nurse Specialist (CNS) position would afford her the best of both worlds in that she could advance career-wise but maintain contact with the patient. For Susan, this was very important and the Higher Diploma programme that she was undertaking potentially allowed her to achieve this goal.

“I would have worked in England before I came over here and mm my experience was that…you know you had both routes you could go. So you could maintain
yourself clinically or you could develop managerially. And, you know, obviously... the more managerial the role...the less they had kind of a clinical hand, and I knew I didn’t want that. So I actually thought that this was the beginning of that sort of development. So that you would be able to still be on a par, you know, with managerial posts as in responsibility and everything, but you would definitely have a clinical hand... You know.....I did want to progress in that... I wanted to maintain the clinical hand but obviously move” (Susan, H Dip, Psychiatric Staff Nurse/CNS, Community).

Even though nurses had altruistic career advancement motives for taking a higher education programme, they were also *pragmatic* in their reasons for doing so. The main pragmatic motives were to *secure recognition for functioning at an advanced level or to change their job* at the same level.

A number of the community psychiatric staff nurses were functioning as Clinical Nurse Specialists (CNS) but not getting recognition for it, promotion-wise. Undertaking the Higher Diploma programme was a necessary prerequisite for that promotional grade and a strong motive for them to undertake a higher education programme.

For Molly, she was in the process of securing a CNS position on the condition that that she would undertake the Higher Diploma programme to support the role.

“For the team that we established here in Manstown, we got our Clinical Nurse Specialist. We got that promotion on the condition that we would undertake further education...Yes, the Clinical Nurse Specialist posts that time that came through, you know the last strike and that, we were given the posts. We were in our positions but at some stage we had to agree to undertake higher study.... At the time some people in our place got through automatically. They didn’t have to sign up to say that they would do a course. We went through the intermediate pathway so we had to say that somewhere down the line that we would undertake...a Higher Diploma” (Molly, H Dip, Psychiatric, Staff Nurse/ CNS, Community).

In this study some of the ACCS nurses stated that they took a higher education programme in order to change their place of work but to stay at the same promotional level. To move to a different job even at the same level, these staff nurses realized that they would now be competing with other higher educated nurses. Therefore undertaking a higher education programme themselves would enable them to compete at interview.
“Well I would like to eventually work in the community... I don’t want to stay in hospitals... Well the degree certainly helps you with mm when you go for the interview... you are graded on that kind of thing” (Lora, ACCS, Psychiatric Staff Nurse, Hospital).

This subtheme relates back to post-registration nurses’ motives to gain a more advanced qualification in order to be educationally equal to their newly-qualified colleagues. When post-registration nurses want to change jobs, but at the same level, they report that they will have to compete at interview with degree level nurses probably younger and less experienced than themselves.

Advancing their careers, for altruistic or pragmatic motives, were motives for most of the nurses in this study to undertake a degree. Another motive that they reported was that they perceived the need to address their experience of low morale.

**Morale enhancement**
The data in this study revealed that morale enhancement was another important motive to undertake a higher education programme for some post-registration nurses. There were two subthemes associated with this theme of morale enhancement: *positive and negative subthemes*. Participants wanted to do a higher education programme because they perceived that they needed to either prove to themselves that they were academically able, *the positive subtheme* or boost their morale in terms of facilitating themselves out of a professional rut or mental stagnation, *the negative subtheme*.

In this study, some of the nurses perceived that they needed to prove something to themselves by undertaking a higher education programme. Nurses perceived that undertaking a degree would enhance their sense of self by proving to themselves that they were intelligent enough to cope with the academic workload.

“No I’d say I took it initially because, I was always interested in education to be honest with you ... I think I started off to prove to myself that I could do it. It was, I’ll give it a try when I started with the ACCS and it just grew from there you know” (Breda, ACCS, General Staff Nurse, Hospital).
On the other hand, other nurses reported that they decided to take a higher education programme because they were feeling burnt out at work and that they were stuck in a rut. Going back to higher education was a way of rejuvenating their enthusiasm for the job.

“Now really I was just totally demoralised and, you know, my morale is very low, suffering from burn out…. And I just really had to do something to make myself feel better about myself and about nursing” (Nichole. ACCS, Focus Group, General Staff Nurse, Hospital).

Yet others said that they took a higher education programme because they had become mentally stagnant. They perceived that they needed to mentally rejuvenate themselves with regards to their clinical practice and work life.

“But I wanted to do it now rather than later when I would have a few grey cells left. Do you know what I mean?” (Molly, H Dip, Psychiatric, Staff Nurse/CNS, Community).

Morale enhancement was a motive for some of the nurses to undertake a higher education programme. Some felt that they had to prove to themselves that they could do the academic work. Others were feeling burnt out or stagnant in their jobs and needed to do something to reignite their enthusiasm for their work. Figure 1 outlines the post-registration nurses’ motives to undertake a higher education programme.

![Figure 1: Post-registration nurses' motives to undertake a higher education programme](image-url)
In this study post-registration nurses' reported motives to undertake a higher education programme were to gain student and team educational equality, to acquire new knowledge, to advance their careers and to enhance their morale. These motives were influenced by contextual issues namely: attitudes towards higher education for nurses, resources and supports which will be outlined next.

Post registration nurses’ experiences of contextual influences on their motives to participate in higher education

In this study, four themes were observed in the data that were classified as contextual issues influencing participants’ motives to undertake a higher education programme. These themes included: Positive and negative attitudes towards higher education for nurses, resources and supports. These themes are further explored below and provide some contextual explanation for participants’ motives to undertake a higher education programme.

Positive and negative attitudes towards higher education for nurses

The data revealed that higher education for post-registration nurses was becoming commonplace and gaining acceptance as the basic level of education to provide a knowledge base for nurses. Some of the ACCS nurses said that, in general, there was a positive attitude towards higher education for nurses. They perceived that colleagues saw higher education for nurses as common place and if nurses were not enthusiastic in seeking a degree they were considered lazy and indifferent towards their career as a nurse.

“I know from talking to other people on our floor, it could be three, four years ago, the degree was a big thing. I mean anybody who was doing the degree was seen to be very, very enthusiastic and very, very towards education. And it was just fantastic they’re doing this degree. And now I think with the new course and the students coming out the degree is just, oh you’re doing the degree oh that’s very good… When are you going to do your masters…..The degree seems to have taken on, I don’t know, a new stance or something because everybody behind us is going to have a degree now. So it isn’t seen as something fantastic as it was maybe a few years ago. It’s just like something that you should have anyway” (Ger, ACCS, General Staff Nurse, Hospital).
Participants in this study perceived that this positive view of higher education for nurses was prevalent in the nursing profession. There was a sense that the profession was embracing higher education for nurses and this positive attitude fed into participants’ motives to undertake their chosen programmes. Although this context could be considered positive in terms of the nursing profession buying into higher education, from the tone of Ger’s response these finding suggest that she experienced an external pressure to undertake a programme of study. The degree was common place, everyone should have been doing it or have it completed.

On the other hand, in this study participants also reported negative attitudes towards higher education for nurses that provided a context that influenced their motives for undertaking a higher education programme. The negative attitudes included: higher education is too academic for nurses and it steers nurses away from the patient.

The majority of the nurses perceived that there was a general view in the profession of nursing that undergraduate student nurses were too academically focused. They perceived that a downside to this new level of education for nurses was that the highly valued nursing skills would become diminished. In other words, higher education for nurses emphasised too much theory and not enough practice. Jean explains:

“I actually think now just..., in relation to students coming out we would, do you know, there’s third years coming out and like basic nursing skills really diabolical,... This has been going on just in relation to certain things like taking somebody’s temperature and like basic hands on stuff... Well I’m not saying all the students, but there has been some students on the ward and they’re not really showing that” (Jean, ACCS, Psychiatric Staff Nurse, Hospital).

It would appear that the nurses who did the old training programmes, Certificate and Diploma, were considered to have a big contribution to make to nursing in terms of their wealth of experience and the fact that they received extensive exposure to clinical skills early on in their training. Nursing skills were traditionally highly valued in the practice-based profession of nursing. Now the degree programme for novice student nurses was being compared with the old training in terms of how it contributed to the skill base of nurses. Ann and Jean highlighted their admiration for
Certificate and Diploma trained nurses in terms of the practical experience they brought to nursing.

“I admire those people because they are true nurses. You know what I mean; they are the people who went into nursing to look after the people in the bed. And they didn’t go into nursing to become CPCs (Clinical Placement Coordinator) and lecturers and go off and work in Tommy College and do research, do you know what I mean, they’re the nurses. They’re the ones who went into nursing specifically to nurse and I have a great admiration for them. …And they’ve been in nursing for a long time and are fantastic nurses because of the experience not because of the education” (Ann, ACCS, General Staff Nurse, Hospital).

Jean talks about the Diploma programme:

“Whereas with the diploma programme like we were out from maybe day one. We were always exposed to the wards and um like we were involved with the patients like from a very early on stage. You know …we were exposed to writing notes and you know like taking temperatures, blood pressures, all that, sort of early on….I do think that the practical experience you know, it’s more prominent. We get more of it obviously in the diploma programme as opposed to the degree” (Jean, ACCS, Psychiatric Staff Nurse, Hospital).

Thus, nurses in this study perceived that the practical aspect of the old nurse training (Certificate and Diploma) was still highly valued in the nursing profession. Furthermore, some nurses viewed the nursing degree as too academically focused and this left student nurses less prepared in terms of valued nursing skills. This negative attitude towards the undergraduate degree provided a context for the post-registration nurses in this study at a time when they were deciding to undertake a degree themselves.

Nurses in this study also echoed a common concern, within the profession, that if staff nurses undertook a higher education programme this meant that they had a desire to be promoted to management. Some of the nurses observed that this was a common opinion. Breda, a staff nurse on the ACCS programme, perceived that even managers perceived that undertaking a degree only meant moving on and moving up into management which steers nurses away from the patient.

“It’s nearly like why aren’t you going on ahead into management. They assume that you are going to go on into management…. the more senior colleagues….and it’s like, WHY? They want you to go on into management, that’s
what they want you to do you know. They would expect that you would go on for the next CNM (Clinical Nurse Manager) post that comes up. But you don’t have to be in that position to make changes. It’s probably easier all right but. I think they should be encouraging everybody at staff nurse level” (Breda, ACCS, General Staff Nurse, Hospital).

Here Susan, a psychiatric nurse expanded on this point saying that she perceived that management saw a degree as a management pathway and not a clinical pathway. Susan stressed that she was undertaking her Higher Diploma programme to enhance her knowledge as a clinically-focused nurse. This point is important because it emphasised her desire to maintain links with the patient.

“But ….it isn’t seen as a clinical pathway. It’s seen as somebody running up, like you know, a managerial pathways… You know people actually want to progress and want to educate themselves and want to continue to develop, but want to remain clinically focused…but I’m thinking that the Director of Nursing wouldn’t, you know, see that you know. …I think that is what she probably thought, that if people want to progress and develop then they are up after managerial posts and that sort of a way you know. Rather than nurturing like a clinical group therapists or specialist workers or whatever you know…” (Susan, H Dip, Psychiatric Staff Nurse/CNS, Community).

The post-registration nurses in this study reported positive attitudes in the nursing community towards higher education for nurses, that it is common place now. However a common attitude within the profession was that undertaking a higher education programme may give nurses the desire to move into management and thus steer them away from the patient. This potential outcome of higher education for some nurses was off-putting considering the high value placed on the practical element of nursing. The majority of nurses in this study conveyed this sense of loss. It is interesting to note that this fear was virtually unfounded as the number of managerial positions available would not satisfy the number of nurses completing a higher education programme. Furthermore, a degree in nursing was the basic level of education to be registered as a nurse. Thus automatic movement into management was not a realistic assumption to make.

In light of the fact that nursing is a practice-based profession these negative attitudes towards higher education could have been a deterrent for the participants. Nonetheless, as discussed earlier few participants reported a desire to move into
management but most emphasised the wish to enhance their careers while maintaining clinical links. The availability of resources also influenced post-registration nurses’ motives to study in higher education.

**Resources**

The availability of resources in the clinical area provided a context for post-registration nurses’ motives to undertake higher education. This theme referred to *resources that were available: financial backing, potential promotional benefits, and resources that were unavailable: no financial rewards.*

Both the ACCS degree and the Higher Diploma programmes were fully funded programmes of study by the local Health Board. A number of nurses commented on the financial *backing* available for undertaking their higher education programme. This support was welcomed by the nurses who reported that they would not have been financially able to undertake their programme without that support.

“So I’d definitely say that they have all been very supportive and my hospital employers have actually paid for the course as well which I don’t think I would have been able to afford to do myself financially…..That spurred me on last year…..Yea, well unless you were financially stable it would be difficult to consider… really because it’s quite expensive really isn’t it?” (Bridget ACCS, General Staff Nurse, Hospital).

Having the financial backing to undertake a higher education programme was a major influence on all participants to study in the ACCS degree or Higher Diploma programmes. This provided a supportive context for all the nurses involved and contributed significantly to their motives to undertake their programmes of study.

One community psychiatric staff nurse undertaking the Higher Diploma, made an interesting observation about the value of undertaking a higher education programme. In the context of this study, community psychiatric staff nurses primarily wanted to do the Higher Diploma so that they could acquire the academic qualifications to be recognised for the role most of them were already performing, namely a Clinical Nurse Specialist role. Unfortunately, this optimism was tempered with the realisation that the promotional grade may not materialise any time in the
near future. This was a deterrent for some of their colleagues to undertake the same programme. However, the *Potential promotional benefit* was a deciding factor for the participants who did undertake the Higher Diploma.

“I’m not sure if everybody would be that keen on doing it now…..Mm well I think it was quite stressful, the workload was very great and there just doesn’t seem to be the reward at the end of it. ...Absolutely, Clinical Nurse Specialist posts, and they are not available at the minute, ….It wasn’t only my perception, we all felt that it was with that in mind and that even looking at the clinical pathway that An Bord Altranais had established, we had felt that we fitted the criteria so, not that we considered it a given mm but we certainly felt that we were on the right road. And mm that’s why we committed to it…Well our line manager would have encouraged us with that in mind as well...You know, like said yea you are doing the right thing and it is where we are going but nobody said you know it’s a definite so I suppose we couldn’t blame anybody. But certainly it did feel strategic and we did think we were going in the right direction and we would be rewarded for it...” (Susan, H Dip, Psychiatric Staff Nurse/CNS, Community).

Participants choosing the Higher Diploma, especially community psychiatric nurses, were hopeful that there would be the CNS grade available to them at the end of their studies. Thus the promise of a promotion influenced these nurses’ decision to undertake the specialist Higher Diploma programme.

On the other hand, most of the nurses perceived that their older staff nurse colleagues could not see the need to do a degree. Particularly if a nurse stayed as a staff nurse, there would be *no financial rewards* associated with it. Therefore they could not see the sense in undertaking a higher education programme.

“Well I would say that in my ward, …the likes of other wards where there is older staff members, not that they’d frown upon you but they’re kind of like oh sure it’s kind of a waste of time, is it not like. ..What are you putting yourself through all this assignments and exams, you know, like I say you’re not going to be better paid?” (Jean, ACCS, Psychiatric Staff Nurse, Hospital).

The availability of funding to undertake both programmes of study provided all participants with a supportive context and this influenced their decision to study in higher education. For the community-based psychiatric nurses undertaking the Higher Diploma, their motives were influenced by potential promotional rewards. However, within the context of the view that it was a waste of time undertaking a degree when a staff nurse would not reap any financial rewards from it, these nurses
still wanted to undertake a higher education programme to gain new knowledge and to advance their careers for altruistic motives.

In addition to resources, the participants received support in the clinical area which influenced their motives to undertake a higher education programme.

**Supports**

Motives to undertake a higher education programme were influenced by the type of support the participants got in the clinical area. The theme *Supports* had two subthemes: Effective supports and Ineffective supports. *Effective supports* encompassed moral support and collaborative planning. *Ineffective supports* encompassed a lack of moral support, no collaborative planning, only short in-service courses encouraged or only Higher Education courses encouraged that were at odds with participants' preferences.

Nurses in this study were influenced to undertake a higher education programme in the context of *effective supports*, the first of these being *managerial moral support*. Some of the nurses perceived that their higher-educated line managers were encouraging of them undertaking higher education. The managers saw this as a progressive move and anticipated potential benefits for their ward as a result.

“Anything that pertained to the older person I was encouraged to go and do it. I suppose the fact that you are interested in studying you are encouraged to go.... It’s like don’t worry about that. I want you to go to this. Do you know that kind of thing and they know that you are interested in it so they send you because it’s going to benefit the ward” (Lizzy, H Dip, General Staff Nurse, Hospital).

And Dianne pointed out that non-higher educated managers can also be supportive of higher education even if they are not interested in undertaking it themselves.

“You know like she has never really condemned the degree but yet she is the type of person that would say like what education. You know like if I *(the nurse manager)* have to go off to do courses, who is going to look after the patients? Who is going to look after that? But I get the sense that she wants us to have the degree” (Dianne, ACCS. General Staff Nurse, Hospital).
Managerial moral support to undertake a higher education programme, particularly if this could potentially benefit service needs, was a common theme in this study. This was considered an effective support. It was interesting to note that while some non-higher education managers did not intend to take a degree themselves they were supportive to post-registration nurses. Within this context, the nurses wanted to undertake a higher education programme with the view to gaining new knowledge that would underpin their practice for the benefit of the patient.

A collaborative planning approach and thus an effective support that influenced post-registration nurses to undertake a higher education programme was evident in this study. For Ed and Molly their employers appeared to take an active role in the participant’s decision to take a higher education programme. Either they helped them to decide on an appropriate programme to take, relevant to their area of work, or they made taking a higher education programme a conditional prerequisite for a promotional role. This was the most interactive collaborate approach used by employers to facilitate nurses to choose a higher education programme. This approach was very evident in community environments, specifically in the discipline of psychiatry. Because there was a shift in the ethos of psychiatric services in the region from institutional care to community care, a new promotional grade (Clinical Nurse Specialist (CNS)) specialising in psychiatric community care was created for nurses to cope with this shift. The CNS position was a specialist role designed to provide appropriate community care to psychiatric clients. Managers were eager to ensure that staff, working in this new capacity, were adequately educated to provide the best service to psychiatric clients now living and coping in the community setting. Thus managers encouraged staff to do Higher Diploma programmes that supported these new roles. One service went as far as sending nurses abroad to England to learn more about community psychiatric services in addition to advising staff to do the Higher Diploma as Molly explains:

“So plus the fact I suppose the job we were in... we were going across to England and coming back learning their ways of doing things. All about community care and so in order to be up to date with, you know, treatments with clients...approaches to care; I felt I needed to be updated. You know what I mean... to see how they set up their services. Their community services there... That was our management. And of course that was great because you came back and you brought ideas with you. But you just felt that by doing the
course you would be more confident in yourself, of the things, the trends nationally and internationally” (Molly, H Dip, Psychiatric, Staff Nurse/CNS, Community).

Ed explains how the staff in his area urged management to help them to choose a suitable programme of study.

“Well from our point of view it was very much from both sides. We wanted to do something and management came back with this. It wasn’t specifically for us, it was for the area and we just grabbed on to it and that’s the way it went” (Ed, H Dip, Psychiatric Staff Nurse/CNS, Community).

An effective support influencing post-registration nurses to undertake a higher education programme was for managers to collaboratively plan suitable programmes of study relevant to the educational needs and interests of the participants and the needs of the clinical area. This type of support was reported by community psychiatric nurses.

*Ineffective supports* also provided a context for post-registration nurses’ motives to undertake a higher education programme. While some nurses said that they received managerial moral support, a number of ACCS hospital based nurses reported that they experienced a *lack of moral support and encouragement to do higher education programmes* from clinical managers. However, once the nurses had decided to undertake a programme of study, the participants stated that management appeared to be supportive.

“But I don’t think from a work point of view they’re pushing… You know but umm. No I wouldn’t have thought that there was much pressure from work to do the course” (Jean, ACCS, Psychiatric Staff Nurse, Hospital).

“Um yes. Once you have made the decision to do the degree, sometimes I don’t see too much kind of umm encouragement to do it. But once you are doing it they certainly are supportive towards you” (Ger, ACCS, General Staff Nurse, Hospital).

While the managers of the psychiatric community nurses appeared to take an active role in collaboratively planning for higher education, some other nurses who were hospital based experienced *no collaborative planning* with their managers.
Participants were asked if there were any mechanisms in their place of work to facilitate staff to identify the most appropriate programme of study for them, for example like staff appraisals or professional development plans. A number of nurses identified that their workplace did not have any type of organised appraisal system which could facilitate staff to identify the most appropriate education programme for them to undertake.

Dianne said that she was aware of a professional development programme or a staff appraisal system, which existed in another area in her hospital. This was run by the manager of the area and she collaboratively identified areas of weakness of staff with the view to indicating what education programmes would suit their learning needs. But Dianne said that her area did not run this type of programme. This next quote indicates that her colleagues were asking about these appraisals in a staff meeting but they were not forthcoming in her area.

“They might say it, and one of them has said something I think at the, you know, at a ward meeting, a couple of ward meetings ago, about the appraisals, you know what I mean. That she had seen them when she was training in England and would we bring them out or something like that as guidance. And nothing ever really came of it, you know what I mean. And, you know….she said (the ward manager) there had to be a written protocol. And then we learned, that there is these professional development programmes…you know. So why, you know… they are even better than these appraisals, you know. Because you go on courses and at least it’s good for managers to identify…this is your weak area and this is the course that’s going to facilitate you….But emm that doesn’t happen on our ward. No. It does happen in theatre but it doesn’t happen in our ward” (Dianne, ACCS. General Staff Nurse, Hospital).

Lora expands on this point. After commencing her higher education programme Lora, a staff nurse undertaking the ACCS general degree, was annoyed that she didn’t get better career advice from her Director of Nursing when she initially looked for funding for her degree. Lora discovered only after she started the degree that she probably should have done the Higher Diploma because she wanted to eventually work in the community and the Higher Diploma was the programme that would have prepared her for that.

“And seeing as the Higher Diploma was there when I was doing it (the ACCS programme), why wasn’t I told. Like when I went looking for funding for the degree, why wasn’t I told, why not do….My line manager said it one time that I
would have been better doing...the Higher Diploma because he had done the Higher Diploma...Like a few other staff nurses would have said the same thing. So I kind of felt that, what the hell....Yes he would have said you are wasting your time doing the (ACCS)... yea...That’s what I feel. If I had, when I went in for funding, maybe if the Director of Nursing at the time, she had have said well I have so many people already actually doing the degree and well like the Higher Diploma is out there. Would you consider doing that? It might be more beneficial. But there was nothing so” (Lora, ACCS, Psychiatric Staff Nurse, Hospital).

A more collaborate approach to planning educational activities in these clinical areas would have helped Dianne and Lora in choosing a suitable higher education programme of study. Nonetheless this was the context in which they became interested in undertaking a higher education programme and the lack of collaborative planning appeared to be an ineffective support for these nurses.

In this study one staff nurse said that although he was encouraged to undertake a higher education programme, management would only encourage short-term courses or in-service courses specific to the needs of the environment the participant was working in. These courses would not necessarily be of higher education level. This participant perceived that the reason why higher education programmes were not encouraged by management was that management did not want nurses to leave their positions having become more qualified to look for promotional posts elsewhere. This was related to the shortage of nurses on the ground.

“No they didn’t mm. They like to see you doing one day courses and all that but there was no real pressure or anything for you to do the degree. They do like to see you doing things and trying to advance yourself but they didn’t talk about the degree now too much. They are more interested in you doing study days and keeping your clinical skills up to date. That’s more what they were interested in” (Benny, ACCS, General Staff Nurse, Hospital).

In terms of ineffective supports, while short courses are more likely to be encouraged than higher education courses some nurses also reported that higher education courses would be encouraged but these could be at odds with what the participants were interested in. Lizzy, for example, stated that while her line manager was very supportive of her undertaking the Higher Diploma in care of the older person, which was Lizzy’s preference, administration in her hospital wanted her to do a Higher Diploma in orthopaedics.
“I suppose what it was; I’m looking after elderly people anyway. I work on a male medical ward. 90-95% of the patients are over the age of 65. And I suppose to be able to deliver them the care that they deserve or to know what the older people expect and know what their needs are and how to deliver care to those needs like …administration in the hospital would have liked people to have done courses. They were going to try and push the Higher Diploma courses…They didn’t specifically want you to go and do gerontology. They wanted to know if we would do the orthopaedic one ... And I just said I would love to do the gerontology…our line managers were, yea, if there was something that took your interest. Go for it absolutely. And they highly, highly encouraged me to go for it. Whereas my ward manager who had known I was doing the gerontology was very very very supportive. … There would be no reason for me to do the orthopaedic because all we do is look after the older person” (Lizzy, H Dip, General Staff Nurse, Hospital).

Lizzy was undertaking the older person strand of the Higher Diploma. While her line manager was supportive of this, Lizzy was aware that the more senior managers would have preferred that she did the orthopaedic strand as they needed nurses who were qualified in this specialty. Lizzy was not working on an orthopaedic ward, she worked on a medical ward with a preponderance of older patients. Thus the older person strand of the Higher Diploma was an obvious choice for Lizzy. Lizzy’s experience provided a good example of an ineffective support that was a contextual influence on post-registration nurses’ decision to undertake a higher education programme.

Figure 2 outlines contextual influences on post-registration nurses’ motives to undertake a higher education programme.

Figure 2 Contextual influences on post-registration nurses’ motives
Summary of chapter

The post-registration nurses in this study had varied motives for undertaking a higher education programme of study. Team educational equality was highlighted and student educational equality was a common motive. The nurses wanted to ensure that they were educationally on par with the student nurses or new graduates that they encountered and mentored on the wards. As the nursing students were now studying at degree level, some of the nurses felt intimidated by them because they were not educated to that level themselves.

Most of the nurses were interested in bolstering their knowledge base to underpin their practice. This meant learning about evidence-based practice and tapping into the most up to date information to underpin their practice. On the other hand, nurses who were undertaking the Higher Diploma wanted to study a specialty area of practice. Some of the community psychiatric nurses were functioning at the level of Clinical Nurse Specialist but they were required to do a Higher Diploma as a prerequisite to that promotional role.

Career advancement was a motive for some nurses. Motives in this theme were either altruistic or pragmatic. Most nurses expressed the desired to advance but still maintain clinical links with patients. A Clinical Nurse Specialist role fits this bill but the number of positions available was limited.

Lastly, some nurses expressed the need to enhance their morale because they felt burnt out at work or mentally stagnant. On a more optimistic note, nurses in this study wanted to prove to themselves that they were able for the challenge of undertaking a higher education programme.

Participants’ reported that motives to engage in higher education were influenced by contextual issues namely: attitudes towards higher education for nurses, resources and supports.

Within the profession of nursing, a perceived positive attitude was that higher education was common place. However, negative attitudes towards higher
education for nurses included higher education is too academic in a profession that values nursing skills and that it steers nurses away from the patient.

Within the context of available resources, nurses still wanted to study in higher education. The financial backing was there and there was the potential to get a promotion especially after undertaking the Higher Diploma. On the other hand, unless one got a promotion there was no financial rewards for undertaking a degree.

Some of the nurses worked in organisations that offered effective supports to nurses to help them to decide on what programme of study to do. Effective support encompassed managerial moral support and collaborative planning. It was noted that only the psychiatric community nurses experienced collaborative planning with their managers for higher education.

Other nurses, mainly based in the hospital setting, experienced ineffective supports with regards to deciding on what programme to do. For some nurses, moral support and collaborative planning did not appear to be available to them. Others, who were encouraged to study, were either only encouraged to do short in-service courses or they were advised to do Higher Education programmes that were at odds with their own preferences.

It appeared that the nurses’ experiences in the community in which they worked had an influence on their motives to engage in higher education. In the next chapter the influences on the post-registration nurses’ experiences during the time they participated in a higher education programme are presented.
Chapter Six: Findings: Challenges and coping strategies

Introduction
This chapter presents the participants' experiences in terms of challenges and coping mechanisms they employed while undertaking a higher education programme. Participants encountered two main challenges while they were undertaking a higher education programme. These formed two themes: time constraints and lack of confidence in academic ability. Another major theme observed in the data was the coping mechanisms employed by participants to deal with these challenges. These coping strategies included: making sacrifices, manipulating work hours, deferring the course, attending all classes and getting someone to read papers.

A further four themes were generated in the data related to these challenges and coping strategies. These themes represent contextual issues that help to further explain the challenges that participants faced and how they coped with them. These contextual issues included: practical college supports, practical clinical supports, moral support and barriers to practical clinical support. These themes are further explored below.

Post-registration nurses’ challenges and coping strategies while undertaking a higher education programme

Lack of time to do academic work
A common theme, reported by the participants was that they were pushed for time to do the academic work involved in the course. Bearing in mind that these nurses were working full-time, some with family commitments and attending a part-time higher education programme, time constraints posed a real challenge for these post-registration nurses. Marie explained that the Higher Diploma programme for
example, which was taken over one year, was too rushed and left her struggling to get her assignments in at a comfortable pace.

“The only thing, when I was doing the course I found it very hard reaching my guidelines. Well not so much reaching my guidelines with assignments and that but I felt very, when I had an assignment to be in, I felt my whole life was taken over with that… Because I felt there was an awful lot in it for the one year course and I felt …when you had just one assignment in and then the next thing you were bombarded with another. And I hadn’t time to relax after one and you were just then trying to get stuff then for the next one and you just hadn’t time. Basically your life was on hold for the whole year” (Marie, H Dip, Psychiatric Staff Nurse, Community).

Participants in this study while they were undertaking their academic course struggled to make time. Even though participants studying on the Higher Diploma had a negotiated designated day off work to attend classes, in addition to two days off, they still struggled with lack of time. Participants shared their stories about how they coped with this challenge.

**Coping with lack of time to do academic work**

**Make sacrifices**

Striking a balance between college, work and home commitments was a challenge for these participants. Some participants explained how post-registration nurses had to make sacrifices in order to cope. Sacrifices they had to make ranged from not being able to spend time with children to not having any time off for themselves, to not being able to socialise with friends. Ann explains:

“Doing this course, it really means that I’m working most weekends, you know. Which is detrimental when you have children going to school, you know, because the weekend is the only time that they have their recreational activities” (Ann, ACCS, General Staff Nurse, Hospital).

Jean elaborates on this theme:

“Well that element of it is very difficult you know. To think that your days off have to be spent maybe doing assignments or doing research. You know, you feel you have no time off. Any time you do have off from work it’s either coming to college or it’s looking up information for assignments. So it is difficult enough to get a balance between both” (Jean, ACCS, Psychiatric Staff Nurse, Hospital).
It appeared that the nurses coped with the workload of study by missing out on their social and family life. Another strategy used was to manipulate their work schedule to make time.

**Manipulate work hours**

In order to cope with the time commitment needed to undertake a higher education programme, most of the nurses resorted to manipulating their work hours. One strategy entailed requesting long work days leaving participants with more days off to do their academic studies. Bearing in mind that the ACCS programme did not come with a designated day off to study, manipulating work hours, as a coping strategy, seemed plausible.

“Umm well I find it helps. I think the fact that I work long days I get more days off whereas if I worked nine to five, if I came home at five o clock I’d say right I’ll start into my assignments. But I know I wouldn’t” (Jean, ACCS, Psychiatric Staff Nurse, Hospital).

Some nurses said they requested annual leave which they used to attend to their academic work.

“But I would be fairly organised so if I had something big coming up I would take my holidays ….But I’d certainly wouldn’t leave it that I’d go down on something because I couldn’t get the time off. You know I would book my holidays to suit” (Kate, ACCS, General Staff Nurse, Hospital).

Others resorted to reducing their hours of work. This strategy also came with a reduction in pay which had financial implications for the nurses.

“I felt it was a little bit much because at the time I was working full-time. But then I stopped and I did thirty hours every week and I felt it was a lot more manageable” (Terry, ACCS, General Staff Nurse, Hospital).

In order to cope with the need to find time to study some nurses deferred parts of their programme which gave them less workload.
**Defer the course**
To cope with lack of time to do the academic work and the stress that it caused, a more drastic strategy used by participants was to defer their course. Some nurses explained how they found they had to defer their course at one time or another in order to cope with the stress of juggling roles. Jean explains how she decided to take fewer modules:

“Well I think in my case, I kind of stretched the programme out over the eighteen months. Like this term I’m only in college on Thursday, whereas the last term I was in college Tuesday and a Thursday. And it was very stressful” (Jean, ACCS, Psychiatric Staff Nurse, Hospital).

Lack of time to do the necessary academic work in order to complete the programme was reported by some nurses in this study. In order to cope with this challenge, making sacrifices was a common strategy used. Manipulating work hours was another coping strategy but this could mean working longer hours in the day just to get more days off, while reducing hours incurred a financial consequence.

The post-registration nurses in this study were very motivated to undertake a higher education programme and when faced with the time restrictions they encountered while trying to achieve their goal they became quite resourceful in finding ways to make time. Figure 3 presents a diagrammatical representation of the challenge ‘lack of time’ and the coping strategy the nurses employed.

![Figure 3 Challenge of lack of time to do academic work and coping strategies](image-url)
Lack of confidence in academic ability

An interesting theme in the data related to the participants’ expressed feeling of a lack of confidence in their ability to do the academic work in their chosen programme of study. Some nurses explained how they felt the return to academia was difficult. They questioned their ability to stay abreast of the standard required at Higher Diploma or ACCS degree level. In particular, writing posed a challenge for them. Molly’s quote here explains the general feeling of the participants.

“To get back into it like. Even as you say, write an essay like. That is just something else…. And oh lord trying to get your ideas and trying to get the proper English” (Molly, H Dip, Psychiatric, Staff Nurse/CNS, Community).

Nurses from both programmes of study reported this lack of confidence in their academic ability. This was not a surprising result as, for example, many of the Higher Diploma nurses had been out of education for some years (3-19 years) while the ACCS nurses were out of formal education from 1-7 years. Nonetheless, while faced with this lack of confidence the nurses again reported that they employed coping strategies to overcome this difficulty.

Coping with lack of confidence in academic ability

Get others to review academic work

Post-registration nurses in this study felt somewhat inadequate in their abilities when it came to academia. One strategy used by the participants to overcome this was to have other people read their work or assignments. Even though Terry, a hospital-based ACCS degree nurse, had only been out of academia for 6 months he explained how he used this strategy which gave him some confidence and reassurance in his academic abilities.

“It’s just very very difficult? Overall the modules I have done, to get the balance right you know like…. And to make sure that, emm, that I feel that what I have presented, is of any type of substance at all. So you are constantly worrying…. and sometimes I even get somebody to read over it….But they may not have any
experience in this field… but they could tell me …you know like I can understand this. ..Anybody, like I mean of average intelligence should be able to make some kind of sense of it, you know like I mean” (Terry, ACCS, General Staff Nurse, Hospital).

A further strategy used to overcome lack of confidence in ability was to attempt to attend all the classes on offer in the programme of study.

**Attend all classes**

To enhance their confidence in their ability to cope with the rigours of academia the participants reported that they attended as many classes as possible. This finding was primarily reported by the ACCS degree nurses who did not have a designated day off to attend class, as was the case for the Higher Diploma nurses. This strategy facilitated them in grasping as much information as possible to enhance their understanding and knowledge level. Therefore, it was imperative that they were able to get the required time off in order to achieve this goal.

“I found it invaluable to be here. And I couldn’t have gone through it unless I attended as many classes as much as possible. I really couldn’t. To me it was like… There’s no point in doing this because you might as well do it on Open University. If you don’t come to class. There’s no point” (David, H Dip, Intellectual Disability Staff Nurse, Hospital).

Some of the nurses in this study expressed a reservation regarding their confidence level in their ability to undertake the academic work required for the higher education programme of their choice. There were two coping strategies used by most participants in order to deal with this challenge. These coping strategies included getting others to review their academic work and ensuring that they attended all classes.

Figure 4 offers a diagrammatical representation of the challenge of ‘lack of confidence in academic ability’ and the coping strategies employed by the nurses.
Participants in this study faced two main challenges while studying in a higher education programme. One of these challenges was lack of time to do the academic work. Participants had to make sacrifices in order to cope with this challenge. That meant less time for socialising and to be with family. Others coped by manipulating their work hours which meant that they were either working longer days, using up their annual leave or cutting their hours which incurred financial hardship.

The second challenge the nurses faced was a lack of confidence in their ability to do the academic work. Some nurses coped with this by getting others to read over their work while others tried to attend all the classes. This last strategy was more of an issue for the ACCS degree nurses because they did not have a designated day off to attend classes. Attending classes helped participants to face their fears head on regarding academic work.

Evidence in this study suggests that there were contextual issues that influenced these experiences. These contextual influences are further explored next.

**Contextual influences on participants’ challenges and coping strategies**
In this study, four themes were observed in the data that were classified as contextual issues influencing participants’ challenges and coping strategies while undertaking a higher education programme. These themes included: practical college supports, practical clinical supports, moral support, barriers to practical
clinical support. These themes are further explored below and provide some contextual explanation for participants’ challenges and coping strategies while undertaking a higher education programme.

Practical college support to learning
Within the theme of practical college supports to learning, two subthemes were observed. These included effective teaching strategies and social networks. These themes primarily represented positive influences on the participants’ reported lack of confidence in their academic ability to complete the academic work required.

Effective Teaching Strategies

Some of the nurses reported that an important type of college support to their learning was the availability and approachability of the lecturers in the college where they undertook their higher education programme. They found that when they felt that they were running into difficulty with the academic work they could easily contact lecturers. When they did this the lecturers were approachable making it easier for them to access the information and help they needed. Bridget explains:

“Having done my nurse training eight years ago when it was all pen and paper and that’s what I was used to. And the whole referencing, Harvard System. …But my academic writing skills wouldn’t have been the best. So I suppose that was the most difficult part for me. But in saying that, um, all of the lecturers that I’ve had always gave out email addresses and contact numbers so they were very very obliging to help. Which was great and very reassuring” (Bridget ACCS, General Staff Nurse, Hospital).

Another nurse, undertaking the ACCS programme, explained that if she could not get to class it was a great help to her to be able to access her notes on the internet. Therefore she did not miss out on any of the learning. Given that ACCS degree nurses did not have a designated day off to go to class this type of support was very important to the participants.

“I thought the college was great. I did. For our first four modules, the first semester and that the um the notes on the internet hadn’t been set up. And I found that, for our last four modules, very very helpful. Um even from the point of view, because um you mightn’t have got into a certain class, sometimes it’s hard relying on friends to get you notes and that kind of carry on. But it was great. You
could just pop onto the internet at home and print it off and they’re all there for you” (Ger, ACCS, General Staff Nurse, Hospital).

While most nurses reported a lack of confidence in their academic abilities, they also reported that the most valuable college supports to build their confidence were access to approachable lecturers and online notes. These types of practical college supports influenced their ability to study and learn at an advanced level with relative ease. Another practical college support to learn was social networks.

**Social networks**

Social networks, created in the college environment, helped participants in this study to learn new ways of doing things in their practice. Participants met other nurses undertaking the same programme of study and social networks were formed. Within these social networks nurses helped each other with academic work and shared experiences from their respective work areas. This facilitated the sharing of knowledge thus enhancing learning and confidence in academic ability. This learning was made possible either because the nurses were meeting colleagues who worked in areas other than their own or they learned from seeing other’s practice during specialist clinical placements. The latter was mostly observed in the Higher Diploma programme, which had a clinical placement component where participants could practice in a specialist environment to learn and observe new ways of doing things and reinforce the specialist learning in class.

Some received support in their academic studies from *study buddies* who were undertaking the higher education programme. A study buddy was another student with whom a post-registration nurse linked up with and worked well with to share the experience of studying. Therefore they were able to support each other in learning how to do things differently.

“No you’d see them just the next day and we’d be in contact on the phone. Um now there’s one girl who is not in this semester because she has done these modules but she was in the last module now and she was a great study buddy” (Ann, ACCS, General Staff Nurse, Hospital).

Specialist placements provided a fruitful learning environment for the Higher Diploma nurses. For a period of six weeks a specialist placement came with a preceptorship
(or mentor) support system. The preceptor’s role was to orient the nurses to the specialist area, introduce them to specialist nursing practice particular to that area and gradually help the Higher Diploma nurses to engage in speciality practice until they could function independently. The preceptor’s role was also to assess the nurses’ ability to function as staff nurses in that specialty area. For a further 24 weeks the Higher Diploma nurses worked in a specialty area without the preceptor. However, they worked alongside the complement of nurses working in that area where they could observe them working and draw on their support to consolidate their learning in practice. The Higher Diploma nurses reported that they learned new ways of doing things from the specialist modules and from observing new practices in *the specialist placements* they were placed on.

Elaine talked about her experience with the preceptor:

“It was great umm, she was great…a great help. She eased you in to the ward. She had a wealth in information about older person care that I could use in my own practice….there was a lot that I knew already from working with older people but new practices also that I could use with my patients… It came alive.. the theory we got in class came alive. With her help I gradually became more confident and by the end of the six weeks I was comfortable, I had settled in well” (Elaine, H Dip, General Staff Nurse, Hospital).

Marie spoke about how she learned from the other nurses in the specialty area:

“I feel … with the placements as well, they were a good thing because you were working in different areas and you seen how things were done there and you know. Like there was one particular drug that seemed to be used a lot in the M area and you know like even talking to the staff there….. And they were giving me examples of clients they had there and how they had benefited from it” (Marie, H Dip, Psychiatric Staff Nurse, Community).

Within this context, the Higher Diploma participants had the benefit of both classroom-based and work-based learning experiences. In this current study the ACCS course was a theory-based course and did not have a clinical or clinical support component. Thus they could not get the benefit of work-based learning.

College supports to learning for these post-registration nurses included effective teaching strategies and social networks. These types of practical college supports were important in terms of mediating participants’ lack of confidence in their ability to do the academic work. In addition to practical college supports, participants also
reported practical clinical supports to learning while they undertook their higher education programme.

**Practical clinical supports to learning while undertaking a higher education programme**

Within the theme of practical clinical supports to learning two subthemes were observed. These included resources and moral support. These themes exerted positive influences on the participants’ reported lack of time to undertake the academic work and lack of confidence in their academic abilities.

**Resources**

One of the most important supports for the nurses in this study was time off from work each week to attend classes at the college. Managers in the clinical area were in control of scheduling these days off to attend classes for the participants. The nurses in the Higher Diploma were automatically guaranteed a day off a week to attend classes. However, this understanding was not a feature of the ACCS programme. Nevertheless, most of the ACCS nurses reported that they did not encounter any difficulty with being accommodated by their managers with days off to attend classes at the college. This was an important support to facilitate learning.

“There was no problem. They slotted my off duty around the days that I was in college. No they were very good about that now…. That end of it was ok you know” (Breda, ACCS, General Staff Nurse, Hospital).

In the Higher Diploma programme students got the necessary study leave built into the programme to attend classes each week. Therefore the commitment by managers to allocate staff the time off to attend class was built into the programme. Elaine indicated here that the Higher Diploma nurses received all the days off they needed to attend their classes.

“No, they just let, oh yea they give me the eight hours… they give me the eight hours every Wednesday. That’s considered a working day and then I get my two days off” (Elaine, H Dip, General Staff Nurse, Hospital).

The most talked about type of support while studying in higher education was getting the time off to attend classes. Without this type of support participants would not
have been able to attend all the classes which were important to most of the nurses in terms of building confidence in their ability to undertake the necessary academic work. All Higher Diploma nurses were able to attend because the college day was scheduled into their work schedule. Most of the ACCS nurses working in hospitals reported getting the time off to attend class.

Related to scheduling days off, a number of the ACCS nurses found that their higher educated staff nurse colleagues offered practical support while they undertook their higher education programme. This took the form of facilitating the participants to attend classes by swapping shifts with them or covering their work for them while they attended classes. Participants found this type of support extremely helpful.

“The majority now would be very, would be very supportive… And you know in that kind of way and then they’d be, I suppose maybe if I was stuck and I needed to switch a shift or something you might find that the people who had already done the degree might kind of just help you out. Maybe they’d say oh God I remember now when I was doing my degree” (Ger, ACCS, General Staff Nurse, Hospital).

And Molly explained:

“They, my colleagues, my immediate colleagues now were very supportive. You know because I had placements to do. We were leaving work, they worked short in order for me to get them placements. Because we wouldn’t have got relief. You know the staff wasn’t there to provide the relief. And they actually worked short because they knew that I was on the course they accommodated me you know what I mean so I would be indebted to those you know what I mean….I never missed any classes. I always made it” (Molly, H Dip, Psychiatric, Staff Nurse/CNS, Community).

One ACCS nurse also referred to her non-higher educated staff nurse colleagues offering practical support to her while she undertook her higher education programme. This support took the form of covering for her while she went to college.

“So I’ve been lucky enough in the sense that um a few of the girls that I would have done my diploma with are on the opposite time to me. So they kind of understand where I’m coming from and are very obliging” (Jean, ACCS, Psychiatric Staff Nurse, Hospital).

In terms of coping with lack of time to undertake the programme, getting the support from colleagues to allow participants to attend classes was an important practical
support to learning. Staff nurse colleagues who were willing to swap days off with participants or cover for them positively influenced their ability to cope with the issue of not getting days off to attend classes.

**Moral support**

Post-registration nurses in this study reported that moral support from colleagues was just as important as practical support, especially in the clinical area, in order to cope with the challenges they faced while undertaking a higher education programme. Moral support was encouraging and spurred the participants on, even in times when they doubted themselves. This support came from managers and staff nurse colleagues.

Some of the nurses explained how they perceived that their *higher educated line managers* understood what they were going through in their programme and were empathetic towards them, giving them moral support. It was important that higher educated managers could identify with the challenges faced by participants as this would make it more likely that the managers would try their best to facilitate them in their efforts.

“Yea…they would sort of be engaging in studying like masters or that so they would sort of understand you know where you’re coming from ….Yea I suppose the fact that they have been through it, you know they kind of understand the stress you’d be under in relation to exams and doing assignments and stuff” (Jean, ACCS, Psychiatric Staff Nurse, Hospital).

While nurses in this study received *moral support from their higher educated line managers*, they also found that their *non-higher educated colleagues* offered similar types of support. The majority of the nurses reported that their non-higher educated staff nurse colleagues offered them moral support while they undertook their higher education programme. This moral support included words of admiration and cheering them on.

“*I think that the group of nurses that I’m working with on the ward now, um, have admiration for me going out to study and work. And to be able to juggle the two they have admiration for me*” (Ann, ACCS, General Staff Nurse, Hospital).
In addition to practical support to undertake the programme, moral support and encouragement was just as important to the participants because it spurred them on to the end of the programme in the midst of a lack of confidence in themselves to have the ability to do it. Most of the nurses experienced this type of encouragement that helped them to believe that they could do it. Moral support from colleagues provided a positive environment in terms of confidence building for participants while undertaking their higher education programme.

While nurses in this study found practical and moral supports helpful during their higher education programme, there were also reports of nurses working in contexts that were less helpful. These contexts formed the theme *barriers to practical clinical support* to learning while undertaking a higher education programme.

**Barriers to practical clinical support**

There were some instances when post-registration nurses in this study were working in contexts that created barriers to practical clinical support to learning while they were undertaking their higher education programme. Within this theme one subtheme were observed. This was labelled: lack of resources. This theme primarily represented negative influences on participants’ reported lack of time to complete the academic work and lack of confidence in their academic ability.

**Lack of resources**

As discussed earlier, there was no memorandum of understanding between the college and the clinical partners built into the ACCS programme whereby post-registration nurses were automatically given paid days off to attend class. Thus while the majority of nurses undertaking the ACCS programme reported that they were accommodated to go to class, others reported that their managers did not support them in terms of facilitating time off to go to class. Participants found that their managers would not schedule in the days off required on the duty roster.
The most striking example of this was Terry, an ACCS nurse working in the hospital setting, who reported that he found that his managers would not automatically schedule in the days off he needed to go to class while he worked in the public sector. In addition, he reported that one ward manager refused to accept nurses to work on her ward who were undertaking a higher education programme because she knew that she would be expected to give them time off and she was not prepared to do this.

“Yes I was. I was already in the course when I worked in public sector and it was extremely difficult to try…. you know…Because you would be lumbered with a week of nights just like that. So therefore like that whole week is gone. So like…I couldn’t come to class. I couldn’t do anything. The following week you … would have off but I have often been contacted during my week off and asked to work extra time when somebody else is out sick…..The practical support was virtually non-existent. …..My colleagues, they have requested not to work on specific wards because the line manager on that ward doesn’t want anybody in the programme at all. Because she cannot literally have people missing from the ward. …. There is a request in the hospital at the minute that I don’t want to be put on that particular ward” (Terry, ACCS, General Staff Nurse, Hospital).

Another striking example of this lack of support for time off to attend class is Lora’s experience who, on informing her Director of Nursing that she wanted to do the ACCS degree, Lora was told from the outset that she should not expect any support in terms of time off to do so.

“I was told when I went into the Director of Nursing to ask for funding for this course. Before I asked, I went in and said I am looking to do the ACCS degree. And the first thing she said to me was, that’s fine but don’t expect any time off. Any study time. So I got no study time. So I could only attend college every other week…. And I felt very much that, god they are paying for me to do this and yet they are not really helping me to make sure I pass” (Lora, ACCS, Psychiatric Staff Nurse, Hospital).

Participants who were undertaking the ACCS programme and hospital based, where managers would or could not provide them with the days off to attend classes posed a direct challenge for the participants in terms of lack of time to do the academic work in their chosen course of study. It was at the discretion of the nurse manager if the nurse got the day off to go to class or exams. Participants who did not get this practical support had to cope by manipulating their work schedules or deferring the course.
As previously discussed, some post-registration nurses found it difficult to get time off to attend higher education programmes of study. If nurses failed to be successful in negotiating with their managers, their next port of call was to turn to their colleagues to negotiate swapping shifts with them. Participants in this study reported that if their managers did not schedule time off for them to go to class, *it was up to them to negotiate with their nurse colleagues to swap days off with them.* Having to negotiate time off to go to class with colleagues meant that the participants had to rely on the generosity of their colleagues in order to get to class. Sometimes this generosity was forthcoming...

“But other than that really there isn’t a lot of support from management in the sense that you have to swap your days. You don’t get any leeway in relation to days. ..... Let’s say if I was due to work, like I’m in as it is now I just come to college on a Thursday .... Well you have to swap it.... Our roster is done on a two weekly basis, we kind of fairly know our duty, you know. It’s the same duty every two weeks. But um you would have to just swap with people and that’s the time to get your day to come to class....So I have to work a day for them” (Jean, ACCS, Psychiatric Staff Nurse, Hospital).

Sometimes negotiations to swap days with colleagues were unsuccessful.

“Well yea the majority of them that are not taking degrees might have young kids anyway or something at home so they are not as flexible anyway for you” (Ger, ACCS, General Staff Nurse, Hospital).

Not getting the days off to attend classes and then having to negotiate the days off with colleagues posed a challenge for participants, particularly in the ACCS programme. If they were unsuccessful in negotiating the time off this prohibited their ability to attend all the classes which, for them, negatively influenced their ability to build confidence in undertaking the academic work.

Some of the nurses in this study perceived that a major reason for managers’ lack of support in terms of giving the time off to go to class was the lack of resources to staff the wards while nurses were away on higher education programmes. As Dianne, a hospital-based general nurse explained, it’s not that the managers begrudged the
nurses going; it’s that they did not have the staff resources to cover the ward to allow them to attend.

“But yet in relation to off duty and trying to schedule time off, that’s the big no no with it. Like you know all great but well how am I going to work this?... It was like oh my God there are four of you. Right well, not all of you will get to go to the class no. ..... As I say the only negative would be in relation to just resources on the ward... You know like off duty. ..You know you will not get off. Don’t think that you will all get off every Tuesday and Thursday. It’s not going to be feasible. ....The only hindrance I’d say would be...staff shortages” (Dianne, ACCS. General Staff Nurse, Hospital).

Lack of resources in terms of staff to cover participants’ work while they attended college influenced managers’ ability to give staff the time off to attend the programme. This was a common reason for inability to attend classes mainly for hospital-based nurses.

Figure 5 illustrates the contextual issues influencing post-registration nurses’ challenges and coping strategies while undertaking a higher education programme.

**Figure 5** Contextual influences on post-registration nurses’ challenges and coping strategies
Summary of chapter
The data revealed that post-registration nurses experienced challenges while they were studying in higher education. The two main challenges highlighted by participants were time constraints and lack of confidence in academic ability. The participants felt that they were time pressured to complete the academic work set for them in their programme of study. In order to cope with this challenge the nurses were resourceful and developed coping strategies to overcome this. Some made sacrifices which meant that they had less time for family and friends and for themselves. Others manipulated their work hours which meant they would work longer hours or they used up their annual leave or they cut their work hours. Others deferred some of the college modules to make more time to cope with the academic work.

The second challenge experienced by the participants was lack of confidence in their ability to do the academic work. Nurses coped with this by getting others to review their work. Others, especially the ACCS nurses, tried to make sure they attended all the classes offered by the college.

The data also revealed that there were contextual issues that influenced these challenges. These included practical college supports, practical clinical supports and barriers to practical clinical supports.

Practical college supports included effective teaching strategies and social networks. Approachable lecturers and access to online course materials were important effective teaching strategies. The participants formed social networks while in the college environment, including study buddies and learning from staff on specialist placements. These formed practical college supports to learning for the participants and helped build confidence in their abilities.

The clinical setting provided another practical support for participants while they were undertaking their programmes of study. This included resources and moral support. The most important resource for participants was getting the days off to attend the college classes. All of the Higher Diploma nurses got this and most of
the ACCS nurses. If ACCS nurses were not successful in negotiating time off to go to class, another practical clinical support was swapping days with their staff nurse colleagues. Moral support was also important to the nurses and they received this from higher educated managers and non-higher educated staff nurse colleagues.

On the other hand, some nurses experienced barriers for practical supports while they were undertaking a higher education programme. These included not getting time off from work, having to negotiate time off with staff nurse colleagues and staff shortages. These issues provided a context which influenced the participants’ experience while undertaking a higher education programme.

This chapter has concentrated on the participants’ challenges and coping strategies while undertaking a higher education programme and the contextual influences on these. The next chapter presents a discussion of the findings.
Chapter Seven: Discussion

Introduction
The research question in this study was “What are Irish post-registration nurses’ experiences of higher education nursing programmes in terms of influences on their motives to engage and their participation in such programmes?”

In this chapter, the findings from the study are discussed in light of relevant literature and concepts from the community of practice conceptual framework.

Post-registration nurses’ motives to undertake a higher education programme
General, psychiatric and intellectual disability post-registration staff nurses, who were undertaking two higher education programmes of study in the North East of Ireland, took part in this study. These participants were highly motivated to undertake a higher education programme and they reported a number of motives for doing so. The evidence in this study suggests that these motives fell into four major categories: Educational equality, knowledge acquisition, career advancement and morale enhancement. It was also observed that there were contextual issues influencing participants’ motives to undertake a higher education programme. These included: attitudes towards higher education, resources and supports. It is within this context that the participants made their decision to engage in a higher education programme. First I will discuss the nurses’ motives for engaging followed by a discussion of the influences on these motives.

Most of the nurses were very experienced in their respective disciplines, some working for over thirty years as a nurse. This time spent in the practice of nursing had shaped their identities as nurses. They were familiar with the activities required to practice as a nurse. Lave and Wenger (1991) presupposed that newcomers came to a community of practice with a “tabula rasa” or blank slate. However, Fuller et al.
(2005) and O’Connor (2010) challenged this view. Evidence from their studies suggested that newcomers come with beliefs, understandings and attitudes or well-formed identities related to the practice they were entering. In this current study, it can be said that the post-registration nurses were entering the academic community of practice as newcomers but not as blank slates. They had a wealth of nursing experience and knowledge behind them which meant they had well-formed identities as nurses already.

With identities already shaped as nurses, these participants wanted to further develop their identities and they looked to higher education to achieve that. The fact that they wanted to engage in higher education can be explained by the concept of imagination in relation to developing an identity, termed by Wenger (1998). Wenger (1998) asserts that the development of an identity entails three modes of belonging: Engagement, Imagination and Alignment. Here the concept of imagination is relevant to explain the post-registration nurses’ motives for undertaking a higher education programme. Wenger (1998) says that Imagination is a process of

“constructing an image of ourselves, of our communities, and of the world, in order to orient ourselves, to reflect on our situation, and to explore possibilities .... These images of the world are essential to our sense of self and to our interpretation of our participation in the social world” (Wenger, 2000, p.225).

For the post-registration nurses in this study, through a process of reflection, they realised that their identities were in need of further development. The findings suggest that imagination helped them to think about where they fit in their social world, the profession of nursing. Their constructed image of their own identity was one of inadequacy in a number of areas namely the need to address issues of educational inequality, knowledge deficits, career enhancement and low morale.
**Educational inequality**

**Team equality**

The post-registration nurses in this study commented on the fact that nurses in general, who did not have a degree, were unequal educationally at entry level to the rest of the multidisciplinary team and this was a motive to upgrade to degree level. Team educational equality was also found to be a motive for Cooley’s (2008) Irish participants to undertake a higher education programme. As multidisciplinary team members, nurses clearly see the need to ensure that they are equal to their colleagues in terms of a basic professional education. The multidisciplinary team consists of doctors, nurses, physiotherapists, occupational therapists, dieticians, etc. and working collaboratively these bring their own unique knowledge and skills to bear on patients’ health problems. Traditionally, nurses were the only members on the team that did not require an entry level degree. By 2002, in Ireland, a degree in nursing became the only route to register as a nurse. This put the nurse on a level playing field, in terms of entry level education, with other members of the team.

The need for the nurses in this study to achieve team educational equality reflects the nurses’ awareness of the contentious discourses around their unique identity within the multidisciplinary team. As Treacy and Hyde (2003) point out, Irish nurses are cognisant of their unique perspective and contribution to health care and the value of this to patient care. Wenger’s (1998) reference to practice as meaning is relevant here. What matters about a practice is the meaning that is produced in a practice. For nurses it is the unique contribution they make to the care of patients. But, Murphy et al. (2006) also noted that post-registration nurses engage in higher education to enhance professional respect from colleagues. Likewise, Marie, in this current study, said “beforehand like nurses weren’t in the same league really” which suggests awareness that nurses have an inferior status on the team. Thus the findings from this study suggest that the nurses felt that undertaking a degree in nursing would solve issues of inequality within the health service that manifest in a lack of respect for the unique contribution nurses bring to the care of patients. However, it has been demonstrated that this belief may have been faulty.
Post-registration nurses, even after obtaining a first degree, can be dissatisfied with their status on the multidisciplinary team and their perceived subordinate role as staff nurses which leads them to go in search of even higher educational qualifications such as Masters degrees. They do this with the view to escaping the experience of an enduring oppressed, subordinate position on the multidisciplinary team (Watkins, 2011; Zahrans, 2013). This oppression is reflected in socio-economic unequal structures with starting salary differentials (INMO, 2014; Careers Portal, 2015) and hierarchical team structures, where the doctor is the most powerful member of the team (Ritzer, 2015) leading to the experience of oppression (Whitehead, 2010). Further evidence exists that nurses are an oppressed group in terms of their struggle to be officially called a profession (Office for National Statistics, 2000). Although gains have been made in this respect (Office of National Statistics, 2010) the nurse’s role is still described as a supporting role for other professionals which has connotations of a subservient position. Other evidence suggests that nurses exhibit or experience oppressed group behaviour such as gregariousness, conformity, horizontal violence, identification with the oppressor, emotional dependence and self-depreciation (Roberts, 1983; Matheson, 2008; Purpora et al., 2012). As a predominantly female profession, the nurse’s experience of oppression at work reflects gender inequalities in the home and at work for women in general (Walbys, 1990; Ritzer, 2015). Thus, for the nurses in this study, their imagined team educational equality may not have satisfied broader equality issues in the community of nursing practice.

Student nurse equality

Through the process of imagination, these post-registration nurses wanted to engage in higher education to bridge the educational gap between them and the other members of the multidisciplinary team to resolve an equality issue. But another group that they wanted to be educationally equal to was the degree nursing students and the newly-qualified nurses that they encountered frequently in their workplace. The introduction of the degree in nursing as an entry level education for Irish undergraduate nurses in 2002 had an impact on these post-registration nurses. They
began to think about where they fit in the profession of nursing educationally, having not studied to that level themselves. The student nurses posed a threat to their identity as nurses in that they realised that the students would be educated to a higher level to them. This caused the post-registration nurses to imagine the possibilities in higher education to resolve this problem. Post-registration nurses realised that they were now expected to be preceptors for students studying on an education programme that they themselves had not experienced and were unfamiliar with.

According to the community of practice theory Wenger (1998) argues that competence may be the driver of experience. That is, when a certain level of competence is required in a practice the members of that practice then need to align their experience to match that level of competence. This is true for newcomers but also for old-timers as the practice evolves. Likewise, in this study with the introduction of an all-graduate profession in Irish nursing, these post-registration nurses realised that a new level of competence for practice, educationally, was required and their past educational experiences did not match that level of competence. Thus they wanted to align their experience to match the degree level of competence so that they would be better able to mentor the students.

Previous nursing studies have also shown that post-registration nurses want to undertake higher education in order to enhance their ability to facilitate the learning of undergraduate nursing student. Wenger (1998) described this as generational encounters. In Gould et al.’s (1999) UK study, for example, their participants wanted to enhance their ability to not only teach patients, but also student nurses and junior colleagues. Furthermore, Dowswell et al. (2000) also found that nurses wanted to engage in higher education in order to do their job better, notably to be more effective educators of nursing students. Similar findings were found in Halcomb et al.’s (2012) qualitative Australian study with practice nurses and their experience of mentoring undergraduate nursing students in the practice setting. These nurses valued the role of mentoring students as a means of promoting practice nursing. They saw this role as an investment in the future of practice nursing. These findings
concur with the current study indicating that post-registration nurses are interested in student nurses and they are keen to pass on their knowledge, skills and experiences to them. According to Wenger (1998) it is through these sustained generational encounters with newcomers that practice is perpetuated.

Reciprocity in the student-practitioner learning situation was not a focus for the post-registration nurses in this study. The nurses did not refer to the undergraduate students teaching them. Rather, they were increasingly concerned with how and what they were teaching undergraduate student nurses. Other nursing and education studies acknowledge reciprocity in learning (Fuller et al., 2005; Halcomb et al., 2012) with Fuller et al. (2005) pointing out that this is underemphasised in the community of practice theory. In this study, the nurses’ lack of reference to learning from the students could be linked to their past traditional educational experiences and pedagogy in nursing. Traditional pedagogies like the banking system (the lecture) view the student as an empty vessel and the teacher as the authority on a subject matter (Freire, 1970). Other researchers have also argued that, in negotiating meaning in a community of practice, practitioners who have full participation, in this case the post-registration nurses, will have a greater role and thus will have more power in negotiating meaning than newcomers (Roberts, 2006). Furthermore, generational encounters between newcomers and practitioners can cause conflict and the voice of the newcomer can become muted due to differences in power relationships (Case and Jawitz, 2004). Thus, contrary to other studies, the findings in this study suggest that the nurses’ past educational experiences may have taught them that the teacher-student relationship involves a power imbalance where the teacher teaches and the student listens. This would explain their lack of reference to reciprocity in the student-practitioner learning situation.

The post-registration nurses in this study were experiencing what Wenger (1998) called generational encounters with student nurses and newly-qualified nurses. This is where newcomers meet old-timers in the practice setting and the newcomers are integrated and allowed to engage in the practice in order to learn. For some of the nurses this encounter made the nurses feel intimidated. On the other hand,
generational discontinuities were also occurring in this study. This is where newcomers become old-timers or they adopt new roles as teachers of newcomers. The old-timers might welcome this situation or they might see it as a challenge because they are expected to know more than they think they do. The latter was the case for the post-registration nurses in this study. Although the nurses were highly experienced they felt intimidated by the newly-qualified undergraduate nurses because their entry level education was at a higher level to the nurses. Thus educational inequality became a motive for them to also engage in higher education. A limitation in Wenger’s theory is that this sense of inadequacy and intimidation in old-timers is not reflected as Wenger only says that old timers see teaching newcomers as a challenge. Wenger (1998) downplays formal learning in favour of learning on the job but he fails to acknowledge that old-timers may be less formally educated than the newcomers. This could leave the old-timers feeling intimidated by the newcomers. The concept of generational encounters could be expanded to address this issue. The nurses in this study recognised this conflict and thus wanted to engage in higher education to relieve this sense of intimidation by gaining educational equality with the student nurses and newly-qualified nurses.

Previous studies have reported the post-registration nurses feel a sense of intimidation, loss of status and respect for their years of experience due to the arrival of more junior higher educated nurses in the clinical area (Bahn, 2007a). As a result, post-registration nurses seek out higher education programmes of study to gain educational equality with student nurses and newly-qualified nurses. According to Dowswell et al. (2000) these motives would be classified as negative professional motives because they stem from negative issues that drive the nurses to study in higher education. Wenger (1998) says that imagination can lead us to imagine a wider social world, which is disconnected from our present reality, and thus leave us unsettled.

“As a mode of belonging, imagination is therefore a delicate act of identity because…it runs the risk of losing touch with the sense of social efficacy by which our experience of the world can be interpreted as competence” (Wenger, 1998, p.178).
In essence the post-registration nurses in this study were losing touch with their sense of social efficacy and competence. Even though the post-registration nurses had a wealth of experience and years behind them, they doubted their competency to teach the student nurses and they allowed themselves to feel intimidated by the newly-qualified nurses. This fed into their identity as nurses. Wenger (1998) said that imagination also helps people see the possibilities in learning. Team and student educational equality were motives to undertake a higher educational programme for these nurses and in doing so they were able to imagine new possibilities in terms of developing their professional identity through the process of undertaking a higher education programme.

The post-registration nurses in this study appeared to find themselves in a position whereby they felt that they needed to catch up, educationally, with undergraduate nursing students who were placed on the wards with them and whom they were required to teach. This provided a motive for them to undertake a higher education programme of study. This situation can be partly explained by Wenger’s (1998) concept of continuity and discontinuity. Here Wenger (1998) suggests that newcomers are not necessarily invested in changing a practice. They are invested in continuity of the practice because it connects them to the history of the practice. They need to learn about the practice in order to fashion their identities. On the other hand, old-timers, while they have great investment in the history of the practice, are not necessarily interested in continuity. That is, as they wish to evolve the practice (discontinue old practices for new one), “they might thus welcome the new potentials afforded by new generations who are less hostage to the past” (Wenger, 1998, p.157). This resonates with the findings in this study in that the newcomers, in this case the nursing students, were not necessarily wanting to change practice; they wanted to learn about the practice in order to fashion their identities. However, the old-timers, in this case, the post-registration nurses, wanted to evolve the practice as they recognised that the standard of education required for entry to nursing had moved on and evolved thus the practice had to evolve too. Hence they welcomed the new perspectives the undergraduate nurses brought to the practice to the extent that they too wanted acquire those perspectives by undertaking a degree.
Knowledge acquisition

While educational equality was one motive for some participants, others perceived that they had knowledge deficits that led them to study in higher education in order to acquire new knowledge to underpin their practice as a nurse. Learning more about evidence-based practice was a motive for nurses. They were aware of the fact that they should be constantly updating their knowledge base for practice and basing their practice on current evidence. Some of these nurses felt out of touch with current knowledge for their practice. Other nursing studies have found that post-registration nurses want to professionally update their knowledge base (Lethbridge, 1989; Murphy, 2006) and as in this study Bahn’s (2007a) participants reported that they could not rely on old knowledge to support their practice so they wanted to learn about research and current evidence-based knowledge and skills to maintain their competence in practice. The findings in this study also concur with other studies of masters post-registration nurses who report that they want to gain new knowledge and skills for their practice with an emphasis on learning more about research and evidence-based practice. Unlike the nurses in Gould et al.’s (1999) study who primarily were interested in gaining technical knowledge and less interested in acquiring reflective practice skills, the participants in this current study appeared to be aware of the importance of gaining skills that would facilitate ongoing learning and updating of their practice. Although the nurses in this study did not emphasise reflection as one of the skills that might facilitate this, they did want to learn about research and evidence-based practice to help them to reflect on their practice in the future.

In a community of practice the members organise themselves around a particular joint enterprise which is understood and renegotiated by all the members of the community. The members of the community of practice are mutually accountable for the enterprise in that the members have a sense of responsibility towards each other and the enterprise (Wenger, 1998). In this study, these post-registration nurses felt a sense of responsibility to the enterprise as they identified that their knowledge base was lacking and they wanted to rectify this.
Nurses in this study, working in a specialist area or who wanted to move to a specialist area, reported knowledge acquisition as a motive to undertake the Higher Diploma in Nursing. In terms of knowledge acquisition this provided these nurses with specialist knowledge for their practice. Similar professional motives to engage in higher education were found by Cooley (2008). Gould et al.’s (1999) participants wanted to engage in English National Board general specialist courses so that they could gain new and enhanced expert knowledge that could be applied in their area of practice. A community of practice is an emergent structure and learning is the driver of the practice. The members negotiate meaning and introduce new elements which evolves the practice. Practice becomes the history of learning (Wenger, 1998). The nurses in this study sought to gain new knowledge or elements that could be introduced and absorbed into their practice. As such their practice becomes the history of that learning. As a mode of belonging, imagination led these nurses to see themselves as changed practitioners working as graduate nurses with an enhanced knowledge base to negotiate new meaning in the nursing community of practice.

**Career advancement**

In addition to acquisition of new knowledge as a motive for most post-registration nurses to undertake a higher education programme, nurses also perceived the need to advance in their careers which became another motive. Wenger’s (1998) concept of imagination is relevant here again when he says that it is about “transcending our time and space and creating new images of the world and ourselves” (Wenger, 1998, p.176). The participants in this study were able to look beyond their immediate work or home life to create new images of themselves in the world they lived in. They imagined that undertaking a higher education programme could mean career advancement, be it for altruist or pragmatic purposes.

The nurses imagined that their programme of study could facilitate them in providing better care for patients and making their care more patient-focused. Nurses who were studying on the Higher Diploma specialist programme imagined that it could facilitate a career change but one that maintained their clinical links rather than
propelling them into management careers. In this study these motives were seen as altruistic and positive motives to undertake a higher education programme. Wenger’s (1998) concept of an outbound trajectory is relevant here. This relates to moving out of a community of practice. This means that the identity formed in the community of practice will have to change and the identity evolves as the person develops new relationships and negotiates meaning in a new enterprise. Although these nurses were not on an outbound trajectory out of nursing altogether, they were hoping to secure a specialist post which would, as Wenger (1998) states, entail negotiating meaning in a new nursing enterprise.

Previous nursing studies have also found that post-registration nurses want to undertake higher education programmes because they want to ensure that they are giving the best care available to their patients. As Dowswell et al. (2000) pointed out, their participants wanted to do a higher education course so that they could do their jobs better. These researchers labelled this motive as a positive professional motive. Likewise, Bahn (2007a) found that the post-registration nurses in that study were cognisant of the fact that their original training was losing currency in terms of the depth of knowledge it provided for them to effectively practice in the current climate of health care. Therefore their reasons for engaging in higher education were linked to competency rather than status. The findings in this current study concur with Bahn (2007a) in that post-registration nurses wanted to use their new higher education qualification to secure promotional posts but ones that keep them at the coal face of nursing care, maintaining their clinical link with the patient. Therefore they were less interested in status and more interested in excellence in patient care. These findings appear to refute the view, observed by McNamara (2005), that the integration of nursing into higher education was a self-serving exercise with nurses being accused of taking up higher education programmes for the sole purpose of enhanced status and more pay.

Even though nurses in this study had altruistic career advancement motives for undertaking a higher education programme, they were also pragmatic in their reasons for doing so. The community psychiatric nurses, in particular, wanted to get
promoted to gain recognition for working at an advanced level. The nursing literature supports this finding in that post-registration nurses have an expectation that undertaking a higher education programme would put them in line for promotional possibilities and salary increases. Participants in Davy and Robinson’s (2002) and Stanley’s (2003) study who did a degree, anticipated better career prospects in the future. Lethbridge (1989) and Dowswell et al. (2000) both reported that participants desired to advance professionally in terms of getting a higher status in their job and Dowswell et al. (2000) classified this as a positive professional motive. High on the priority list of motives to take a higher education management course for Murphy et al.’s (2006) participants was career satisfaction and the expectation that their course would lead to a promotion. However, in Murphy et al.’s (2006) study, employers did not recognize employees’ efforts to upskill and it was the case that promotion or career advancement was unlikely. Likewise, Zuzelo (2001) found that while nurses were elated that they were undertaking a degree, this was overshadowed by the realisation that they would stay at the bottom of the credentials ladder despite many years of service.

The realisation of poor career prospects can deter post-registration nurses from engaging in higher education. In terms of motives to undertake a higher education programme of study, Davy and Robinson (2002) highlighted the problem with poor career prospects. These researchers found that 48% of the nurses who did not want to undertake a programme of study felt that way because it was unlikely to lead to an increase in pay which could only happen if they got a promotion. As suggested by Davy and Robinson (2002), a deterrent to undertaking a higher education programme is the lack of career prospects. In this current study the community psychiatric nurses were pragmatic in their motives to undertake a higher education programme in that they anticipated that they would gain recognition for working at an advanced level. One of the goals of the pre-registration nursing programme and the two post-registration programmes was to foster a life-long approach to learning (Government of Ireland, 2000; Dundalk Institute of Technology, 1998; Dundalk Institute of Technology, 2003). If these promotions were not forthcoming this could have been a deterrent to engaging in higher education in the future.
Some nurses in this study reported that they wanted to change their job but at the same level. In order to do this they would have to compete with newly-qualified nurses who had a basic education at degree level. Previous nursing studies have also found that post-registration nurses want to engage in higher education in order to secure a move to a different post but at the same level. Dowswell et al. (2000) discussed this issue in the context of competition with new higher educated graduates. They concurred with this finding and discussed it in terms of not being able to move to a similar position until one had a higher education programme completed. This was considered a negative professional motive to undertake a higher education programme. In this current study, the pressure of competing at interview with newly-qualified higher educated nurses could also be seen as a negative motive to engage in higher education.

**Morale enhancement**

In this study, the nurses wanted to undertake a higher education programme in order to address the experience of a low morale. They reported experiences of mental stagnation and burnout as a motive to undertake a higher education programme. Similar to the participants in Dowswell et al.’s (2000) study these participants perceived that they were coming to a dead end in their work life. The environment was not providing them with any new challenges so they were getting into a rut and realised that they needed to mentally challenge themselves to keep themselves interested in their jobs. Lethbridge (1989) also found that participants wanted to undertake a higher education programme to prevent a vegetative state from setting in or as they called it becoming a “cabbage” (Lethbridge, 1989, p.207). These self-deprecating descriptions of the self can be linked to nurses’ experiences of oppression and oppressed group behaviour (Freire, 1970; Roberts, 1983; Purpora et al., 2012). Post-registration nurses do experience emotional exhaustion or burnout and this has been linked to depersonalization of nurses, psychosomatic complaints and the intention to leave the profession (Jourdain et al., 2010). Furthermore, excessive workloads and lack of emotional support has been linked to emotional exhaustion and cynicism in post-registration nurses (Garcia-Izquierdo et al., 2012).
Likewise, the post-registration nurses in this study were experiencing burnout and mental stagnation in their jobs. This suggests that their workplace was no longer a stimulating environment for them. This situation became a reason for them to engage in higher education. This is contrary to results in Kovner et al.’s (2012) American study which suggested that working in a stimulating and complex environment energised nurses and influenced them to return to school. However, in this current study it was the lack of a stimulating environment and mental stimulation that influenced the nurses to engage in study again.

These motives to engage in higher education are contrary to nursing students’ reasons for entering the profession of nursing initially. Wilkes and Johnson’s (2014) student nurses reported that they chose nursing because they were excited about the prospect of nursing and they saw it as an avenue to nurture their enjoyment of interacting with others and taking care of people. The experience of mental stagnation and burnout as motives for undertaking a higher education programme cited in this current study suggest that the environment where nurses work can curb this sense of excitement for working as a nurse. The nurses in this study looked to higher education to rejuvenate that sense of excitement.

In terms of boosting morale, the nurses in this study wanted to undertake a higher education programme to satisfy a sense of personal achievement and enhance their level of confidence. They imagined that they could achieve a degree and they wanted to prove to themselves and their children that they could do it. In Zuzelo’s (2001) study participants also reported that they were wanted to engage in higher education in order to feel a sense of personal accomplishment. Likewise, at Masters level, post-registration nurses want to challenge themselves as Watkins’s (2011) personal challenge seekers reported. The personal challenge seekers were previous underachievers who wanted to achieve personal development. Dowswell et al.’s (2000) participants also wanted to make up for not engaging in higher education in the past and, like the participants in this study, they wanted to prove to themselves they could do it.
These findings relate to Wenger’s (1998) notion of participation as discontinuities. Wenger (1998) suggested that participation in a community of practice creates discontinuities in the evolution of a practice. Here he refers to how members come and go, move on to new positions or become jaded in their work. The concept of participation creating discontinuities can be related to these post-registration nurses’ motives to enhance morale. For some of the nurses in this study participation in the community of nursing practice was creating discontinuity in terms of the nurses feeling jaded in their practice. They were coming to a dead end in terms of their enthusiasm for their work. Morale was low and they needed to engage in higher education to recharge their excitement for their job and prove to themselves that they could do.

Through the achievement of educational equality, the acquisition of new knowledge, the possibility of career advancement or the enhancement of morale, the post-registration nurses in this study created new images of themselves and, according to Wenger (1998), added to the construction of their own identities. Wenger (1998) talked about the concept of identification through imagination and he said that identifying with something in a broader context takes the work of imagination. The nurses in this study identified with a different identity as a nurse. Through the process of imagination they identified with others who had studied in higher education programmes and they imagined that this would bring educational equality, knowledge acquisition, career advancement and morale enhancement. This fed into their sense of identity as nurses.

In this study the participants’ motives for engaging in higher education were influenced by contextual issues primarily within the community of practice where they worked. These contextual influences included attitudes towards higher education for nurses, resources and supports.
Influences on motives to engage in higher education

Attitudes towards higher education for nurses

The findings in this study demonstrate that higher education for nurses in Ireland was gaining ground and acceptance especially among the nursing community. This provided a backdrop and context for some of the post-registration nurses and had an influence on them in terms of their motives to participate. Wenger (1998) said that imagination is not a solitary process. It is a social process in that there is communal imagination because others are imagining the same things as ourselves. The post-registration nurses’ colleagues and the community of nursing as a whole were also imagining and accepting of nursing education at degree level. For some nurses in this study, this was viewed as a positive attitude toward higher education for nurses and influenced the post-registration nurses positively to undertake a higher education programme. However, Dowswell et al.’s (2000) termed this as a negative professional motive to engage in higher education because the profession was now placing a new expectation on post-registration nurses to participate in higher educational.

On the other hand, negative attitudes towards higher education for nurses were also noted in this study. These too provided a context for some post-registration nurses’ decisions to undertake a programme of study. The negative attitudes were related to the notion that higher education for nurses was too academic and it downplayed the highly valued practical and clinical skills dimension of nursing. The clinical aspect of nursing brings the staff nurse in close contact with the patient as opposed to management positions which steer nurses away from patient care. Fealy et al. (2007) highlighted the prominent discourses in the international medical and nursing community that reflected a general unease with the notion of academia diluting the practical aspects of nurses’ work. The results of this current study suggest that this view still exists in Irish nursing circles at least. It shows an enduring and cherished legacy of the apprenticeship model of education which emphasised the practical aspect of nursing and downplayed the academic side. Avis et al. (2002) concluded in their study that communities of practice were formed by “the material conditions and
discursive contexts in which teachers and learners are placed” (Avis et al., 2002, p.45). This suggests that the environment within a community of practice can influence how well newcomers are integrated into a community of practice. The general undercurrent or culture of unease with academia within the nursing community of practice in this study provided a backdrop to the post-registration nurses’ decisions to undertake a higher education programme.

This anti-academic attitude in the community of practice of some of these nurses did not deter them from engaging in a higher education programme. These findings are contrary to those found in Bathmaker and Avis’s (2005) study. These authors demonstrated that if the culture of the community of practice does not match trainees’ professional identities this can lead to marginalisation and alienation rather than allowing full participation in a community of practice. The identities of some of the nurses in this study were evolving in that they were pro-academia which did not match the culture in their community of practice. Yet the nurses were not marginalised to the point that they were deterred from participation in the academic community of practice. These findings also do not concur with Tame’s (2011) results where an anti-academic culture in the nursing community of practice of perioperative nurses forced the nurses to study in secret for a university degree. Fortunately, the anti-academic culture did not deter the nurses in this study from proceeding with their higher education studies.

Resources

In this study both of the programmes of study, ACCS and Higher Diploma, were fully funded by the Irish Health Department which meant that any post-registration nurse who wanted to avail of higher education programmes nationally, their fees were fully funded. This was a clear sign of encouragement for post-registration nurses to engage in higher education. This funding commitment provided a motive for all the post-registration nurses in this study to undertake a higher education programme. This support was welcomed by the nurses who reported that they would not have been financially able to undertake their programme without that support. This practical support is in stark contrast to support that post-registration nurses receive internationally where cutbacks, staff shortages, increased workloads, lack of
protected time to study were seen as deterrents to post-registration nurses’ engagement in continuing professional development (Watkins, 2011; Schweitzer and Krassa, 2010).

Internationally post-registration nurses struggled to get funding to do higher education programmes to catch up with higher educated graduates (Dowswell et al., 2000; Bahn, 2007b; Schweitzer and Krassa, 2010). Kovner et al. (2012) also concluded that the cost for nurses to get a degree was a major barrier for American nurses and to counteract this they suggested that government and philanthropist investment was needed in order to achieve the United States’ goal of 80% of the Registered Nurses having a Bachelors Degree in Nursing by the year 2020. On the other hand, as a result of the Irish Commission on Nursing in 1998 (Government of Ireland, 1998), all of the nurses in this study were working in a context in which funding was made available to all post-registration to undertake higher education programmes designed to upskill to higher education level. This finding is also reflected in Cooley’s (2008) Irish study.

The concept of reification, in the context of communities of practice, termed by Wenger (1998) is relevant here in terms of explaining this finding. Reification is:

“the process of giving form to our experience by producing objects that congeal this experience into ‘thingness’. In doing so, we create points of focus around which the negotiation of meaning becomes organized” (Wenger, 1998, p.59).

Reification then is about making real our experiences by producing objects. With regards to this finding, the Irish Health Department policy to provide funding for all post-registration nurses to engage in a higher education programme is the reification of the commitment of the Health Department to ensure that post-registration nurses had the opportunity to achieve the same level of education as the newly-qualified nurses who were required to have a degree as an entry level qualification. This reification influenced the nurses’ decision to engage in higher education.
For psychiatric community nurses in this study the potential promotional benefits of undertaking a higher education programme was a motive to engage. These nurses were already working at an advanced level in the community but they did not have the recognition for this in terms of promotions (Clinical Nurse Specialist). Undertaking the Higher Diploma put them in line for this promotion even though this was not guaranteed. Nonetheless the staff nurses wanted to do the programme in the hope of a promotion. In the nursing literature Dowswell et al.’s (2000) participants reported that they wanted to enhance promotion prospects even though it was not clear that the environment in which they worked guaranteed this. For the nurses in this study the potential to receive a promotional grade was a reification of the commitment of management to reward them for functioning at an advanced level. Thus the promise of a promotion was enough to influence these nurses’ decision to undertake the specialist Higher Diploma programme.

While the potential to achieve a promotion, and thus an increase in pay, was a deciding factor for some post-registration nurses to engage in higher education, others, primarily staff nurses working in the hospital environment, still wanted to engage even though they were certain that there would be no financial rewards for doing so. Studies have shown that this could have been a deterrent (Davy and Robinson, 2002) and it was for some of the colleagues of the participants in this study. But it can be said that the nurses in this current study were on, what Wenger (1998) describes as, an insider trajectory. This means that the formation of their identities as nurses did not end after they became full participants in the nursing community of practice. They anticipated that their identities would continue to evolve as the practice evolved due to their engagement in the higher education programme. The knowledge that undertaking a degree would not necessarily earn them any financial rewards did not deter them from this insider trajectory as the evolution of their identities was their primary goal.
Supports

Effective supports

In this study, some post-registration nurses were actively encouraged to undertake a higher education programme. One way this happened was through moral support and words of encouragement from managers and clinical colleagues. According to Wenger (1998) this is another example of reification. The managers and colleagues of these nurses were reifying the national policy to provide opportunities for post-registration nurses to engage in higher education programmes in order to upskill in line with new nursing graduates. The concrete encouragement of the nurses was the thingness that facilitated the negotiation of meaning behind the national policy. That meaning being that the profession of Irish nursing supported the notion that all nurses should be educated to the level of higher education. Within the context of some negative attitudes towards higher education for nurses this moral support was invaluable in term of helping the nurses to decide to engage in their chosen programmes of study.

In this study, another effective support was collaborative planning for higher education programmes. The managers of the community psychiatric nurses collaboratively planned courses with the nurses. Here, in addition to reifying the national policy by simply encouraging nurses to attend higher education programmes, the managers were actively participating in the endeavour to ensure that the policy became a reality. This collaboration is characteristic of a community of practice as was seen in Avis et al.’s (2002) study where lecturers and learners collaboratively worked together to resolve problems leading to a negotiated curriculum.

In terms of providing a context that helped post-registration nurses to decide to engage in higher education programmes then the community psychiatric nurses experienced, as Wenger (1998) suggested, the right balance of participation and reification from their managers. Their managers were reinforcing the meaning of the national policy to enhance the educational standard of nursing to the level of degree
by encouraging the nurses and collaboratively planning the programmes of study the nurses might engage in for the benefit of the development of the nurses’ identities and the evolution of the community of practice.

**Ineffective Supports**

While some nurses in this study experienced active encouragement and collaborative planning as supports to help them decide to undertake a higher education programme, in this study evidence suggests that other nurses, in the hospital setting, were not adequately supported in terms of encouraging them to engage in higher education programmes. The findings suggested that some were not encouraged by their managers, or there was no collaborative planning of the programmes of study. It could be construed from this that, in terms of support from managers to help nurses plan their lifelong learning in order to catch up with the all graduate trend in nursing, the nurses who were working in environments where no encouragement was offered were being discriminated against and deprived of the same opportunities as those in other working environments. It was the organisational practices or lack thereof, that determined if the nurses were encouraged or not.

This discrimination is similar to, although not the same as, that seen in Adeniran et al.’s (2013) Philadelphia study. In that study, organisational practices within the health service organisation positively influenced white United States educated nurses but deterred internationally-educated Asian nurses from engaging in higher education. The way the organisation had structured the mentorship of both sets of nurses was discriminatory on the basis of social class. As a result the Asian nurses were deterred from engaging in higher education. Although the nurses in this current study may not have been discriminated against on the basis of social class or ethnicity as in Adeniran et al.’s (2013) study, it can be said that the organisational practices favoured some nurses over others in terms of encouragement and collaborative planning to undertake a higher education programme.
The nursing literature concurs with the findings in this study suggesting that collaborative planning between management and potential higher education post-registration nursing students is essential in terms of ensuring staff choose the course that best suits the needs of the community of practice and the nurses. Through a system of staff appraisals Bahn (2007a) also found that post-registration nurses were more likely to be supported in their studies by management, e.g. approval of courses and subsequent time off to attend them.

On the other hand, a lack of encouragement and collaborative planning for post-registration nurses to engage in higher education can have an impact on the evolution of a community of practice. Avis et al. (2002) found that if learners are excluded from a community practice as active participants, then the formation of a vibrant community of practice is undercut. In this current study it is post-registration nurses that were not being supported to consider higher education as an educational base for their practice. This lack of support could have an effect on the vibrancy of the nursing community of practice.

Some of the nurses in this study were only encouraged to undertake short in-service type courses while others were encouraged to take higher education programmes but these were at odds with the interests of the nurses. Fuller et al. (2005) highlighted that Lave and Wenger’s (1991) community of practice theory was too dismissive of formal education as a source of learning. Findings from their studies indicated that novices and experienced employees also learned from in-service type courses or sessions within the workplace and outside of it. They suggested that formal learning was a form of participatory learning and can be an integral part of wider learning within a community of practice on the condition that it is seen as a legitimate activity for both newcomers and old-timers. The findings in this current study and other nursing studies resonate with this as the post-registration nurses reported that often in-service type learning was encouraged as a form of lifelong learning for post-registration nurses in the health service.
However organisational practices can overemphasise in-service type courses at the expense of underemphasising higher education programmes and it has been demonstrated that these organisational practices can serve as a deterrent to post-registration nurses to engage in higher education. This was evident in Orsolini-Hain’s (2012) study with Californian Associate Degree prepared nurses. These nurses were not interested in returning to study to obtain a Bachelors degree. There was no pay differentials or differences in term of work role between these nurses and the Bachelors degree nurses. They both did the same in-service training which provided highly relevant knowledge and skills for their practice. More importantly the organisational culture reinforced the view that there was no need to upskill to a Bachelors degree because there was the possibility for advancement without this type of formal education. Similar organisational practices were observed in the United Kingdom, where plans were considered by The Department of Health to recognise Registered Nurses’ experiences rather than supporting them to do a degree (Nursing Standard Analysis, 2009) when the UK was operationalising the call to an all-graduate profession in nursing.

Similar hospital practices were observed in this current study. While in-service training is an important means of updating staff, in this study there was an overemphasis on this type of education at the expense of a lack of encouragement of some staff nurses to undertake a higher education programme. Even when the nurses were encouraged to undertake a degree, for some nurses they were advised to do degrees that were at odds with the preferences of the post-registration nurses. These organisational practices only serve as deterrents for post-registration nurses to engage in higher education.

As Wenger (1998) suggested, some nurses in this study did not experience the right balance of participation and reification of the national policy to move to an all graduate entry level for nursing from their managers which provided a context or backdrop to the nurses’ decision to undertake a higher education programme. In this study this was classed as an ineffective support which influenced the nurses’ decision to engage in higher education. Fortunately the nurses in this study were not deterred by such organisational practices.
Challenges of undertaking a higher education programme

The two main challenges encountered by post-registration nurses while they undertook their higher education programmes were lack of time to do the academic work and issues around not feeling confident in their ability to undertake the academic work.

Lack of time to do academic work

For the participants in this study, one of their main concerns while they were undertaking their course was that they struggled to make time for their academic work while juggling full-time employment and attending to family commitments. According to the nursing literature participants in other studies discussed this in terms of juggling roles as was the case in the Irish study by McCarthy and Evans (2003) and Robinson’s (2002) United Kingdom study. Similar to other nursing studies, the nurses in this study found that they were pushed for time due to having to juggle too many roles. Dowswell et al. (2000) found that their participants’ experience of a lack of time spent with the family put a strain on relationships. Later in 2003, Stanley also found that the stress of combining work, home and study meant that participants did not have enough time for their families and partners resulting in feelings of guilt and tensions between partners. Tame (2013) also reported that the competing demands of juggling multiple roles raised perioperative nurses’ levels of stress leaving them with no time to relax or socialise. Likewise, in Dacanay et al.’s (2015) study it emerged that registered nurses, undertaking distance RN to BSN programmes, experienced role stress related to multiple role. It has already been demonstrated that nurses suffer from emotional exhaustion in the workplace (Jourdain et al., 2010; Garcia-Izquierdo et al., 2012) which has to be factored into the issue of juggling multiple roles.

Similar to this study’s findings, Webb and Kevern (2003) pointed out that mature women in higher education have to bear a double life load in order to achieve their
academic professional development goals. It appears that for the mature nurses in this current study and those cited in the literature, once they enter higher education programmes they are, as Webb and Kevern (2003) say, hijacked by the greedy institutions of home, work and college.

The idea of juggling roles is related to Wenger’s (1998) concept of identity as a nexus of multi-membership. Wenger (1998) said that our identities are constructed as a result of being a member of different communities of practice, somewhat like a jigsaw. In this study, the nurses’ identities were made up of a number of identities including staff nurse, mother, father or parent and college student. Wenger (1998) said that when moving from one community of practice to another we carry our identities across the boundaries of these communities of practice. A nurse’s identity in the home does not cease when he or she goes to work or college. Evidence in this study suggests that the nurses had to balance multiple roles and this impacted on the amount time they could dedicate to their studies.

The nurses struggled to strike a balance as a result of this nexus of multi-membership. The nurses had to work out for themselves how to cope with the time commitment that was required. However, even presented with this challenge, this study and the studies in literature demonstrate (Bahn 2007a) that post-registration nurses were up for the challenge and they were not deterred on their path to achieve higher education credentials.

**Coping with lack of time to do academic work**

Lack of time to do the academic work, while undertaking a higher education programme, became a symptom of the post-registration nurse’s multi-membership in different communities of practice. Wenger (1998) acknowledges that our identities are made up of a multi-membership of different communities of practice and he suggests that a person’s whole identity can only be realised by constantly reconciling or restoring a state of harmony by different forms of engagement or participation in
different communities of practice. While engaging in multiple communities of practice, in their quest to develop their identities, the post-registration nurses in this study devised different ways of engaging to restore a state of harmony to their identities. The nurses found ways to make time by making sacrifices, manipulating work hours and for some nurses deferring the programme of study.

Make sacrifices

Striking a balance between college, work and home commitments was a challenge for these participants. One coping strategy was to make sacrifices. Something has to give when presented with too much to do and, for the participants in this study, their focus was to make time to study. For them, they were so committed to the goal of learning that studying took priority and family and social life seemed to suffer. Similar findings were reported in Tame’s (2013) research which found that perioperative nurses, studying on a university course, had to make sacrifices which were related to having to juggle multiple roles of mother, carer, partner, nurse and student. In Glass’s (1997) study, the post-registration nurses’ shared woman’s voice said that these women, who experienced a lack of support from partners to allow them the time to do their academic work, elected to adapt the multiple roles while shouldering their usual responsibilities. However, the nurses in this current study did not seem to shoulder all their responsibilities while adopting multiple roles. On the contrary, they appeared to prioritise their responsibilities leaving some to suffer as a result, mainly family commitments.

Manipulate work hours

In this study, it was the ACCS nurses who had to manipulate their working hours in order to ensure that they could attend college. The nursing literature does not report this as a strategy to deal with limited time to attend classes or to study. However, since most of the hospital-based nurses were undertaking the ACCS programme, which did not involve a designated day off to attend classes or to study, this finding highlights the need for higher education programmes of study to include a negotiated day off for the purpose of attending college and for study. The Higher Diploma in
this study included this facility which meant that those nurses did not have to manipulate their working hours to attend class. The need to do this would have increased the stress levels of the nurses in addition to the stress they may have experienced from undertaking the course.

**Defer the course**

Some ACCS nurses had to defer their course at one time or another in order to cope with the stress of juggling roles. Bahn’s (2007b) post-registration nurses reported similar tactics of coping with the pressures of juggling roles indicating that participants were more likely to extend their course rather than leave the course altogether. In this study the evidence concurs with Bahn’s (2007a) findings in that the nurses did not leave the programmes but they deferred some modules in order to make more time to cope with the academic work.

On the other hand, the experience and stress of having to deal with juggling roles for post-registration nurses could deter them from entering higher education again as was seen in Murphy et al.’s (2006) study. The nursing literature highlights, as Davy and Robinson (2002) suggested, the need for employers to give more support to post-registration nurses in terms of helping them to cope with juggling roles while undertaking higher education programmes. In terms of college support, alternative modes of delivery of the programmes of study, such as e-learning, may have meant that the ACCS nurses did not have to make sacrifices manipulate their work hours or defer modules in their programme of study. Participants in McCarthy and Evans’s (2003) study highlighted this, calling for more e-learning teaching strategies to resolve access issues. For nurses who have many competing demands on their time an examination of the mode of delivery of higher education programmes is paramount. This issue will be discussed in more detail in the section on effective teaching strategies.
The nurses’ preoccupation with trying to get enough time to do the academic work demonstrates how the nurses felt the need to engage with the experience of higher education in order for them to learn and succeed at further developing their identities as professional nurses. This desire to engage as much as possible with the experience of higher education can be explained by Wenger's (1998) concept of Identification through engagement. This is related to formation of identity and how we identify with an enterprise through engagement in it. Wenger (1998) said that through engagement with the world or practice we figure out what to do and how to engage with others or we identify with these and that way we find out who we are. “Our enterprises and our definition of competence shape our identities through our very engagement in activities and social interactions” (Wenger, 1998, p.193). Thus our identities are developed through doing or engagement and identifying with others and activities to find out what we are competent in. In this study it is clear that the nurses endeavoured to identify with a new professional identity, that of the graduate nurse, and they realised that it was through engagement with the activities and social interactions related to that identity that they would be able to identify with it and develop competence in it. So getting time to engage with it was important to them. The ACCS nurses appeared to have less time to do this than the Higher Diploma nurses due to the fact that the ACCS nurses did not have a designated day off. Not having enough time to do the academic work was one issue the nurses had to deal with but they also reported a lack of confidence in their academic abilities.

**Lack of confidence in academic ability**

A number of students explained that they felt the return to academia difficult. They questioned their ability to stay abreast of the standard required at Higher Diploma or ACCS degree level. In particular, writing posed a challenge and contributed to a lack of confidence in their academic abilities. It has been highlighted in the nursing literature that top stressors for post-registration nurses undertaking higher education studies are ‘preparing assignments for submission’, ‘doing the course assignments’, and ‘writing an assignment to the necessary academic level’ (Evans et al., 2006). Likewise Stanley (2003) found that writing into portfolios caused stress for participants. Thus the nursing literature reiterates the findings in this study indicating
that post-registration nurses feel a degree of anxiety regarding their abilities around academic work on entry to higher education.

What the nurses were experiencing here can be related to Wenger’s (1998) concept of boundaries and boundary markers. Being a member of a community of practice involves engagement in that practice but also relations with other communities of practice. Every community of practice has a distinct enterprise which creates boundaries or discontinuities between communities of practice (Wenger, 1998). In this study, all of the post-registration nurses were members of the nursing community of practice but now they were encountering another community of practice, that of the academic world. As such this community of practice also has boundaries which have to be crossed. Wenger (1998) asserts that crossing boundaries into a different community of practice exposes a person to different enterprises, different ways of engaging in practice and a different community of practice history which creates a tension between experience and competence whereby learning is possible or even hindered. The nurses in this study were experiencing academia which they were not exposed to before. The nurses had to engage in this community of practice differently to their previous experiences in nursing education. This created a tension between their experience and sense of competence.

The academic assignment seemed to create the most tension between experience and competence for the nurses in this study. According to Wenger (1998) the boundary of a community of practice can be reified with markers of membership which signify where one community of practice ends and another one starts. Boundary markers, for example the use of jargon, can mark who is an insider or outsider and can create a subtle barrier to participation. The academic assignment could be construed as a boundary marker into the community of academia for the nurses in this study. It was the evidence or reification for the college that the nurses had reached a certain academic level of competence. For both the Higher Diploma and Access nurses this boundary marker made the nurses question their academic ability. For the nurses it marked that they were outsiders until the assignment
received a pass grade at which point it indicated that they were insiders. They were competent and confident practitioners before entering academia but the academic assignment was the boundary marker that knocked their confidence in their abilities.

Similar findings were reported in Johanson and Harding's (2013) Norwegian study. Their post-registration nurses had limited previous experience of academic writing and they associated it with personal issues like lack of confidence. They reported that there was more emphasis put on what the essay looked like, termed as ‘cracking the code’, than the content within it. Johanson and Harding’s (2013) findings questioned the usefulness of acquiring the skill of academic writing for post-registration nurses because the structure of writing in patients’ notes and clinical protocols was unrelated to the structure required for an academic essay. These authors asserted that post-registration nurses who are expert clinicians and critical thinkers may be assessed as less competent from an academic perspective purely because they lacked academic writing skills. These authors content that ‘crack the code’ of academic writing should be replaced with more relevant and engaging assessment strategies for post-registration nurses that capture critical thinking skills and deep learning. They suggest journaling, concept mapping, questioning, debate, role play and team-based teaching and assessing strategies as a means of facilitating critical thinking and promoting a culture of lifelong learning. In this current study ‘cracking the code’ of academic writing presented these very experienced and competent post-registration nurses with a challenge and knocked their confidence in their academic ability. As post-registration nurses are already time pressured with juggling multiple roles, they may spend their time sacrificing content for style of writing which is contrary to their motive for entering the course.

The nursing literature suggests ways that post-registration nurses can be facilitated to overcome the anxiety related to writing assignments in college. As a priority, it should be recognised that post-registration nurses may have been out of formal education for some time and even at that they may not have ever been required to write an academic essay. The Apprenticeship programme for example was assessed by a national exam. Thus an information management programme prior to
commencement of a programme of study like that advocated by Tarrant et al. (2008) may be beneficial. Such programmes might consist of searching and accessing literature, referencing and academic writing. The participants in this current study did have access to a foundations module in academic writing which exposed the nurses to the fundamentals of academic writing. This module occurred prior to commencement of the programmes. Since the findings in this study suggest that the nurses had ongoing difficulty with academic writing it may have been beneficial if the nurses had ongoing support and input on academic writing during the programmes. To further support post-registration nurses with academic writing Dacanay et al. (2015) suggested that more flexible deadlines for assignment submission for post-registration nurses. These suggestions would help nurses to cope with the rigours of writing academic assignments.

Unlike this current study previous nursing studies do not highlight what self-initiated coping strategies post-registration nurses use to deal with these challenges. However in this study an array of self-help coping strategies were employed by the participants.

Coping with lack of confidence in academic ability

Evidence in this study suggests that these post-registration nurses were having a crisis of confidence in their ability to succeed in their studies. But they took steps to ensure that they overcame their anxieties and fears. These steps involved getting others to read over their academic work and attending as many classes as they could.

As both the Higher Diploma and the ACCS nurses were essentially crossing boundaries between the nursing communities of practice and the academic community of practice it could be said that they were on, what Wenger (1998) terms as, a boundary trajectory. Trajectories are aspects of identity formation involving continuous movement linking the past, present and future. A boundary trajectory is
movement across community boundaries, linking communities of practice. Wenger (1998) suggests that maintaining identities across boundaries is a challenge for individuals and involves brokering. The concept of brokering is helpful here in explaining how these nurses coped with the challenge of writing assignments and academic work. A broker is a person who participates in more than one community of practice and spanning boundaries is part of their function or role (Wenger, 1998). In this case, in order to cope with a lack of confidence in their academic ability to write assignments, the nurses used brokers. Brokers were others who had spanned the boundaries of academia and nursing practice before and who had some knowledge of academic writing. The brokers read their work and guided them to achieve the academic standards required in the academic community of practice. The brokers in this case could have been other students who had gained confidence in mastering assignment writing or even colleagues at work who had undertaken a higher education programme. Regardless of who they were, they acted as brokers coordinating and aligning the different communities’ perspectives of academia and nursing as suggested by Wenger (1998). These brokers helped the nurses to cope with a lack of confidence in their academic ability.

Another strategy the post-registration nurses used to cope with a lack of confidence in their academic ability was to attend as many classes as they could. This strategy would also have allowed the nurses to have exposure to brokers such as the college lecturers. The nursing lecturers were brokers who spanned two communities of practice, that of the nursing and academic communities. The lecturer’s job was to facilitate learning, introducing elements of the academic community of practice into the nursing community of practice. However, as both of the educational programmes required learners to attend the college for all of the instruction, the post-registration nurses’ only recourse to remedy a lack of confidence in academic ability was to attend or engage with as many classes as possible. Wenger (1998) highlighted engagement as a mode of belonging which contributes to the process of identity development. Engagement is about doing, engaging with others and producing artefacts. It is through this engagement that learners identify with an enterprise and identities are shaped. As a coping mechanism, these post-registration nurses made the effort to attend as many classes as possible so that
they could engage fully with the learning opportunities that were designed to shape their identities as graduate nurses.

For the post-registration nurses in this study their lack of confidence in their academic abilities, especially in the writing tasks, pushed up stress levels. In this study evidence suggests that the post-registration nurses did take steps to minimize the experience of lacking confidence in their academic ability. Through getting others to review work or attending all the classes their confidence in their academic abilities was strengthened through the use of brokers and engagement with the academic community of practice.

**Influences on participants’ challenges and coping strategies**

**Practical college support while undertaking a higher education programme**

**Effective teaching strategies**

Post-registration nurses in this study found that teaching strategies utilised in the college positively influenced their experience in higher education. Some nurses found the approachability of lecturers and the availability of lecture notes online particularly helpful to their learning.

**Approachable lecturers**

It has been demonstrated in the nursing literature that college lecturers are pivotal in terms of support for post-registration nurses who encounter higher education. Zuzelo (2001) found that the personal attention given by faculty at the college was an important resource for students. Lecturing staff were seen as important in terms of helping students through even personal difficulties so that they could continue and complete their studies. While Bahn’s (2007b) and Cooley (2008) found varied levels
of support from college tutors, Stanley (2003) suggested that the university tutor, termed as the “tour guide”, was pivotal to the success of the traveller’s journey through academia.

In this current study, and in terms of effective teaching strategies, the post-registration nurses placed high value on the fact that the lecturers were approachable. This indicated that the lecturers were open to discuss any issues the students had. Given that the nurses were already stressed and time pressured with having to deal with multiple roles and the rigours of academia, it was crucial for them that there were no barriers to accessing the help of the academic staff. This finding concurs with Thrysoe et al.’s (2010) observations. Linking their findings to Lave and Wenger’s (1991) concept of legitimate peripheral participation, these authors found that final year nursing students in Denmark travelled on a continuum from less participative to more participative but this depended on the learning situation they found themselves in, the seasoned practitioner they were working with and their own level of engagement. One observation they made was that participation was strengthened when the student was integrated not only professionally but also socially. These and the current study findings suggest that the relationship between the teacher and the learner needs to be professional but also social which breaks down any barriers to communication in the learning situation so that learning can take place. In this study, while Wenger (1998) would describe the lecturers as brokers for the post-registration nurses as they encountered the boundaries between academic and nursing communities of practice, the social nature of that relationship had a positive influence on the nurses’ learning experience.

**Lecture notes**

Classed as an effective teaching strategy in this study, the post-registration nurses emphasised the lecture over other teaching strategies. This was observed in their satisfaction with having access to lecture notes online. Even if they could not attend classes they were comforted by the knowledge that they could access lecture notes. The lecture is a traditional teaching strategy which was heavily used in the Apprenticeship model of nurse education. Traditional pedagogies have been criticised as a means of perpetuating oppression and unequal societal power
relationships and structures (Freire, 1970; 1981; Weiler, 1988). Feminist theorists have also blamed traditional pedagogies for reproducing a society where gender determines the distribution of power and resources (Chinn, 1989; Kenway & Modra, 1992; Scering, 1997). In the 1980s there was a call for a change in nursing education to content and how nurses were taught in order address power inequalities within the health care system (Stevens & Hall, 1992). In terms of content nursing education has moved away from the overemphasis on disease or masculine knowledge (the doctor’s domain) to focus more on caring and the human health and illness experience or feminine knowledge (the nurse’s domain). However, Diekelmann (2001) asserts that nurse educators continue to teach using traditional teaching methods, namely the lecture. Likewise, at the time that the nurses in this study were experiencing the Higher Diploma and the ACCS programmes (2006-2007) the lecture was still very prominent as a teaching strategy.

The lecture has been described as a banking model of education where the student is viewed as an empty vessel to be filled and the teacher is the authority on the subject matter. The lecture prevents the student’s creativity, controls thinking and action in the learning situation and fosters dependency on authority (Chinn, 1989; Freire, 1970). This establishes an unequal relationship where the teacher has all the power and the student is silenced. The student learns submissiveness and reliance on authority for knowledge in the classroom and beyond. In nursing, traditional pedagogy, like the lecture, has been implicated for perpetuating this dynamic leading nurses to exhibit and experience oppressed group behaviours.

The post-registration nurses in this study reported that they wanted to engage in higher education because they sought educational equality, morale enhancement and the acquisition of knowledge. This evidence suggests that they were aware that they were not equal to the multidisciplinary team or even student nurses. From this evidence it could be construed that the nurses were still working in oppressive environments and they looked to higher education to correct this situation. Furthermore, the nurses emphasised knowledge acquisition over lifelong learning skills like critical thinking skills and reflection. This could also be explained by
working in environments where they relied on authority figures to provide them with information. Thus it is not surprising that the nurses in this study welcomed the lecture as a teaching strategy. It is the teaching method they were used to in their traditional nurse education but it did not serve them well in terms of empowering them as nurses within the health care system. Now in their degree programme they were encountering the lecture again, although it comforted the nurses, it potentially only served to perpetuate the power inequalities and the status quo (Freire, 1970) they may have been already experiencing in the health service.

Freire’s (1970) critical pedagogical teaching strategy is not unlike Wenger’s (1998) idea of how a community of practice member develops an identity which involves the three modes of belonging, imagination, engagement and alignment. Freire’s teaching strategy involves an initial study of the students’ social reality followed by a codification session. Here students identify key factors in their lives and then they find a symbol that represents this (imagination). Students are then asked to look at the symbol not as reality but as a problem, first as an individual problem, then as a collective problem. Then through group discussion and reflection they explore what they know about the problem and what more they want to know (engagement). Finally, once their reality is viewed from a different perspective they then develop plans to enact change in their lives (alignment).

It has been demonstrated that Freire’s critical pedagogical teaching model, as an alternative to traditional pedagogy, has the potential to facilitate consciousness raising in nursing with the view to action (Jacobs et al., 2005). Based on Freire’s critical pedagogical teaching model, the research process in Jacobs et al.’s (2005) study provided post-registration nurses with a tool to reflect on their work lives beyond the study situation. The group interaction that took place in this study increased the nurse’s awareness, promoted reflection on the status quo, and energised the nurses to come up with possible solutions to changing that status quo in their work lives. One the other hand whether these identified actions were actually implemented was beyond the scope of that study.
The feminist pedagogical approach to teaching nursing students shares Freire’s critique of the banking system in that it leads to powerlessness and passivity. But the feminist pedagogical approach focuses on the empowerment of women, enhancing awareness of and exposure of oppression within social environments including schools, home and work (Ironside, 2001; Weyenberg, 1998). Feminist pedagogy involves similar teaching methods to critical pedagogy such as active participation, collaboration, connected and relational learning, and critical thinking and praxis or action (Weyenberg, 1998). As nursing is primarily a female profession, feminist pedagogical approaches are advocated in nursing curricula and have been found to increase nursing students’ empowerment over the course of a class and that classroom empowerment is likely to extend beyond the classroom to personal and work environments (Falk-Rafael et al., 2004). But more evidence is needed to substantiate these claims. Although feminist pedagogy may have the potential to enhance critical thinking skills and some evidence suggests it can empower nurses, it has been criticised for its claim to empowering learners. The notion of the educator as the one who empowers in itself has connotations of a hierarchical unequal relationship (Weyenberg, 1998; Welch, 2011) and this is contrary to the goal of critical pedagogy. Furthermore, whether empowerment of students and personal change actually happens beyond the classroom as a result of feminist pedagogical approaches in nursing education is in question (Weyenberg, 1998).

Thus, going forward in the education of post-registration nurses, critical pedagogy and feminist pedagogical approaches would appear to be a good alternative to traditional pedagogical approaches with the view to providing nurses with lifelong learning skills and a tool to reflect on their personal and professional lives in order to enact change. In this study, the post-registration nurses wanted to engage in higher education because they sought educational equality, morale enhancement and the acquisition of knowledge. Critical and feminist pedagogies may have better served these nurses to address this issues. On the other hand, more evidence is required to support the notion that learners are actually empowered to enact change beyond the classroom. The learner may only have acquired the skills of reflection which
Clegg (1999) argues may succeed in evoking powerful emotions and may even provide for small scale resistance. But the level of empowerment may be limited to the micro level (Clegg, 1999). These approaches appear to place all the responsibility on the learner to go forth beyond the classroom situation and the assumption is that they then have the power to enact change in their personal and professional lives. This may not be a realistic expectation as they may not be able to align with the communities of practice when they return. As the literature suggests, when nurses who have had exposure to feminist pedagogies in higher education that might be the last time they would have exposure to them beyond the classroom situation (Weyenberg, 1998). This raises the question about the need for a facilitator, or as Wenger (1998) suggests, a broker, beyond the classroom to help nurses as a collective to not only reflect on nursing practice and social inequalities but also come up with solutions and act upon them with the view to making changes a reality.

**Online access**

Post-registration nurses in this study referred to the use of online materials as effective teaching strategies and these positively influenced their experience in higher education. This suggests that the extent of the use of online modes of delivering of the ACCS and Higher Diploma programmes was limited to uploading lecture notes online for retrieval by the nurses.

Online access to course material is further highlighted in the nursing literature in relation to e-learning courses. It is becoming increasingly obvious that post-registration nurses do not have the time to attend classes and e-learning courses may remedy this. As was demonstrated in the study by McCarthy and Evans (2003), nurses working in rural hospitals found it difficult to access programmes of study that were more likely to be located in the urban areas. These nurses called for e-learning courses to resolve this. This trend was further highlighted in Davy and Robinson’s (2002) study, which showed an increase in the numbers of post-registration nurses undertaking higher education programmes via e-learning. Orsolini-Hain (2012) also
concluded in their study that one strategy to encourage nurses to return higher education to undertake a degree was to provide highly relevant programmes of study and through collaboration between the academic institution and the health service organisation to bring formal education to the bedside. This accessibility to higher education can be achieved through direct contact and online learning. Therefore, this study concurs with the nursing literature in terms of the importance of providing online learning resources for busy post-registration nurses. Although in this study its use was limited, the nurses appeared to find it beneficial.

On the other hand, it has been noted that e-learning may not be for all post-registration nurses. Kovner et al.'s (2012) participants questioned the quality of online courses. In Seven et al.'s (2014) Turkish study with post-registration nurses, half of their nurses were in favour of distance education stating that it provided the opportunity for those who wanted to engage in education. About half of the nurses said they did not know about distance education and had concerns about the quality of that type of education, the cost of it and its potential to yield sufficient practical training. They felt that they would miss out on role modelling and instant feedback. Even though post-registration nurses have to juggle multiple roles and may find it hard to get time to attend college, these findings suggest that nurses may be wary of online delivery of higher education courses if they are not used in conjunction with face-to-face classes.

Learners' dissatisfaction with online courses may be associated with the student's academic ability. As was seen in Owston et al.'s (2013) study, their findings suggested that higher achievers were the most satisfied with blended learning whereas low achievers were less likely to be able to cope with blended learning modes of delivery. Although these findings do not relate to post-registration they suggest that their academic ability may have to be factored in when deciding to adopt online modes of delivery of higher education for post-registration nurses.

Another consideration in the adoption of e-learning courses for post-registration nurses is the pedagogical beliefs of the lecturers. In this current study, although the
online technology could have been used more comprehensively, the evidence suggested that the lecturers only used the online facility to upload notes for the nurses to access later. Even if the infrastructure is in place, e-learning may not be used due to the pedagogical beliefs of lectures. In this current study the lecturers appeared to fall into what Petit et al. (2012) described as the pragmatist lecturer type who sees e-learning as a means to supplement what they have already covered in class. Pragmatists believe that it is the lecturer’s responsibility to cover all the content to ensure the development of safe and competent practitioner and they do not think that students should find out information for themselves. In this current study, the lecturers delivered lectures and used the technology in an ‘online dumping’ fashion which suggests that the lecturers controlled the information rather than facilitating the nurses to discover information for themselves. As Friere (1970) suggests, these types of pedagogies and pedagogical beliefs can perpetuate oppressive structures in society.

What would have served the nurses in this current study better was what Petit et al. (2012) described as e-advocates. E-advocates see the potential in e-learning to increase interaction between the learner and the teacher. They are not proponents of the traditional lecture format. The e-advocate places emphasis on learner autonomy and self-directed learning, although they also believe that there should be some direction given regarding what information to access. The authors concluded that e-advocates see e-learning as a means to encourage autonomous practitioners to take control and responsibility for their own learning, not passive recipients of information. This belief aligns well with the purpose of moving nurse education into the higher education.

In this study effective teaching strategies had a positive influence on the experience of post-registration nurses as they engaged in higher education. The lecturers’ approachability provided them with an effective broker into the rigours of academia. The nurses welcome the lecture format and online access to lecture notes. On the other hand these pedagogical practices may have not addressed their motives for entering higher education in the first place.
Social networks

In this study post-registration nurses reported that social networks were important in terms of influencing their experience in higher education. The ACCS nurses, who did not have a clinical component to their programme, learned from other post-registration nurses, study buddies in the college. Higher Diploma nurses also learned from colleagues in the specialist placements they attended during the Higher Diploma programme. These social networks created communication channels and an avenue for sharing knowledge and learning. Similar findings have been reported by Zuzelo (2001) indicating that post-registration nurses develop important relationships with fellow students in nursing programmes in order to acquire social and academic support to facilitate their learning academically and clinically. These relationships should be fostered in any higher education nursing programme.

Wenger's (1998) discussion about negotiability through imagination is relevant here. Wenger (1998) said that we can adopt meanings through imagination through the use of stories in order to develop an identity. “Stories can transport our experience into the situations they relate and involve us in, producing the meanings of those events as though we were participants. As a result, they can be integrated into our identities and remembered as personal experience, rather than as mere reification. It is this ability to enable negotiability through imagination that makes stories, parables, and fables powerful communication devices” (Wenger, 1998, p.204). The post-registration nurses in this study learned by adopting meanings through imagination and through the exchange of stories with study buddies and specialist nurse colleagues. As negotiability through imagination is a social process (Wenger, 1998) it is important that educators, facilitating higher education for post-registration nurses, provide group activities of storytelling and sharing of experiences in order to ensure learning takes place and professional identities are shaped and developed. In this study all of the participants were experienced nurses with a wealth of experience that could be shared through the social networks they formed.
In this study, the Higher Diploma participants had the benefit of both classroom-based and work-based learning experiences. The Higher Diploma programme was a specialist nursing programme and it had a clinical component whereby the learners spent a period of time in the specialty area corresponding to their chosen programme of study. The time spent in these specialty areas was six months, six weeks of that was supervised and assessed. This component was not a feature of the general ACCS programme. Thus the Higher Diploma participants were able to engage clinically with specialist practices as part of their course. It could be said that these nurses were on two different types of trajectories during this period of six months. The first trajectory was what Wenger (1998) termed as a peripheral trajectory in their assigned specialist clinical placements. Peripheral trajectories do not lead to full participation in a community of practice but allow enough access to it to add to a person’s identity (Wenger, 1998). In the six weeks supervised aspect of the placement the Higher Diploma nurses were considered students during that time. This allowed for enough peripheral access to the specialist enterprise to add to the identity of the Higher Diploma nurses. Then, for the remaining 18 weeks clinical placement, the nurses were working in an area relevant to their specialty and here they were on an inbound trajectory. Wenger (1998) defined inbound trajectories as joining a community of practice with the intended expectation of becoming a full member in it. While their present participation might be peripheral their identities are devoted to their future full participation in the community of practice.

Both the Higher Diploma and ACCS nurses were on what Wenger (1998) termed as on insider trajectories which means that the formation of identities does not end after full participation in a community of practice is achieved. Identities continue to evolve and are renegotiated as the practice evolves. Both these groups of nurses were practising nurses undertaking a higher education programme and, as such, were full members of the nursing community of practice but their identities were evolving as a result of their learning experiences in the college and for the Higher Diploma nurses in specialist placement.
The Higher Diploma nurses in this study found that their specialist clinical experiences helped them to consolidate their learning and the preceptors and nurses in the clinical areas facilitated this learning. This was also found in Gould et al.’s (2007) study. Post-registration nurses appear to prefer eclectic modes of programme delivery. That is, theory and practice elements similar to the undergraduate nursing programmes. Gould et al. (2007) reported that participants felt that work-based learning for post-registration nurses was just as important as classroom or theory-based learning. Their participants perceived that learning on the job had the greatest impact on patient care.

The community of practice theory emphasises the importance of immersion in practice to facilitate learning. Lave and Wenger (1991) conceptualised learning, not as a discrete cognitive process divorced from its meaning in the context of the lived-in-world or practice. On the contrary, they saw learning as situated within a community of practice. Furthermore, Wenger (1998) emphasized that there was interplay between the identity of a community member and the identity of the community of practice and that the community of practice shaped the identity of the member. In this study, Higher Diploma nurses found that engagement in the clinical component of their specialist programme was an important practical support to shape their identities as specialist nurses.

Wenger’s (2000) concept of engagement, as a mode of belonging and a way to develop an identity, is again relevant here particularly in relation to the participants who undertook the Higher Diploma. Engagement is

“doing things together, talking and producing artefacts (e.g. helping a colleague with a problem or participating in a meeting). The ways in which we engage with each other and with the world profoundly shape our experience of who we are. We learn what we can do and how the world responds to our actions.” (Wenger, 2000, p.225).

Through engagement in the specialist clinical placement, the Higher Diploma nurses had the benefit of immersing themselves in the enterprise of specialist nursing thus
helping to consolidate their college learning and shape their identities as specialist nurses.

In order to facilitate the application of specialist theory to practice, further to engagement in specialist practice, the Higher Diploma nurses were assigned a preceptor whose role was to facilitate learning in the specialist clinical placement. The nurses were able to observe their preceptors at work and they found this a great support for their learning. Wenger’s (1998) concept of the broker is again useful here. The preceptor in the specialist clinical placement was a broker for the Higher Diploma nurses. As such the preceptor was able to introduce elements of specialist nursing practice to the Higher Diploma nurses’ existing knowledge base for practice. This preceptor, as suggested by Wenger (1998), participated in more than one community of practice spanning the boundaries of the specialist area but also had an academic background commensurate to the role. The preceptor’s roles was to coordinate and align the specialist community of practice and the academic community of practice for the Higher Diploma thereby facilitating a boundary encounter and the application of theory to practice.

Within the specialist community of practice, the preceptor was able to facilitate learning by making use of and exposing the post-registration nurses to what Wenger (1998) terms as boundary objects. These are “artefacts, documents, terms, concepts, and other forms of reifications around which communities of practice can organise their interconnections” (Wenger, 1998, p.105). A good example of this is the patients’ files in the specialist area. The Higher Diploma nurses would have been familiar with the artefact of a patient’s file creating the connection between their own community of practice and the specialist practice. However, the specialist practice files would refer to different data about patients.

According to Wenger (1998) a broker needs to have enough legitimacy to be able to influence development of practice. Being part of the staff in the specialist placement allowed the preceptors, assigned to the Higher Diploma nurses, enough legitimacy to
be able to influence practice. The Higher Diploma nurses had exposure to this process thus they learned how to negotiate meaning related to that particular practice.

The legitimacy of the preceptors was also strengthened by the fact that they were all educated to Higher Diploma level. Thus the post-registration nurses could see them as credible preceptors. This is unlike Stanley’s (2003) participants who were assigned preceptors who had knowledge of the clinical area but the quality of the support the participants received was varied and few preceptors were actually educated to the same level as the learners (Diploma or Degree level) themselves. This situation can have consequences, as was observed in Adeniran et al.’s (2013) study where the credibility of mentors to Associate Degree Asian nurses, already educated to Bachelors Degree level, was compromised because the mentors were also ethnically diverse and most were not in leadership positions to which the nurses could aspire to. Thus the Asian nurses were not inspired to undertake a Bachelor degrees themselves.

Previously, I referred to the need for critical and feminist pedagogies in higher education for post-registration nurses with the view to addressing their experience of inequalities in their personal and work lives. But the efficacy of these approaches to empower learners to address inequalities beyond the classroom is unclear (Weyenberg 1998). The role of the broker or the preceptor in nursing clinical placements may be useful in extending critical and feminist pedagogies beyond the classroom situation. As a given, the preceptor familiarises newcomers to the activities of a practice and should be demonstrating expert practice. But their role could be extended to facilitating newcomers to challenge unequal structures within the health service that are designed to oppress nurses. Wenger’s (1998) definition of the role of the broker is to “introduce elements of one practice into another” (Wenger, 1998, p.105). It is “a complex job of coordinating and aligning the different communities’ perspectives” (Wenger, 1998, p.109). This definition suggests that the broker’s role is to essentially orient newcomers to expert practices but Wenger does not suggest that the role involves facilitating learners to challenge the status quo or
oppressive structures in a community of practice. I suggest that the role of the broker in higher education for post-registration nurses could be extended to include facilitating post-registration nurses to challenge the status quo through the use of critical and feminist pedagogies.

This type of brokering may only be possible in post-registration nursing education if collaborative educational support systems are negotiated between higher educational institutions and their clinical partners much like the Clinical Academic Practice Partnership (CAPP) model adopted by the John Hopkins University School of Nursing in Maryland for undergraduate nursing students described by Jeffries et al. (2013). The CAPP model involved a number of roles in the clinical learning situation including the preceptor as mentor to the student, the university faculty as mentor and consultant to the preceptor, hospital coordinators and unit managers playing an active role in facilitating the learning environment for students and preceptors (Jeffries, 2013). A support structure like this for post-registration nurses and indeed undergraduate nursing students, involving all of these brokers, may facilitate the ongoing use of critical and feminist pedagogues beyond the classroom thereby helping nurses to enact change in their professional and personal lives.

The paradigmatic trajectories that the Higher Diploma nurses were exposed to had a positive influence on their experience of learning in higher education. Wenger’s (1998) concept of paradigmatic trajectories suggests that coming in contact with visible models of career pathways, provided by a community of practice, influences a newcomer in a positive way to learn how to become a full member of a community of practice. However, he does not allude to negative consequences of how paradigmatic trajectories might turn newcomers off such trajectories. Hill and Vaughan’s (2013) study identified female medical students' experiences of a surgery rotation which was mostly modelled by men. The female medical students were considered as “other” in their surgery rotation. Thus they were marginalised in terms experiences of participation and they could not imagine a future for themselves as successful female surgeons. Based on the paradigmatic trajectories constructed from their exposure to the surgical rotation, the female medical students opted out of
careers in surgery. Thus Hill and Vaughan’s (2013) concluded that the concept of paradigmatic trajectory could be extended to explain not only positive learning experiences of participation but also as a deterrent to career choices. In this current study, the post-registration Higher Diploma nurses were exposed to preceptors and other nurses in the specialty areas. Contrary to Hill and Vaughan’s (2013) findings, these formed positive models of paradigmatic trajectories of careers in specialist practice. As Wenger suggested these models influenced the post-registration nurses in a positive way to learn how to become a full member of that community of practice.

A competency that a community of practice member must have is being able to negotiate and use the repertoire of a community of practice. The repertoire is “words, artefacts, gestures and routines …recognizable in their relation to the history of mutual engagement” (Wenger, 1998, p.83). In this study the Higher Diploma nurses had exposure to the repertoire of specialist placements and together with the preceptor (broker) they had the opportunity to use the repertoire relevant to the specialty area. In doing this they were gaining familiarity and competence in negotiating the words, artefacts and routines related to a particular specialty. Negotiability of the repertoire is “the ability to make use of the repertoire of the practice to engage in it. This requires enough participation (personal and vicarious) in the history of the practice to recognize it in the elements of its repertoire” (Wenger, 1998, p.83). The Higher Diploma nurses had six weeks’ exposure to the repertoire in their chosen specialty area which allowed enough time for the participants to negotiate the repertoire. On the other hand, it is interesting to note that Wenger (1998) states that competency can also be achieved by negotiating a repertoire vicariously. In terms of the ACCS nurses in this study, who did not have the added advantage of a clinical component, negotiating the repertoire of a community of nursing practice relevant to their programme of study had to be done vicariously within the classroom through lectures and discussions if used as teaching strategies.
When both the Higher Diploma and ACCS nurses in this study returned to their workplaces they may have wanted to implement the learning they had gained in their chosen programme of study. As Wenger (1998) argues, experience can drive competence. That is, if a community member has an experience (for example did a degree and acquired new knowledge or clinical experience) which falls outside of the regime of competence of a community of practice they may want to change the community’s regime of competence so that it includes their experience. To do this they would have to negotiate that experience’s meaning with the community of practice members and have enough legitimacy to be taken seriously (Wenger, 1998). It could be assumed that the Higher Diploma nurses may have been more capable of and had more legitimacy than the ACCS nurses to negotiate the repertoire anew in their place of the work as they had the added advantage of placement and a preceptor (broker) to demonstrate how this could be done.

The idea of implementation of learning in practice is associated with what Wenger (1998) terms as alignment. According to the community of practice theory a mode of belonging and mechanism for developing an identity is alignment. Alignment is “making sure that our local activities are sufficiently aligned with other processes so that they can be effective beyond our own engagement” (Wenger, 2000, p.225). We might engage with our community of practice and imagine about a broader enterprise or community without alignment or wanting to align with that broader enterprise (Wenger, 1998). Thus effective alignment means putting what we learn into practice. In this study, as the Higher Diploma nurses had the opportunity to engage in specialist clinical placements as part of their programme of study, they had the opportunity to align what they had learned in college with practice in placement. The ACCS nurses did not have the same opportunity while they were in college. What happened after the nurses undertook their higher education programme in terms of alignment and implementation of learning beyond their experience in Higher Education is beyond the scope of this study. However, this issue would be an important consideration for future research.
The educational design that the Higher Diploma nurses experienced reflects Wenger's (1998) educational design which highlights that an educational curriculum should be designed with the development of the learner's identity in mind. This education should incorporate the three modes of belonging: engagement, imagination, and alignment. In addition to traditional educational experiences a curriculum design should provide the learner with opportunities for engagement in a community of practice where they can contribute to an enterprise and engage with others around that enterprise. In this study, in addition to theoretical input, the Higher Diploma nurses were able to engage actively in the community of practice, relevant to their study specialty area, thus providing opportunity for the learners to develop the identity of members of that community. In this study, the Higher Diploma nurses reported that they were able to consolidate their learning as result of engaging in specialty clinical placements.

The educational design of the Higher Diploma also allowed the nurses to engage in imagination. Wenger (1998) said that it was not enough to provide opportunities of engagement thus building learners’ capabilities, but they also need to have a sense of possible paradigmatic trajectories within the various communities. In order to achieve this the educational design must build in imagination. Thus the learner can explore who they are and who they could be. Strategies to achieve imagination include orientation, reflection and exploration. Learners should be oriented to a community of practice by providing a panoramic view of it and all the possible paradigmatic trajectories. The Higher Diploma nurses in this study had a good opportunity to orient themselves to the possible paradigmatic trajectories within the specialty placements. They were exposed to the preceptor and other nurses in specialty areas who represented that specialty career trajectory and how a practitioner functioned in that speciality. Through imagination the Higher Diploma nurses were able orient themselves to that paradigmatic trajectory and explore and experiment with new practices relevant to that specialty. According to the learning outcomes of both the ACCS and Higher Diploma programmes an emphasis was placed on critical thinking and reflection (Dundalk Institute of Technology, 1998; Dundalk Institute of Technology, 2003). In terms of curriculum design, therefore, both
programmes advocated imagination through reflection where the learners could distance themselves from what is obvious to look at it in a new way.

Educational alignment requires that learners not only engage and get a panoramic imagination of a community of practice but learners then must have first-hand experience of what it takes to contribute to an enterprise. They must figure out what the demands of participation are in a community of practice and how they can effect that practice (Wenger, 1998). Here it is suggested that the learner, while still on the periphery but approaching full participation in a community of practice, feels what it is like to be a full member of that practice understanding all the nuances and responsibilities and accountabilities of what it is to be a full member. In this study the Higher Diploma nurses had first-hand experience of aligning their learning or theory to practice while still on the periphery and under the supervision of the preceptor. In fact, within the specialty area these nurses were assessed on the competency of alignment by the preceptor who was officially called a clinical assessor (Dundalk Institute of Technology, 2003). The ACCS programme nurses did not have the opportunity to actually align learning to practice within that Higher Education programme of study, however they were expected to demonstrate alignment through reflection and critical thinking in assignment writing. There was an assumption that the ACCS programme nurses would be able to align their learning with practice in their workplace. Whether this happened or not was beyond the scope of this study but further research could explore this.

The Higher Diploma nurses’ experience of the six weeks supervised clinical experience can be likened to Wenger’s (1998) concept of legitimate peripheral participation. The idea behind this placement component was to allow them to participate in the specialist clinical placements commensurate to their chosen specialty programme so that they could consolidate the learning that they received in classes. Newcomers need to be granted sufficient legitimacy to be treated as a potential community member (Wenger, 1998). The designated clinical placements in the Higher Diploma programme were negotiated through a memorandum of understanding with the health service providers and this gave Higher Diploma nurses
enough legitimacy to be accepted as students in those clinical placements. This legitimacy provided the opportunity for the post-registration nurses to be considered learners as they negotiated the meaning of the specialist community of practice.

In addition to legitimacy, the Higher Diploma nurses’ experience in the speciality placements involved what Wenger (1998) called peripherality. Peripherality refers to the opportunity for a newcomer to have exposure to a practice but not fully participating in it. This can be achieved in different ways such as being supervised or given lessoned responsibility (Wenger, 1998). In this study the Higher Diploma nurses enjoyed six weeks of placement where they worked alongside a preceptor who supervised their work. This peripherality gave them the space to gradually learn and form an identity related to that speciality area. Wenger (1998) stated that a newcomer does not stay on the periphery indefinitely however. There is progression to full participation by virtue of the newcomer taking on more and more responsibility and accountability for actions, the tasks becoming more difficult and complex. At the same time the newcomer is progressively adopting the identity of a master practitioner (Lave and Wenger, 1991). In the Higher Diploma Programme the post-registration nurses continued to work with a preceptor to the point that they no longer needed supervision and from there they continued to practice in a specialty area for a further 18 weeks unsupervised. Thus by the time they had completed the entire clinical component they could work independently in that specialty area.

In order for the Higher Diploma nurses in this study to learn and form identities in their respective specialty placements it was not enough for them to just observe a preceptor at work, they had to participate in the work. During the supervised part of their placement Wenger would call their participation ‘non-participation’ because they were on the periphery and supervised (Wenger, 1998). Wenger (1998) says that for a learner to be on the periphery, and thus non-participation, this provides an opportunity to learn as the non-participant. The learner observes a community member performing a skill before having to undertake the skill. But this is only in the case of a learner who is on an inbound trajectory towards full participation in a practice which was the case with the Higher Diploma nurses.
On the other hand, Wenger (1998) makes a distinction between the concept of peripherality and marginality with regards to non-participation. Where non-participation involves marginality the learner is kept in the margins of a community of practice preventing the learner from becoming a member of the community of practice. Reasons for this marginalisation may be because of deep-seated practices within the community of practice that the new learner is not privy to preventing a trajectory to full participation. In this study, there was no evidence to suggest the Higher Diploma nurses were marginalised as they practiced in the specialty placements as they referred to the placements in a positive light indicating that their learning was consolidated there.

**Practical clinical supports while undertaking a higher education programme**

**Resources**

With the introduction of an all-graduate profession in Irish nursing this created what Wenger (1998) termed as a destabilizing event in the community of nursing practice. Destabilizing events can cause a disruption to the stability of a community of practice. However, Wenger (1998) argues that “communities of practice reorganize their histories around them, developing specific responses to them that honour the continuity of their learning” (Wenger, 1998, p.98). For the post-registration nurses in this study, one response by the nursing community of nursing practice to the introduction of an all-graduate profession, the destabilizing event, was to provide resources for post-registration nurses to engage in higher education learning as well as the undergraduate nursing students. Clinical resources were found to be important practical supports to learning for the post-registration nurses while undertaking a higher education programme. In this study, evidence suggests that post-registration nurses relied on practical clinical support in the form of resources from their managers and staff nurse colleagues in order to continue with their studies in a higher education programme. Most nurses experienced the resource of a scheduled day off to attend classes in the college an important practical clinical support to allow them to continue in college. This finding concurs with Kovner et al.’s
(2012) findings that working in environments with flexible shift work patterns were predictors of enrolment on an additional degree (Bachelors or Masters). For the Higher Diploma nurses days off to attend classes was a given.

On the other hand, the ACCS programme nurses did not have this negotiated day off. While some were able to negotiate a day off with their managers, others accessed this resource by swapping days off with colleagues or their colleagues covered their work while they were in college. Wenger (1998) suggested that the enterprise of a community of practice is essentially indigenous. Although the community of practice develops within a larger context, which imposes constraints and conditions on the community of practice, the participants respond with certain inventiveness in order to negotiate the enterprise within these constraints and conditions. For the Higher Diploma nurses in this study their practice areas were able to respond to the call for an all-graduate profession by dealing with the constraints on health care budgets and resources in an inventive way in order to provide the negotiated day off to ensure that the nurses could fully avail of their higher education programme. Some of the ACCS nurses were able to negotiate with their community of practice to get the day off they needed to continue with their studies.

On the other hand, some ACCS nurses were unable to negotiate the days off they needed to attend college. Thus Wenger’s (1998) assertion that the participants in a community of practice will respond successfully with inventiveness in order to negotiate the enterprise within constraints and conditions from outside is not always the case. On the contrary some hospital-based ACCS nurses in this study did not experience practical clinical support, thus they experienced a lack of resources. They reported that managers were not able to schedule time off for them to attend classes and some of their colleagues were less than helpful in terms of facilitating them to swap days off with them. The inability to get study leave to attend higher education programmes was also a common theme in the Irish and British nursing literature (Dowswell, 2000; Davy and Robinson, 2002; McCarthy and Evans, 2003; Murphy et al., 2006; Bahn, 2007b and Cooley, 2008). Furthermore, as was noted in
McCarthy and Evans’s (2003) study, the number of nurses who wanted to avail of the opportunity to undertake a degree in nursing was too great to allow for all to have study days to attend.

Lack of resources in terms of staff shortages to cover participants’ work while they attended college influenced the managers’ ability to give the nurses in this study the time off to attend class. This was a common reason for inability to attend classes mainly for hospital-based nurses. Similarly, in Ireland and England, McCarthy and Evans (2003) and Dowswell (2000) demonstrated that nurse managers who were unable to provide practical support to post-registration nurses to do a degree were branded as unsupportive and viewed as not encouraging of nurses to study. Evidence suggests that poor work conditions, lack of resources and management support affects a community of practice leading to burnout, low morale and a loss of commitment to students. This means that newcomers to a community of practice can be marginalised (Bathmaker and Avis, 2005). These findings resonate with this current study which highlights that the lack of clinical resources marginalised some of the ACCS nurses, leading to their inability to engage fully in the academic community of practice.

In a community of practice participation and the negotiation of meaning is not always about equality. Community members need to negotiate meaning even in relationships that are unequal through participation. Participation is not always about collaboration; it can be conflictual or competitive (Wenger, 1998). Fuller et al. (2005) suggested that Lave and Wenger (1991) had not fully investigated the importance of conflict and unequal power within an organisation and its impact on the community of practice and the wider context. From their case studies, Fuller et al. (2005) found that power was an importance factor in relation to opportunities or barriers to learning for study participants. Control and the organisation of work can affect learners’ opportunities to learn. “Those with control over such resources can exert their power to create or remove barriers and boundaries which facilitate or inhibit participation” (Fuller et al., 2005, p.66). In this study there was an unequal power relationship between the ACCS post-registration nurses and management in that
management had the power to control the resources to allow the nurses to participate in higher education learning. Some nurses were able to negotiate that collaboration, others were not. However, managers’ hands were tied in terms of resources to cope with the large number of post-registration nurses who were now wanting to avail of higher education in Ireland. This led to unrealistic demands for time off to attend college while still maintaining safe staffing levels to care for patients.

It’s clear from the literature that finding someone to blame for lack of clinical practical support is common. As was seen in Bahn’s (2007b) study, post-registration nurses themselves were criticised for not being assertive enough to demand the time they needed to do the necessary higher education upgrading in order to maintain their competence as registered nurses. But this assumption does not take into account the unequal power structures that prohibit nurses from demanding such support.

Wenger (1998) makes some reference to power when he suggests that some aspects related to the concept of stability can affect the evolution of a community of practice. While, for example, policies and procedures can maintain consistency, powerful people can create stability that discourages negotiations of meaning and these people can stop progress. Gould et al.’s (2007) British study results reflects this idea of powerful people stopping progress. The nurses in that study alluded to unsavoury practices in United Kingdom Trusts such as luring nurses into employment with the promise of Continuing Professional Development opportunities which did not materialise. Once employed there was not enough staff available to cover for nurses to undertake professional development. Thus these managers had the power to stop progress in that practice. Likewise in this study, some of the ACCS nurses experienced this power and control that managers have over resources that influenced their ability to engage in their programme of study, essentially marginalising them and potentially stopping progress.

Lack of resources is also at the root of this issue and it provides a context that influenced post-registration nurses’ ability to cope with the challenges of undertaking a higher education programme. Policy makers need to consider the resource
implications of developing a national policy to educate a large group of registered nurses. While the provision of funding for a nurse to pay for fees is admirable, policy makers need to go one step further and consider how the nurse will be able to participate on the higher education programme of study while maintaining staffing levels in health care facilities. Future programmes of study in higher education might consider building in a memorandum of understanding with Local Health Authorities so that staff attending the programmes would have designated time off to attend. This suggestion is supported by Kovner et al. (2012) who advocated that to make it easier for American Associate Degree nurses to return to higher education there was a need for more academic – clinical partnerships where both sides were supporting the nurses through, for example, offering credit for prior learning to make the programmes shorter and negotiating funding and scheduled time off to make it possible for the nurses to attend classes.

Moral support

In this study, another valuable resource for nurses while they were studying in a higher education programme was the moral support they received from their managers and staff nurse colleagues. Moral or emotional support is highlighted in the literature as an important resource for post-registration nurses while they are undertaking higher education programmes. The literature acknowledges the need for post-registration nurses to get this type of support from family members and colleagues alike. This support helps nurses to navigate their way through the trials of undertaking their programme of study (Cooley, 2008; McCarthy and Evans, 2003).

Both Higher Diploma and ACCS post-registration nurses in this study reported that moral support from colleagues was just as important as practical support, especially in the clinical area, in order to cope with the challenges they faced while undertaking a higher education programme. Moral support was encouraging and spurred the participants on even in times when they doubted themselves. In this study evidence suggests that the nurses had some self-doubts about their academic abilities. Thus for these nurses it was important that they got this moral support from their managers and work colleagues to dispel any doubts they had about their ability to succeed in Higher Education.
Moral support, as a clinical practical support offered to the post–registration nurses while undertaking a higher education programme can be related to Wenger’s (2006) definition of a community of practice. He defined a community of practice 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” (Wenger, 2006). The nurses in this study were working with other nurses and they shared the concern of caring for patients. Wenger (1998) suggested that knowledge can be developed in a community of practice when the social community is driven by their common interest. When communities of practice interact with other communities of practice this is when innovation happens (Wenger, 1998). The post-registration nurses in this study undertook a higher education programme, interacting with the academic community of practice in order to develop their knowledge base for the benefit of their practice. They had identified gaps in their knowledge base and were reaching out to discover new developments that could be used and implemented in their own community of practice. The colleagues of the post-registration nurses in this study offered them moral support so that they could pursue their studies for their own good and the good of the community of practice.

According to Wenger (1998) accountability to a joint enterprise is a competency a member is required to have in order to be a member of a Community of Practice. Accountability to the joint enterprise is “the ability to understand the enterprise of a community of practice deeply enough to take some responsibility for it and contribute to its pursuit and to its on-going negotiation by the community” (Wenger, 1998, p.137). People in a practice are responsible to each other to share information and help each other for the good of the enterprise (Lave and Wenger, 1991). The nurses in this study worked with other nurses who had a responsibility to ensure that the practice developed and thrived. They could achieve this goal by facilitating these post-registration nurses in their endeavour to learn and implement that learning for the benefit of patients. Thus those who were providing practical clinical supports were helping to negotiate meaning in the community practice and those who were unable to facilitate practical supports were not. As all nurses are responsible for their practice it is the responsibility of the whole community to facilitate any member to engage in education for the good of the practice. This is what was seen in this
study in terms of moral support for the post-registration nurses. Nurses helping other nurses to realise their goal of gaining a higher level of education in order to enhance the practice of nursing.

The level of practical or moral support that the post-registration nurses received from their respective communities of practice in order to proceed with their studies can be related to Wenger’s (1998) concepts of continuities and discontinuities. Continuity means that while a community of practice is always reinventing itself, it stays the same community of practice. However, discontinuity means that as change is inevitable, the members of the community must renegotiate their mutual relationships and how they participate in order to accommodate the requirement for change. In this study, the post-registration nurses were working in a health care service that was experiencing change in terms of the educational preparation of the nursing workforce. Nursing students and new nursing graduates were infiltrating the health service with a Higher Education knowledge base. This new entry level qualification was expected to make a change to the level of care patients received (discontinuity) yet the community of nursing practice remained a unique enterprise recognisable as nursing (continuity). The post-registration nurses in this study needed to renegotiate their mutual relationships in order to make the changes necessary (discontinuity). The first step to doing that was to undertake a higher education programme themselves.

On the other hand, Wenger (1998) points out that people and their identities are so heavily invested in the history of a practice that it is difficult to become a different person (discontinuity) within the same community of practice (continuity). This transformation requires the support of the members of a community of practice. The post-registered nurses in this study, in their endeavour to undertake a higher education programme, needed the support of the nursing community of practice. Although most of the nurses experienced the moral support they needed while they were undertaking their programmes of study, there was mixed practical support for these nurses from the clinical areas where they worked. This had an influence on
their experiences as they tried to cope with undertaking a higher education programme.

**Summary of chapter**

In this chapter I have discussed the findings from the study. The findings gave an account of a group of Irish post-registration nurses’ experiences of higher education nursing programmes in terms of influences on their motives to engage and their participation in such programmes. Previous nursing studies, literature on oppression, critical pedagogy and a selection of concepts from the social learning theory communities of practice have been useful in explaining most of the study findings. The common thread between the nurses’ motives to engage and their experiences during their time in a higher education programme was the nursing community of practice where they worked. The concept of the community of practice was particularly helpful in demonstrating that the nursing community of practice influenced the nurses’ motives to engage in higher education and their experiences during their engagement in the higher education nursing programmes. Further to this the academic community of practice influenced the nurses’ experiences while they undertook a higher education programme.

The post-registration nurses’ motives to engage in higher education included educational equality, knowledge acquisition, career advancement and morale enhancement. The concepts of imagination and discontinuities were supported by these findings and were helpful in explaining these motives as the nurses imagined the possibilities of engaging in higher education. On the other hand, I argued that the concept of generational encounters could be expanded to reflect the consequences of old-timers having lower educational qualifications to newcomers.

The post-registration nurses’ motives to engage in higher education were influenced by the nursing community of practice in terms of attitudes towards higher education
for nurses, available resources and supports. The concepts of imagination and reification were useful in explaining these findings.

The two main challenges for post-registration nurse while undertaking a higher education programme were a lack of time to do the academic work and a lack of confidence in their ability to do it. The concept of a nexus of multi-membership in different communities of practice, restoring one’s identity to a state of balance and identification through engagement were useful concepts to explain how the nurses coped with a lack of time while juggling multiple roles. Writing assignments was the boundary marker that affected the nurses’ confidence in their academic abilities but the nurses coped through the use of various brokers and consistent engagement in the academic community of practice.

As the post-registration nurses endeavoured to cope with the challenges of undertaking a degree, practical supports within the academic and nursing communities of practice influenced these experiences. The practical college supports included effective teaching strategies and social networks. I drew on the concept of the broker and modes of belonging to discuss how approachable lecturers and lecture notes influenced their experiences. But the communities of practice theory was less helpful in my discussion about online access as an effective teaching strategy.

All the nurses drew on social networks like study buddies that created communication channels to share knowledge. But the Higher Diploma nurses had an additional enriching social networks experience in their specialist clinical placements. While the concept of negotiability through imagination was useful in discussing the ACCS nurses’ experiences of social networks, the Higher Diploma nurses’ experiences provided rich data to support a number of community of practice concepts including trajectories, imagination, engagement, alignment, legitimate peripheral participation, legitimacy of brokers and boundary object.
Post-registration nurses’ participation in a higher education programme were influenced by practical clinical supports, namely resources and moral support. Most nurses experienced moral support but the availability of resources in terms of days off to attend college was varied for some nurses. A number of concepts from the community of practice theory were useful in discussing the level of support these nurses received particularly destabilizing events, community of practice as an indigenous enterprise, stability and power, accountability to a joint enterprise, continuities and discontinuities and the definition of a community of practice.

The next chapter presents the conclusions and implications drawn from the findings in this study.
Chapter Eight: Conclusions and Implications

Introduction
In this chapter final conclusions drawn from the findings in this study are presented. The conclusions which highlight the contribution the community of practice theory made to explain the findings and concepts from the theory that could be expanded upon are emphasised. The strengths and limitations of the study are outlined followed by the implications of the findings for nursing education, practice, policy makers and research.

Conclusions
Seventeen post-registration nurses in the North East of Ireland took part in a descriptive phenomenological study which explored their experiences of undertaking a higher education programme in terms of the influences on their motives to engage and their participation in such programmes. One-to-one interviews were conducted with the nurses who were studying on one of two higher education nursing programmes, an ACCS General Degree or a Higher Diploma Specialist programme commensurate to their particular speciality. A further nine nurses took part in two focus group interviews for the purpose of triangulation of the data.

The reported motives for engaging in a higher education programme in this study included: educational equality, knowledge acquisition, career advancement and morale enhancement. These motives were influenced by attitudes towards higher education for nurses, resources and supports within the nursing community of practice. Post-registration nurses experienced two challenges while they were studying in a higher education programme: lack of time to do the academic work and lack of confidence in their academic ability. Influences on these challenges included practical college supports within the academic community of practice, practical clinical supports and barriers to practical clinical supports within the nursing community of practice.
Motives to engage in higher education

Evidence suggests that post-registration nurses are highly motivated to study in higher education in order to attain educational equality with other members of the multidisciplinary team and with student nurses studying in higher education. Through the process of imagination (Wenger, 1998) nurses strive to enhance their identities within the profession of nursing. Post-registration nurses, cognisant of the unique contribution they bring to the care of patients, are motivated to ensure that they earn professional respect from other members of the multidisciplinary team by bridging the educational entry level gap between them (Treacy and Hyde, 2003; Murphy et al., 2006). Regardless of years of experience, the professional identity of the post-registration nurses is under threat by the advent of the entry level degree in nursing. Post-registration nurses feel intimidated by student nurses and newly-qualified nurses because they know they have a responsibility to mentor them at a higher level. Thus through the process of imagination, post-registration nurses see the possibilities in higher education in terms of developing their professional identity in order to resolve this unease in their sense of identity.

While Wenger (1998) downplays formal learning in favour of learning on the job, I argue that he fails to acknowledge that old-timers may be less formally educated than newcomers. This situation could lead to feelings of intimidation for old-timers as they encounter newcomers in the community of practice. Thus the concept of generational encounters could be expanded to address this issue.

The acquisition of new knowledge is also a motive for post-registration nurses to engage in higher education for application in their practice. They are aware that they need to base their practice on sound evidence and that they will learn how to achieve this by studying in higher education. Post-registration nurses who are working in specialist areas of practice want to learn specialist knowledge to support that practice. These findings are supported by the nursing literature.

Through the process of imagination post-registration nurses see the possibilities in higher education to advance their careers. Career advancement can be for either
altruistic or pragmatic motives. Nurses who have altruistic motives for undertaking a higher education programme want to get a promotion for the purpose of maintaining clinical links with patients and to give better nursing care to patients. However, post-registration nurses are also pragmatic in their motives for undertaking a higher education programme in that they want to gain recognition for already working at an advanced level or they need to compete with newly-qualified nurses at interview for posts at the same level. If career advancement does not materialise for post-registration nurses this may deter them from engaging in higher education again or in future lifelong learning in general.

Post-registration nurses report experiencing burnout or mental stagnation in their workplace. This becomes a motive to engage in higher education which suggests that for some nurses, the nursing community of practice is not stimulating enough and they become jaded. This situation is supported by the concept of discontinuities (Wenger, 1998).

The concept of imagination as a mode of belonging has been useful in explaining post-registration nurses’ motives to engage in higher education nursing programmes. Identification through imagination (Wenger, 1998) explains nurses’ efforts to identify with others who have studied in higher education thereby creating new images of the self and accordingly adding to the development of their own identities.

Influences on post-registration nurses’ motives to engage in higher education
Post-registration nurses engage in higher education programmes amid both positive and negative attitudes towards higher education for nurses. Nurses are influenced by the attitude that higher education for nurses is becoming common place. On the other hand, they are aware of negative attitudes that criticise higher education for being too academic and for steering the nurse award from the patient. In a highly-valued practical-based profession, higher education programmes that are purely academic in nature might be criticised for their lack of clinical components. This
feeds into an enduring discourse that academia dilutes the practical aspects of nurses’ work (Fealy et al., 2007).

The availability of funding to pay for college fees has a positive influence on post-registration nurses’ motives to engage in higher education programmes. Funding reifies (Wenger, 1998) the Health Service Authorities’ commitment to the policy initiative to provide higher education for post-registration nurses. The potential for promotional grades for nurses is also a reification of managements’ commitment to reward nurses for working at an advanced level. On the other hand, evidence in this study suggests that the lack of potential promotional grades for nurses did not deter them from engaging in higher education. Post-registration nurses require managerial moral support and collaborative planning for higher education programmes of study, between nurses and managers, to provide a positive influence on their motives to engage in higher education.

These findings support Wenger’s (1998) concept of reification and it has been useful in explaining the types of support within the nursing community of practice that influence post-registration motives to engage in higher education. Effective supports represent the right balance between participation and reification (Wenger, 1998) of policy initiatives to move nursing education into higher education. On the other hand, ineffective supports that reflect no moral support, no collaborative planning, only encouraging short courses and higher education courses that are at odds with the nurses interests, are examples of an imbalance between participation and reification in terms of management commitment to such policy initiatives. Higher education programmes that are collaboratively planned are more likely to be supported by management after post-registration nurses begin a programme of study. The right balance between participation and reification by management of the policy is required to ensure nurses are supported to engage in higher education.

Most of the nurses in this study experienced positive attitudes toward higher education for nurses within the nursing community of practice. I have argued that
this supports Wenger’s (1998) concept of communal imagination and it had a positive influence on their decision to participate. On the other hand, when post-registration nurses’ pro-academic attitudes towards higher education for nurses did not match the community of practice attitudes, the nurses were not deterred or marginalised as previous studies have indicated (Tame, 2011; Bathmaker and Avis, 2005).

**Experiences while undertaking a higher education programme**
Post-registration nurses are challenged by a lack of time to do the academic work involved in undertaking a higher education programme. Lack of time is a symptom of juggling work, home and college life roles. To develop a whole identity, post-registration nurses have to reconcile a nexus of multi-membership of a number of communities of practice (Wenger, 1998). To do this they developed coping strategies.

Post-registration nurses do not tend to shoulder all the responsibilities of all the multiple roles they juggle as suggested by Glass (1997). Instead they tend to sacrifice spending time with family and friends while prioritising academic work.

Another coping strategy used by post-registration nurses to deal with not having enough time to do academic work is manipulating work hours. The lack of a negotiated day off to attend higher education programmes necessitates this coping strategy. Having to manipulate work hours means that post-registration nurses have to work more hours in the day, they use up their annual leave or they need to cut their hours which incurs a cut in pay. This finding contributes to the nursing literature as other studies do not refer to this as a coping strategy.

Post-registration nurses also cope with lack of time to do the academic work by extending their programme of study rather than stopping it, a finding that was also cited in the literature. This finding demonstrated the commitment nurses have to higher education for nurses.

Post-registration nurses implement coping strategies to deal with a lack of time to do the academic work required in a higher education programme. I argue that the concept of identification through engagement explained the nurses’ commitment to finding the time to develop a new professional identity, that of the graduate nurse.
Post-registration nurses also experience a lack of confidence in their ability to do the academic work when they engage in higher education. Writing poses a particular challenge for those who have been out of academia for a considerable time. This finding concurs with the nursing literature, but previous studies do not offer coping strategies that post-registration nurses use to deal with this challenge. I have described the academic assignment as a boundary marker between the academic and nursing communities of practice and this marker influenced the nurses’ confidence levels. The concept of the broker was also useful in explaining how the nurses dealt with the task of academic writing. Evidence in this study suggests that post-registration nurses get others to read over their academic work and they attend all the classes on offer in order to cope with a lack of confidence in their academic ability. The use of brokers and engagement in the academic community of practice were important coping strategies that the nurses used to restore their confidence.

**Influences on experiences while undertaking a higher education programme.**
The challenges faced by post-registration nurses while undertaking a higher education programme can be positively influenced by practical college supports. I argue that lecturers or brokers who are approachable provide a professional but also a social dimension to the teacher-learner relationship that breaks down barriers enhancing the learning experience. Access to lecture notes online positively influenced the nurses’ experiences. But I argue that the lecture, a traditional pedagogical teaching strategy, and the use of e-learning resources as an online banking system can lead to dependency and the perpetuation of nurses’ inability to challenge societal inequalities beyond the classroom. I also argue that critical and feminist pedagogies, as alternatives to traditional pedagogies, may serve post-registration nurses better in their continued struggle for an enhanced status on the multidisciplinary team. I suggested that these pedagogies resonate with Wenger’s (1998) concepts of imagination, engagement and alignment as modes of belonging in the development of identities.
Post-registration nurses tend to develop social networks in the form of study buddies and learning from other nurses in specialist clinical placements. Social networks encourage storytelling and foster the negotiation of meaning through imagination. I argue that higher education lecturers should provide opportunities that encourage the development of social networks in college for post-registration nurses.

On the other hand, I argue that the social networks that the Higher Diploma nurses were exposed to, in the clinical component of their programme, provided an additional enriching experience. A number of concepts from the community of practice theory were supported by the data from the experiences of these nurses including trajectories, imagination, engagement, alignment, legitimate peripheral participation, legitimacy of brokers and boundary object. But I argue that the concept of a broker might be expanded to include not only the coordination and alignment of communities of practice, but the facilitation of newcomers to challenge the status quo within communities of practice. The nursing literature and my data point to an enduring oppression of nurses in the nursing community of practice. I argue that the academic and nursing communities of practice could strengthen their collaboration to facilitate and empower nurses, beyond the higher education classroom, to identify and challenge inequalities they might face in their work and personal lives. This could be done through expanding the role of brokers from both communities to use critical and feminist pedagogies to facilitate nurses to challenge the status quo.

While practical college supports are important influences on post-registration nurses’ experiences while undertaking a higher education programme, practical clinical supports are just as important. Post-registration nurses require clinical resources to support them during their programmes of study. An important type of support is time off to attend classes. The Higher Diploma nurses received this prior negotiated support. But because there was no prior negotiations for this type of support for the ACCS nurses some of them did not receive it. The findings highlight the importance of a collaborative approach between higher education institutions and health service providers to negotiate how nurses will be supported to engage in lifelong learning in higher education. I argue here that Wenger’s (1998) assertion that a community of practice will respond with inventiveness in order to negotiate the enterprise within
constraints and conditions from outside may not always be the case. On the contrary, to negotiate the nursing enterprise practitioners must be supported to engage in lifelong learning, but I argue that learners may be marginalised if the community of practice is not able to respond to imposed resource restrictions. Furthermore, drawing on Wenger’s (1998) concept of stability, I argue that marginalisation may also result from unequal power structures that leave learners powerless to demand support.

Moral support is an important clinical support for post-registration nurses while coping with the challenges of undertaking a higher education programme. Both groups of nurses in this study experienced this type of support from their work colleagues while they engaged in their programmes of study. Drawing the concept of accountability to the joint enterprise I argue that clinical managers and staff nurses, who are accountable to the joint enterprise of nursing, need to give moral support to post-registration nurses in order to encourage them to continue with their studies for the benefit of the enterprise.

**Strengths and limitations of the study**

**Strengths of the study**
The phenomenological approach to this enquiry allowed me the flexibility to explore in depth the lived experience of Irish post-registration nurses undertaking a higher education programme. Thus the dynamic, holistic, and individual aspects of the human experience could be illuminated. The study findings, grounded in real life experiences of the participants, are presented with thick descriptions of their experiences. Thus the reader can judge the transferability of these findings to other contexts and settings.
Limitations of the study

Out of 17 nurses, four of these were male nurses. Although this is a fair representation of males in this cohort, the inclusion of additional males and an exploration of the differences in the experiences between males and females may have enhanced the findings of this study.

Implications

Implications for Nursing Higher Education

Post-registration nurses see the possibilities in higher education in terms of developing their professional identity in order to gain educational equality, acquire knowledge, advance their careers and achieve morale enhancement. Since the time of the data collection in this study, most of the Irish post-registration nurses have either upgraded to a degree in nursing, decided not to or retired. But this does not preclude nurses from ongoing engagement in higher education. Higher education institutions need to continue to provide opportunities for nurses to engage in higher education at levels 8 and 9 in order to promote lifelong learning for nurses. These opportunities may be full programmes, particularly specialist programmes of study or intensive specialist modules that can be added to nurses’ portfolios to accumulate credits towards degrees and masters.

The findings in this study suggested that the Higher Diploma nurses’ specialist programme with a clinical component provided an additional enriching experience for those nurses. The use of the preceptor or broker helped them to negotiate meaning and align formal learning with the community of nursing practice. Higher education institutions need to consider building in clinical components into higher education programmes for registered nurses similar to the provisions that undergraduates experience. But the role of the preceptor/broker needs to be expanded to facilitate undergraduate student nurses and post-registration nurses to challenge to status quo in terms of unequal oppressive structures and anti-academic attitudes towards higher education for nurses. Critical and feminist pedagogies, as opposed to
traditional pedagogies and online banking, within the classroom and in the clinical area may have the potential to provide useful tools to achieve this aim. The academic and nursing communities of practice need to strengthen their collaboration in this regard.

Post-registration nurses in this study referred to the use of online materials as having a positive influence on their experience in higher education. But it appeared that this technology was used as a banking system to upload lecture notes for later retrieval by the students. Given that the findings also suggested that these nurses were time pressured, higher education institutions need to consider how future nursing education programmes could make more efficient use of online modes of delivery of nursing programme for nurses which would reduce the amount of time they need to attend classes. However, consideration should be given to the comfort level of nurses with online delivery and the pedagogical beliefs of the lecturers.

As the findings in this study suggested that lecturers who are approachable had a positive influence on post-registration nurses’ experiences in higher education, lecturers need to continue to adopt this social dimension to the teacher-learner relationship that breaks down barriers enhancing the learning experience.

Post-registration nurses tend to develop social networks in the form of study buddies. The study buddy, as a social network, encouraged storytelling and fostered the negotiation of meaning through imagination for nurses who did not have a clinical component to their programme of study. Higher education lecturers should provide opportunities that encourage the development of these social networks in college for post-registration.

It was acknowledged in this study that nurses experience a lack of confidence in their academic abilities when they enter higher education especially with regards to academic assignment writing. Higher education institutions need to ensure that post-
registration nurses are supported at the commencement of a programme of study and during it to become familiar with academic writing skills. This support should include ongoing supervision of assignments with feedback provided. Flexible deadlines for assignment submission would also help post-registration nurses who have reported in this study that they struggle to get time to complete assignments. In addition to this, lecturers might consider alternative assessment strategies such as journaling, concept mapping, questioning, debates, role play as means to facilitate critical thinking and deeper learning.

**Implications for Nursing Practice**

The availability of funding to pay for college fees and the potential for a promotional grade had a positive influence on post-registration nurses’ motives to engage in higher education. Thus these types of provisions need to continue in order to encourage nurses to engage in higher education in the future.

Post-registration nurses are challenged by a lack of time to do the academic work involved in undertaking a higher education programme. Lack of time was a symptom of juggling work, home and college life. This forced the nurses to make sacrifices, manipulate their work hours or even to defer their studies. To address this, ongoing managerial moral support and collaborative planning for higher education programmes of study between nurses and managers, should ensure that details of the nurses’ work patterns can be worked out so that they can effectively plan their lives around the requirements of college life. Further to this, such collaborative planning can also ensure that nurses are undertaking relevant programmes that are of interest to the nurses and that will benefit the clinical area. This collaborative approach should extend to higher education institutions and health service providers to negotiate a memorandum of understanding on how nurses will be supported to engage in lifelong learning in higher education.
Implications for Policy Makers

In this study the national initiative to increase the entry level education for undergraduate nursing students to degree level prompted the further initiative to provide higher education for post-registration nurses as well. But the resource implications of this appeared to not have been effectively considered. Many nurses wanting to undertake this education meant that staff shortages made it difficult for the nurses to engage in the programmes. Policy makers going forward need to consider carefully the staffing implications of sending nurses on higher education programmes. Funding and replacement staff needs to be put in place for the ongoing education of nurses at higher education level. One option would be to hire agency nurses to bridge the temporary gap.

Implications for Research
As Wenger (1998) suggested, identity formation involves alignment as a mode of belonging. This concept refers for application of learning or aligning one’s practice with the wider community. Whether the nurses in this study aligned their learning when they returned to their respective communities of practice was beyond the scope of this study. Further research could explore how well nurses can align formal learning in higher education into practice.

Seventeen post-registration nurses, four of which were male nurses, took part in this study. While this is a fair representation of males in this sample size future studies might ensure that more male nurses are included and their experiences are compared to female nurses’ experiences.

Final reflection
This study explored a group of Irish post-registration nurses’ experiences of higher education nursing programmes in terms of influences on their motives to engage and their participation in such programmes. Viewing their experiences through the lens of the communities of practice theory, it appeared that the nursing community of practice influenced their motives and their engagement in a higher education programme. In addition to this, the academic community of practice influenced their
experience of engagement in their programme of study. I was struck by the findings in Aiken et al.’s (2014) study that suggested that the more nurses are educated to degree level and given fewer patients to care for, the more the mortality rates went down on hospital wards. This echoes Walby’s (2007) assertion that how women are treated at work has implications for the productivity of the economy. If women are not supported at work productivity suffers (Walby 2007). From these last statements it is evident that, in the interest of patient safety and the provision of quality care, it is crucial that nurses are educated to degree level and beyond. This is where the academic community of practice can have an impact on the care patients receive from nurses. But the nursing community of practice must ensure that nurses’ conditions at work are conducive to safe practice also. Collaboratively, the academic and nursing communities of practice should work together to support nurses in their ongoing lifelong learning endeavours in the interest of safe nursing care for patients.
References


Johanson, E. and Harding, T. (2013) “So I forgot to use 1.5 line spacing! It doesn’t make me a bad nurse!” The attitudes to and experiences of a group of Norwegian post graduate nurses to academic writing. *Nurse Education in Practice, 13*, 366-370.


Appendices
Appendix A Example of Coding Interview Extract

Example of Open Coding Interview Extract

| Just qualified with the diploma in nursing and it was the done thing to go ahead and get a degree |
| Knew the degree would help her career |
| Motivated to do degree by what was happening at the time in nurse education |
| Wants to change job to work in community psychiatry |
| ACCS degree helps when you have to compete at interview for a job |

| Lora: Interview Ten: 2\textsuperscript{nd} April 2007: (DW-A0010) |
| Discussion about why Lora did the ACCS degree |
| Kathleen |
| Why did you do the ACCS course? |
| Lora |
| It was probably because of the, I wouldn’t have been qualified, if I had been longer qualified I could have looked at, but it was because I was only qualified. It was just the done thing where I trained. You automatically went on and done it. And I knew it would benefit my career like you know if I had a degree more so than going in with a diploma…..I wasn’t qualified long enough. I was only a year qualified. It was kind of the next step kind of thing that you had to take |
| Kathleen |
| So the, your decision to take your course was based on what was happening, then at the time. |
| Lora |
| Influence probably from what was happening at the time around me. |
| Discussion about Lora’s regret that she didn’t do the Higher Diploma |
| Lora |
| Well I would like to eventually work in the community. That would be I don’t want to stay in hospitals. And even acute psychiatry, I don’t even, wouldn’t be my area. Community is and I don’t know if the higher, well the degree certainly helps you with mm when you go for the interview you are graded on that kind of thing. |
| Feeling of being tricked | Kathleen  
|                        | A lot of people like yourself took it up. Took up the ACCS course to try and get themselves up to par with the other students who would be coming out with degrees.  
| Better course came along | Lora  
|                        | Yea. It seems like a bit of a con. Kind of. We were tricked. Do this and then suddenly we have a better thing that you know.  
| Feeling of wasting time | Kathleen  
|                        | Mm  
|                        | Lora  
| Like you wasted your year | Kathleen  
|                        | Mm do you feel like, your course that you took isn’t just, wouldn't be as valuable as the Higher Diploma.  
| Feeling that ACCS programme not as valuable as Higher Diploma | Lora  
| Happy she did ACCS degree | I feel like that because so many people are saying that the higher diploma is the thing to do, I do kind of feel that. Not that, I’m glad I done it but I do feel that I would have been better; I might as well have done the higher diploma. Or that if I want to do something now. Some of the jobs they tell you that you have to have your higher diploma.  
| Regret that she didn’t do Higher Diploma | Kathleen  
| Realised that Higher Diploma may be needed for a future job she might want | Yea. What jobs are you interested in that you would want to do the Higher Diploma for.  
| Wants to move to community Psychiatry | Lora  
|                        | Well I’d like to work in the community eventually. Now I know home base and that, if you want, is just a staff nurse. You don’t have to. But there are others.
| Wants to become a CPN  
| Pre requisite to CPN is Higher Diploma |
| Disappointed that she was not advised to do the Higher Diploma to prepare for CPN role. |
| Funding available for Higher Education |
| Felt that Director of Nursing should have discussed career planning in terms of the most appropriate course to take |
| Discussion on career planning not available |

| You know you hear of. I think a CPN, you have to have your Higher Diploma now is it. There is one of those that is a clinical... you have to have your Higher Diploma to do it. |
| Kathleen |
| What's CPN again |
| Lora |
| Community Psychiatric Nurse. |
| Kathleen |
| Ok |
| Lora |
| I think it's that. Do you have to have your Higher Diploma |
| Kathleen |
| I don't know |
| Lora |
| Yea there is something that you have to have your higher diploma anyway it's a, you know. And seeing as the Higher Diploma was there when I was doing it, why wasn't I told. Like when I went looking for funding for the degree why wasn't I told not do that. ……that's what I feel if I had, when I went in for funding, maybe if the Director of Nursing at the time she had have said well I have so many people already actually doing the degree and well like the Higher Diploma is out there would you consider doing that . It might be more beneficial. But there was nothing so. |

**Discussion about attitudes about nurses doing degrees**

| Kathleen |
| Now your colleagues, the others you work with, your nurse colleagues. What was their opinion of you doing higher education? |
| Some colleagues felt threatened by someone doing a degree | Lora  
Mm they would have mm I think there will have been an element of kind of mm the staff would have felt threatened by someone who was and it’s kind of who do you think you are... doing. You know ... oh so you need a degree now to do nursing is that you know. You will have had sarcastic kind of comments from people. So whether it was that people just felt a threat by it or  
Kathleen  
These are the ones now that weren’t taking higher education ok. But that’s all they would say.  
Lora  
Mm  
Kathleen  
So you just sort of felt that they didn’t feel that it was necessary to do any kind of higher education. That the practice or the education they already had was enough.  
Lora  
But I think its people who are afraid to do it themselves and that they just project it that way because really they do think it is beneficial secretly they would like to have the bottle themselves to do it but they just.  
Kathleen  
Yea  
Lora  
You know I don’t think that they think it’s a waste. I think they secretly would like but they are fearful of doing it. Or they are fearful that they wouldn’t be able. And you might look better, you know I think. I think so now I think it’s just insecurities and |
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Some colleagues don’t feel a degree is necessary in order to be a nurse</td>
<td></td>
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<tr>
<td>Lora feels colleagues are just afraid to do the degree</td>
<td></td>
</tr>
</tbody>
</table>
| Colleagues fearful of doing the degree  
Colleagues may be afraid they are not able for the academic aspect of the degree  
Colleagues may feel inferior to someone doing a degree  
Colleagues may feel insecure |  |
<table>
<thead>
<tr>
<th>Had to attend class 2 times a week</th>
<th><strong>Discussion about getting days off to go to class</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Kathleen When you were trying to get to your classes. How often did you have to go to class once a week?</td>
</tr>
<tr>
<td></td>
<td>Lora <strong>Twice a week</strong></td>
</tr>
<tr>
<td></td>
<td>Kathleen Two days a week</td>
</tr>
<tr>
<td></td>
<td>Lora Tuesdays and Thursdays yea</td>
</tr>
<tr>
<td></td>
<td>Kathleen And would your, how did that work. Were you given the days off to go?</td>
</tr>
<tr>
<td></td>
<td>Lora No. I was told when I went into the Director of Nursing to ask for funding for this course. Before I asked I went in and said I am looking to do the ACCS degree. And the first thing she said to me was that’s fine but don’t expect any time off. Any study time. That was my first. So I got no study time. So I could only attend college every other week. Because the way my shifts worked, I would work every second Tuesday and Thursday. So I went every other week. And I felt very much that god they are paying for me to do this and yet they are not really helping me to make sure I pass it.</td>
</tr>
<tr>
<td>Days off to attend class not available</td>
<td></td>
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<tr>
<td>Could only attend class every other week</td>
<td></td>
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<tr>
<td>Did not feel practically supported in clinical to succeed in the course</td>
<td></td>
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</tbody>
</table>
Appendix B  Example of a Procedural Memo

Example of a Procedural Memo based on Lora’s interview 2nd April 2007

Lora, a psychiatric hospital-based staff nurse, wanted to change her job and enhance her career as a nurse. She wanted to redirect her career to work in community psychiatry. She felt she would have to compete at interview with the newly-qualified nurses coming out of college with degrees to make this change. So she wanted to do a degree to level the playing field and give her the best opportunity to succeed at interview to get the job she wanted. Thus her motive to do the degree was influenced by the changes in nurse education in Ireland at the time.

I need to compare Lora’s motives with previous and subsequent interviews to see if there are any commonalities or differences.

Also this discussion may become a subtheme of career advancement under pragmatic motives for undertaking a degree.

I need to take note of where Lora worked, hospital, and see if her experience compares with others in the hospital or indeed the community.

Lora did the ACCS degree but regrets that she didn’t do the Higher Diploma. She is of the opinion that her manager should have advised her on her choice of higher education programme to do. She asks why she was not told. She now realises that the Higher Diploma was a pre-requisite for getting a community psychiatric nurse post. Thus she feels she has wasted time undertaking the ACCS degree when she should have been undertaking the Higher Diploma.

I think this discussion relates to collaborative planning between managers and staff about careers and what education is required to further nurses’ careers. From this discussion it appears that collaborative planning is not done in the hospital environment. This leaves staff nurses to decide for themselves what course they will do. However, it appears that this did not work out well for this participant. Indeed she appears to not have researched the prerequisite education for the career move she wanted to do. There may be some value in collaborative planning where managers and staff nurses work out what careers are of interest to the staff, relevant to the area, and then what education, higher education or otherwise is appropriate.

I need to see if this theme comes up in other interviews and within what context does it appear. So I need to compare Lora’s experience of this issue with other participants working in the hospitals and community to see if there are any commonalities or differences.

It appears that this issue may become a subtheme of supports that influence participants’ motives to undertake higher education.

Lora was working with non-higher educated staff nurse colleagues who didn’t appear to think that undertaking a degree was necessary in order to function as a staff
nurse. Lora analysed this saying that she felt that they were fearful of the academic aspect of undertaking a degree and they may feel intimidated and insecure by others who have degrees.

This discussion appears to be relevant to the context that Lora was in, and it may have influenced Lora’s motives to undertake a higher education programme. It is about the attitudes of Lora’s colleagues about higher education and these attitudes appear to be negative.

This issue may become a subtheme in the theme of positive and negative influences on participants’ motives.

I need to compare this discussion with other interviews and also see if participants in hospital and community settings experience any difference related to this.

Lora reported that she found it difficult to get time off to attend to her studies. She appeared to have difficulty in getting her manager to schedule the required days off for class.

I need to see if this is a common experience for all participants. I am aware that the Higher Diploma nurses had an agreed day off every week to attend class. This was written into the memorandum of understanding between the college and the clinical sites. So I need to see if all the ACCS nurses found it difficult to get the time off to attend classes.
Appendix C Example of a Bracketing Memo

Example of a Bracketing Memo based on Lora's interview 2nd April 2007

Lora’s interview appears to come across quite negative. She appears to not have had good support from the clinical area from the beginning in terms of her desire to engage in higher education (collaborative planning) and then when she was undertaking the programme (time off). It appears from this interview that the support from her manager was not there. This gives me the impression that managers especially in the hospital environment are not supportive of nurses to engage in higher education. I need to be cognisant of the fact that I was of this opinion from before I started this study. I was teaching post-registration nurses on the ACCS and the Higher Diploma programmes and I was hearing from them that they were having difficulty getting support from their managers to attend classes and exams. So I was expecting to hear staff nurses reporting in the negative related to clinical support in this study.

However, I need to suspend my own preconceived ideas about this issue least I bring in this bias to the study findings. I need to be careful, when I am interviewing subsequent participants and when I am analysing interviews, to ensure I don’t lead participants in discussions about clinical support. I need to be open to all experiences in this area positive and negative, so that I can report the experience of the participants and not allow my biases to creep into the findings. I now need to be open to positive stories about nurses’ experiences around getting support from managers.
Appendix D  Giorgi's Method of Data Analysis

Giorgi's Method of Data Analysis

- Read through the text to get a sense of the whole
- Suspend belief of the outer world to avoid having preconceived ideas (bracketing)
- Determine natural meaning units that make up the whole as told by the participants. Do this by re-reading transcripts to identify participants’ experiences related to the phenomenon under study. (Intuiting/analysis))
- Interrogate the natural meaning units and central themes in them. Do this by asking questions of the data related to the research question in an ordered and systematic way. The final themes are developed from this questioning process (Intuiting/analysis)
- Then the themes that are developed are described in relation to the research question (Describe) (Giorgi, 1985).
## Appendix E Data Analysis Summary

### Data Analysis Summary

<table>
<thead>
<tr>
<th>Meaning Units from Open Coding Process</th>
<th>Final Subthemes after Interrogation of Natural Meaning Units</th>
<th>Final Themes after Interrogation of Natural Meaning Units</th>
<th>Overall Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team educational equality</td>
<td>Team educational equality</td>
<td>Educational equality</td>
<td>Motives</td>
</tr>
<tr>
<td>Student educational equality</td>
<td>Student educational equality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence based practice</td>
<td>Evidence based practice</td>
<td>Knowledge acquisition</td>
<td></td>
</tr>
<tr>
<td>Specialist focus</td>
<td>Specialist focus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>To provide better patient care</td>
<td>Altruistic</td>
<td>Career advancement</td>
<td></td>
</tr>
<tr>
<td>Recognition for functioning at advance level</td>
<td>Pragmatic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change job at same level</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prove I can do it</td>
<td>Prove something to self</td>
<td>Morale enhancement</td>
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<tr>
<td>Get self out of a rut/burn out</td>
<td>Get self out of a rut/burn out</td>
<td></td>
<td></td>
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<tr>
<td>Mental stagnation</td>
<td>Mental stagnation</td>
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<tr>
<td>Higher education is common place</td>
<td>Positive attitude towards higher education for nurses</td>
<td>Attitudes towards higher education</td>
<td>Contextual issues influencing motives</td>
</tr>
<tr>
<td>Higher education is too academic</td>
<td>Negative attitudes towards higher education for nurses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Steers nurses away from patient</td>
<td></td>
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<td></td>
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<tr>
<td>Financial backing</td>
<td>Available resources</td>
<td>Resources</td>
<td></td>
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<tr>
<td>Potential promotional benefits</td>
<td>No financial rewards</td>
<td>Managerial moral support</td>
<td>Collaborative planning</td>
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<tr>
<td></td>
<td>Unavailable resources</td>
<td>Effective supports</td>
<td>Supports</td>
</tr>
<tr>
<td>Lack of moral support</td>
<td>Ineffective supports</td>
<td>No collaborative planning</td>
<td></td>
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<tr>
<td>No collaborative planning</td>
<td>Short term courses only suggested</td>
<td>Higher education programmes suggested at odds with interest of nurses</td>
<td></td>
</tr>
<tr>
<td>Make sacrifices</td>
<td>Coping strategy</td>
<td>Lack of time to do academic work</td>
<td>Challenges of taking a higher education programme and coping strategies</td>
</tr>
<tr>
<td>Manipulate work hours</td>
<td>Defer programme</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Get others to review work</td>
<td>Coping strategy</td>
<td>Lack of confidence to do academic work</td>
<td></td>
</tr>
<tr>
<td>Attend all classes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lecturers approachable</td>
<td>Effective teaching strategies</td>
<td>Practical college supports influencing challenges and coping strategies</td>
<td>Contextual issues influencing challenges and coping strategies</td>
</tr>
<tr>
<td>Access to notes online</td>
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<td></td>
</tr>
<tr>
<td>Study buddies</td>
<td>Social networks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Observe new practices on specialist placements</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scheduled days off to attend classes</td>
<td>Resources</td>
<td>Practical clinical supports influencing challenges and coping strategies</td>
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<td>Higher Diploma nurses got agreed days off to attend classes</td>
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<td>Staff nurse colleagues offer practical support swap days or cover work</td>
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<td>Higher educated line manager</td>
<td>Moral support</td>
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<td>Non higher educated staff nurse colleagues</td>
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<td>Days off not scheduled</td>
<td>Lack of resources</td>
<td>Barriers to practical clinical support</td>
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<td>Had to negotiate with staff nurse colleagues</td>
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<td>Not enough staff to cover</td>
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<td>Specialist focus</td>
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<td>Career advancement</td>
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<td>Pragmatic : Recognition for functioning at advance level</td>
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<tr>
<td>Change job at same level</td>
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<td>Morale enhancement</td>
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<tr>
<td>Prove something to self</td>
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<td>Get self out of a rut/burn out</td>
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<td>Mental stagnation</td>
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<td>Higher education is too academic</td>
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<td>Steers nurses</td>
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<td>Resources</td>
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<td>Manipulate work hours</td>
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<td>Defer programme</td>
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<td><strong>Lack of confidence to do academic work</strong></td>
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<td><strong>Coping strategy</strong></td>
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<td>Get others to review work</td>
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<td>Attend all classes</td>
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Appendix G  Letter of Invitation to Participants: One-to-One Interviews

Letter of Invitation to Participants of the Research Project
One-to-One interviews

Irish nursing education has moved into higher education: The lived experience of post-registration nursing students of this policy initiative: A phenomenological study.

Dear Participant,
I am writing to invite you to take part in a research project investigating post-registration nurses’ experiences of undertaking further nursing studies. I am a lecturer in the Department of Nursing at Dundalk Institute of Technology (DKIT) and I commenced study on a Doctor of Education Programme at the University of Sheffield in October 2003. As part of the requirement to graduate, I am currently undertaking a research project investigating the lived experience of undertaking further studies in nursing for registered nurses.

As a participant in the study your input will provide valuable insights into the shared experiences of post-registration nursing students. In addition you will be contributing to the development of the body of knowledge around Registered Nurses’ efforts and experiences of keeping pace with the need to undertake further study.

Your involvement in the study will entail participation in an interview, which will take about one hour to complete. The interview will be tape recorded to ensure that all that is discussed can be later transcribed and adequately analysed. I propose conducting the interviews in the months of January to April 2006. The venue for the interview can be negotiated to ensure that you feel as comfortable as possible.

Your confidentiality in this study will be maintained by using a pseudonym and by only reporting common themes derived from all the interviews. It is anticipated that the findings of this research will be published in nursing and educational journals. You are completely free to decline the invitation to participate in this study. Just before the interview I will ask you to sign a consent form however you can still change your mind about participating in the study at any time without repercussions. To ensure your privacy, the tape-recorded interviews will be stored in a locked filing cabinet in my office at Dundalk Institute of Technology, which is also locked when unattended. The transcripts of these tapes will be stored on computer disk and a backup on the hard drive of my computer in my office at work. The computer disk, when not in use, will be locked in a drawer in my work office or home office. Access to my computers at work and home requires a password, which I alone possess. I will also destroy all transcripts and tape recorded interviews one year after the research is complete.

I would like to take this opportunity to thank you for taking the time to consider my invitation. I can be contacted at the phone numbers and Email address below if you have any further queries regarding the research.
Appendix H  Letter of Invitation to Participants: Focus Group

Date 8th March 2007
Letter of Invitation to Participants of the Study
Focus Group

Irish nursing education has moved into higher education: The lived experience of post-registration nursing students of this policy initiative. A phenomenological study.

Dear Participant,

I am writing to invite you to take part in a research project. I am a lecturer in the Department of Nursing at Dundalk Institute of Technology (DKIT) and I commenced study on a Doctor of Education Programme at the University of Sheffield in October 2003. As part of the requirement to graduate, I am currently undertaking a research project that explores the experiences of Irish post-registration nurses in higher education programmes (ACCS and Higher Diploma).

Your involvement in the study will entail participation in a focus group interview that will take about one hour to complete. I hope to arrange the interview for the period of time during the two weeks after Easter 2007 (the weeks of 16th and 23rd April). The interview will be tape recorded to ensure that all that is discussed can be later transcribed and adequately analysed. The venue, date and time of the interview can be negotiated to reflect that which is most convenient to you and the other participants in the group. However, I anticipate that for your convenience, the most suitable venue will be a room in your college at a time and on a day that you are attending classes.

Your confidentiality in this study will be maintained by using a pseudonym and by only reporting common themes derived from all interviews. You are completely free to decline the invitation to participate in this study without any repercussions. Just before the interview I will ask you to sign a consent form. To ensure your privacy, the tape-recorded interviews will be stored in a locked filing cabinet in my office at Dundalk Institute of Technology. The transcripts of these tapes will be stored on my computer in my work office.

Your input in this project will provide valuable insights into the shared experiences of post-registration nursing students taking higher education programmes. The findings will have implications for education and practice in terms of strengthening the collaborative approach to delivering educational programmes to post-registration nurses. It is hoped that the outcomes of this study will help us to learn more about how to support post-registration nurses in their quest to enhance their professional identity and thus strengthen their ability to pass on that identity to students and contribute to quality care of patients.

The findings of this research will be published in nursing and educational journals. As nursing education has moved into higher education in the last five years the outcomes of this study will be fed into the evaluation process of this policy initiative.
Please let me know of your decision to participate in this study by emailing me at [REDACTED]. Please indicate in your email, the higher education programme you are currently undertaking (ACCS Degree or Higher Diploma) and the day of the week you attend classes.

I would like to take this opportunity to thank you for taking the time to consider my invitation. I can be contacted at the phone numbers and Email address below if you have any further queries regarding the research.

Regards

Miss Kathleen Rooney

**Lecturer**

Dundalk Institute of Technology  
**Dublin Road, Dundalk, Co. Louth, Ireland**

Phone Work: [REDACTED]  
Mobile: [REDACTED]  
Email: [REDACTED]
Appendix I Participant Consent Form

Title of Project: *Irish nursing education has moved into higher education: The lived experience of post-registration nursing students of this policy initiative. A phenomenological study.*

Name of Researcher: Kathleen Rooney

Participant Identification Number for this project:

Please initial box

1. I confirm that I have read and understand the information sheet dated: [Date] for the above project and have had the opportunity to ask questions.

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

3. I understand that my responses will be anonymised before analysis. I give permission for members of the research team to have access to my anonymised responses.

4. I agree to take part in the above project.

Name of Participant __________________________ Date __________________________ Signature __________________________

Name of Person taking consent (if different from researcher) __________________________ Date __________________________ Signature __________________________

Researcher __________________________ Date __________________________ Signature __________________________

Copies:

One copy for the participant and one copy for the Principal Investigator / Supervisor.
Appendix J  Sheffield Ethical Approval Email

From: JEAN BOOKER
To: 
Subject: EdD(Dublin) - Ethics Application Approval
Send reply to: 
Date sent: Thu, 3 Nov 2005 14:15:45 -0000

Dear Kathleen

EdD (Dublin)

"Irish nursing education has moved into higher education: The lived experience of post-registration nursing students of this policy initiative. A phenomenological study"

The above Project has now been ethically reviewed and approved with the following suggested, optional amendments (i.e. it is left to the discretion of the applicant whether or not to accept the amendments and, if accepted, the ethics reviewers do not need to see the amendments):

Issues of potential psychological distress (eg that could arise from being identified) are not addressed in A7 of the form. However, this issue is addressed in terms of procedures actually in place (eg data storage). It is important that the potential for psychological distress is considered within the supervision of the thesis to check the student is fully aware of this matter.

Suggest acknowledging that the answer to question A5 is not exactly accurate, the research will not ‘involves only anonymised or aggregated data’.

With best wishes

Jean Booker
EdD (Dublin) Course Secretary
Appendix K  GMIT Letter to Head of Department

Ms. Geraldine Murray,  
Head of Nursing and Health Science,  
Dept of Nursing and Health Science,  
Galway Mayo Institute of Technology,  
Castlebar,  
Co Mayo,  
.

Dept. of Nursing, Midwifery & Health Studies,  
Dundalk Institute of Technology,  
Dublin Road,  
Dundalk,  
Co. Louth.

Phone: [Redacted]  
Mobile: [Redacted]  
Email: [Redacted]

Date: 26th February 2007

Dear Geraldine

Thank you for agreeing to allow the post-registration nursing students at GMIT to volunteer for my study titled: Irish nursing education has moved into higher education: The lived experience of post-registration nursing students of this policy initiative: A phenomenological study. The overall aim of the study is to explore the experiences of post-registration nurses undertaking a higher education programme (ACCS and Higher Diploma programmes). Additionally, I am interested in examining what influences their experience.

As a lecturer in the Department of Nursing at Dundalk Institute of Technology (DKIT) I commenced study on a Doctor of Education Programme at the University of Sheffield in October 2003. As part of the requirement to graduate, I am required to carry out this research project.

To collect the data I am conducting one-to-one interviews here in DKIT (with ACCS and Higher Diploma students) but I would like to conduct a focus group interview with the ACCS students in GMIT for the purpose of comparison of participants’ experiences and triangulation of data. My task now is to get volunteers, and set up the focus group interview.

As you have already advised, I am making contact with Maggie Wood to facilitate me with getting the interview underway.

My plan now is to forward to all of the ACCS students a cover letter via email inviting them to partake in the study and explaining more about what is expected from them. I have my email address in the cover letter and I have asked them to reply directly to me via email if they would like to partake. I have asked Maggie Wood to forward the cover letter to the students via your college email system. As trying to get volunteers via email could prove unfruitful I am sending the cover letter in hard copy as well. I hope Maggie will be able to help me to distribute these by placing them in the class with the students so they can be further reminded of my invitation.
If I do get volunteers I will then be able to communicate with them via email directly to arrange a suitable date and time agreeable to all participants to conduct the interview. Then I will request Maggie to book a room at GMIT so that I can conduct the interview.

I anticipate that the focus group interview will take about one hour to complete. I hope to arrange the interview for the period of time during the two weeks after Easter 2007 (the weeks of 16th and 23rd April). Just before the interview I will ask participants to sign a consent form.

I anticipate that the findings from this study will provide valuable insights into the shared experiences of post-registration nursing students taking higher education programmes. The outcomes will have implications for education and practice in terms of strengthening the collaborative approach to delivering educational programmes to post-registration nurses. It is hoped that the outcomes of this study will help us to learn more about how to support post-registration nurses in their quest to enhance their professional identity and thus strengthen their ability to pass on that identity to students and contribute to quality care of patients.

The findings of this research will be published in nursing and educational journals. As nursing education has moved into higher education in the last five years the outcomes of this study will be fed into the evaluation process of this policy initiative.

I would like to take this opportunity to thank you for helping me to complete this part of the study. I will continue to make contact with Maggie Wood in this regard. I can be contacted at the phone numbers and Email address below if you have any further queries regarding the research.

Regards

Miss Kathleen Rooney

Lecturer
Dundalk Institute of Technology
Dublin Road, Dundalk, Co. Louth, Ireland
Phone Work: [Redacted]
Mobile: [Redacted]
Email: [Redacted]
Appendix L  GMIT Permission to Conduct Study

Subject: Re: Fwd: Focus group interview with post-reg nurses at GMIT
From: Kathleen Rooney
Date: Thu, 01 Mar 2007 09:32 +0000
To: Geraldine Murray, Maggie Wood

Dear Geraldine

Thank you very much for your assistance in this matter.
I will get in touch with Maggie to make the arrangements.
Perhaps I will see you when I go over to do the interview.

Regards

Kathleen

Geraldine Murray wrote:

Hello [Redacted]

Thank you for your email and contents.
We would be delighted for your participation in focus groups as identified below.

Maggie Wood currently co-ordinates the cohort so perhaps you can correspond with her in this regard.
I have included her on this email for convenience and her contact number is [Redacted]

Best of luck with the process

Geraldine

Geraldine Murray
Head of Nursing and Health Sciences
Galway Mayo Institute of Technology @ Castlebar
Westport Road
Castlebar
Co Mayo
Email: [Redacted]
Telephone: [Redacted]

Maggie Wood 28/02/2007 12:09 >>>

Hi Geraldine
Kathleen is a former colleague of mine. I would be more than happy for her to go ahead with this research.

Maggie

Geraldine Murray 26/02/2007 15:28 >>>

Ladies
Would you be happy for Kathleen to proceed with these focus groups

Geraldine
Geraldine Murray
Re: Fwd: Focus group interview with post-reg nurses at GMIT

Head of Nursing and Health Sciences
The McHugh Centre
Galway Mayo Institute of Technology @ Castlebar
Westport Road
Castlebar
C/o Mayo
Email: 

Kathleen Rooney [REDACTED] 26/02/2007 09:14 >>>

Dear Ms Murray

My name is Kathleen Rooney and I am a lecturer in Dundalk Institute of Technology. I would like to ask your permission to do a focus group interview with volunteer post-reg nurses from the level ACCS programme in GMIT.

I am doing an EdD through Sheffield University, and I am interviewing similar participants from our own college. I am asking them about the impact of higher education on their professional identity. I would like to get the views of the post-reg students in GMIT also.

I have investigated the possibility of doing a focus group interview in Letterkenny and Georgy McFadden's response has been positive. I am also awaiting Athlone's response. By expanding the research to other colleges that teach the same programme as us, I hope to verify the information our students are telling me therefore strengthening the claims I might be making in the research.

If I was able to access the students in GMIT, would I have to go through an ethical approval process in GMIT to carry this out? Of course, I have ethical approval at my college in Sheffield but I was wondering if it would be necessary in GMIT.

I look forward to hearing from you.

Regards

Kathleen Rooney
Mr. George Mc Fadden,  
Director of Nursing Studies, 
Department of Nursing Studies, 
Letterkenny Institute of Technology, 
Port Road, 
Letterkenny, 
Co. Donegal. 

Date: 8th March 2007

Dear George
Thank you for agreeing to allow the post-registration nursing students at Letterkenny IT to volunteer for my study titled: Irish nursing education has moved into higher education: The lived experience of post-registration nursing students of this policy initiative: A phenomenological study. The overall aim of the study is to explore the experiences of post-registration nurses undertaking a higher education programme (ACCS and Higher Diploma programmes). Additionally, I am interested in examining what influences their experience.

As a lecturer in the Department of Nursing at Dundalk Institute of Technology (DKIT) I commenced study on a Doctor of Education Programme at the University of Sheffield in October 2003. As part of the requirement to graduate, I am required to carry out this research project.

To collect the data I am conducting one-to-one interviews here in DKIT (with ACCS and Higher Diploma students) but I would like to conduct focus group interviews in Letterkenny IT for the purpose of comparison of participants’ experiences and triangulation of data. My task now is to get volunteers, and set up the focus groups. From the Letterkenny IT website I see that you offer Higher Diplomas in Science in a number of Specialist Nursing areas. I did not see the ACCS programme mentioned on the website. So I am not sure if you offer this programme as well. If you do offer this programme then I am interested in talking to both your ACCS students and your Higher Diploma students.

I would like to conduct one focus group interview with your ACCS students and another focus group interview with Higher Diploma students. So two interviews in all, that is if you have an ACCS programme currently running.

My plan now is to forward to all of the students (ACCS and Higher Diploma) a cover letter via email inviting them to partake in the study and explaining more about what is expected from them. I have my email address in the cover letter and I have asked them to reply directly to me via email if they would like to partake. I would be grateful if you could forward the cover letter to the students via your college email system. As trying to get volunteers via email could prove unfruitful I am sending the
cover letter in hard copy as well. I would appreciate your help in placing these in the class with the students so they can be further reminded of my invitation.

If I do get volunteers I will then be able to communicate with them via email directly to arrange a suitable date and time agreeable to all participants to conduct the interviews. Then I would be grateful if I could have your permission to utilize a room at Letterkennedy IT to conduct the interviews.

I anticipate that the focus group interviews will take about one hour each to complete. I hope to arrange the interviews for the period of time during the two weeks after Easter 2007 (the weeks of 16th and 23rd April). Just before the interviews I will ask participants to sign a consent form.

I anticipate that the findings from this study will provide valuable insights into the shared experiences of post-registration nursing students taking higher education programmes. The outcomes will have implications for education and practice in terms of strengthening the collaborative approach to delivering educational programmes to post-registration nurses. It is hoped that the outcomes of this study will help us to learn more about how to support post-registration nurses in their quest to enhance their professional identity and thus strengthen their ability to pass on that identity to students and contribute to quality care of patients.

The findings of this research will be published in nursing and educational journals. As nursing education has moved into higher education in the last five years the outcomes of this study will be fed into the evaluation process of this policy initiative.

I would like to take this opportunity to thank you for helping me to complete this part of the study. I can be contacted at the phone numbers and Email address below if you have any further queries regarding the research.

Regards

Miss Kathleen Rooney

Lecturer
Dundalk Institute of Technology
Dublin Road, Dundalk, Co. Louth, Ireland
Phone Work: 
Mobile: 
Email: 

Appendix N LyIT Permission to Conduct Study

Restructuring the Professional Identity of Irish Post Registration Nurses

Subject: Restructuring the Professional Identity of Irish Post Registration Nurses
From: "McFadden George"
Date: Thu, 8 Mar 2007 10:16:11 -0000
To:]

Dear all,

I am forwarding the attached on behalf of Ms. Kathleen Rooney who is a Lecturer in Nursing at Dundalk Institute of Technology. She is currently undertaking a study as part of her Doctor of Education Degree and would appreciate your volunteering to participate in this study.

Please see attached for further details. Should you wish to volunteer to be included in this study please e-mail Kathleen directly.

Regards,
George Mc Fadden

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Appendix O  DkIT Letter to Head of Department

To: Mr. Gerry Mc Taggart, Head of Dept. of Nursing, Midwifery and Health Studies  
Dundalk Institute of Technology (DkIT)  
Dublin Road,  
Dundalk,  
Co. Louth.

From: Kathleen Rooney  
Lecturer, Dept. of Nursing, Midwifery and Health Studies  
Dundalk Institute of Technology,  
Dublin Road,  
Dundalk,  
Co. Louth.

Phone: [redacted]  
Mobile: [redacted]  
Email: [redacted]

Date: 1st September 2005

Dear Gerry,

I am writing to request approval to conduct a research project, which I am undertaking in the Department of Nursing, Midwifery and Health Studies. I commenced study on a Doctor of Education programme at the University of Sheffield in October 2003. As part of the requirement to graduate, I am currently undertaking a research project that explores the experience of post-registration Irish nurses undertaking a higher education programme.

The title of the study is: Irish nursing education has moved into higher education: The lived experience of post-registration nursing students of this policy initiative: A phenomenological study.

I am seeking to interview post-registration nursing students undertaking the ACCS and Higher Diploma nursing programmes here at Dundalk Institute of Technology. The involvement of the students entails participation in one-to-one interviews that will take about one hour to complete. I hope to arrange the interviews for the period of time during February and March 2006. The interviews will be tape recorded to ensure that all that is discussed can be later transcribed and adequately analysed. The venue, date and time of the interviews will be negotiated with the participants to reflect that which is most convenient to them.

Participant confidentiality in this study will be maintained by using pseudonyms and by only reporting common themes derived from all interviews. Participants are completely free to decline the invitation to participate in this study without any repercussions. Just before the interview I will ask participants to sign a consent form. To ensure privacy, the tape-recorded interviews will be stored in a locked filing...
cabinet in my office at Dundalk Institute of Technology. The transcripts of these tapes will be stored on my computer in my work office.

I anticipate that the outcomes of this study will provide valuable insights into the shared experiences of post-registration nursing students taking higher education programmes. The findings will have implications for education and practice in terms strengthening the collaborative approach to delivering educational programmes to post-registration nurses. It is hoped that the outcomes of this study will help us to learn more about how to support post-registration nurses in their quest to enhance their professional identity and thus strengthen their ability to pass on that identity to students and contribute to quality care of patients.

The findings of this research will be published in nursing and educational journals. As nursing education has moved into higher education in the last five years the outcomes of this study will be fed into the evaluation process of this policy initiative.

I would like to take this opportunity to thank you for taking the time to consider my study. I can be contacted at the phone numbers and Email address below if you have any further queries regarding the research.

Regards

Miss Kathleen Rooney

Lecturer
Dundalk Institute of Technology
Dublin Road, Dundalk, Co. Louth, Ireland
Phone Work: [redacted]
Mobile: [redacted]
Email: [redacted]
23rd March 2007

Ms Kathleen Rooney
Lecture
Dept of Nursing Midwifery & Health Studies
Dundalk Institute of Technology
Dundalk
Co Louth

RE: Research Study (Ed D Degree)

Dear Kathleen,

Thank you for your letter requesting approval to conduct your research project with students registered with the Department of Nursing, Midwifery and Health Studies DkIT which I received today. My examination of the documentation provided suggest that this is a very interesting research area and should contribute to the development of our understanding of the Restructuring of the Professional Identity of Irish Post-registration Nurses.

I am therefore pleased to grant you permission to conduct the study with post registration nursing students at this Institute.

I would advise however that you consider the need to seek permission from the Health Service Managers who employ the students you intend using for data collection as a number of the questions appear to relate to service issues.

Can I wish you every success with your research.

Yours sincerely,

Gerry Mc Taggart
Head of Department of Nursing Midwifery & Health Studies
## Appendix Q Semi Structured Topic Guide

### Semi Structured Topic Guide

<table>
<thead>
<tr>
<th>Research Objectives</th>
<th>Probing Questions</th>
</tr>
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</table>
| To find out the demographic profile of the participants                              | Participant Name  
What discipline do you work in? (Psych, Gen, ID)  
What setting do you work in?  
Where in the region?  
What is your gender?  
What is your personal situation (Wife, mother, father, children, looking after a parent)?  
Are you working full time or part time?  
How many years are you qualified?  
What rank are you at work?  
What programme are you taking? |
| To find out participants’ motives to engage in Higher Education and what influenced their decision to engage | Can you tell me why you choose to do this programme?  
What were your expectations of the course?  
What kind of professional role were you intending to develop?  
What influenced your decision? |
| To find out participants’ experiences of undertaking a Higher Education Programme     | Can you tell me about your experience of taking a Higher Education Programme?                                                                  |
| To find out facilitating or preventative factors in participants’ attempts to gain a Higher Education Programme | What were the challenges you faced?  
What kind of support did you experience (clinical or college)? |
Appendix R Learning outcomes ACCS programme

Learning outcomes
B.Sc. (Hons) in Nursing (ACCS) programme

On completion of the programme the graduate will be able to:

1. Critically evaluate the contribution of the core concepts of research, contemporary issues in healthcare and applied sciences in the provision of a quality and equitable health service.

2. Evaluate in a critical manner the knowledge, skills and attitude required to deliver optimal care within the health care environment.

3. Demonstrate an appropriate level of competence and critical thinking ability, which enhances assessment, planning, delivery and evaluation of nursing care through discursive knowledge, reflection and evidence-based practice.

4. Analyse the cultural, political, economic, social and ethical factors that influence decision-making in the delivery of direct and indirect nursing care.

5. Demonstrate effective communication and interpersonal skills in the delivery of evidence-based health care.

6. Critically evaluate collaborative practice within the context of a changing and evolving health care system.

7. Develop, implement and evaluate policies and criteria for appropriate nursing interventions across a wide range of health services.

8. Ensure that professional accountability is maintained in accordance with clinical guidelines to ensure the safe and effective delivery of healthcare.

9. Through evidence-based knowledge, empower patients and their families and other members of the interdisciplinary team, whilst ensuring that appropriate treatment and optimal care is being implemented.

(Dundalk Institute of Technology 1998).
Appendix S  Learning outcomes Higher Diploma

Learning outcomes
Higher Diploma

On completion of this programme the student will be able to:

1. Critically evaluate the contribution of the core concepts of research, management, and contemporary issues in healthcare, in the provision of a quality and equitable health service.

2. Evaluate in a critical manner the specialist knowledge and skills required to deliver optimal care in a healthcare environment.

3. Demonstrate an appropriate level of competence and critical thinking ability in relation to the assessment, planning, delivery and evaluation of care in specialist nursing practice.

4. Analyse the cultural, political, economic, social and ethical factors that influence decision making in the delivery of direct and indirect care in specialist nursing practice.

5. Demonstrate effective communication and interpersonal skills in the delivery of evidence-based healthcare.

6. Implement the skills necessary to act as a patient advocate.

7. Demonstrate critical thinking ability which enhances clinical diagnosis, treatment implementation and evaluation through discursive knowledge, reflective of evidence-based practice.

8. Develop, implement and evaluate policies and criteria for appropriate nursing interventions across a wide range of health services.

9. Ensure that professional accountability is maintained in accordance with clinical guidelines to ensure the safe and effective delivery of healthcare.

10. Through evidence-based knowledge, empower patients and their families and other members of the interdisciplinary team, whilst ensuring that appropriate treatment and optimal care is being implemented.

(Dundalk Institute of Technology 2003)